



# **Study on Corruption in the Healthcare Sector**

*HOME/2011/ISEC/PR/047-A2  
October 2013*

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## **ABSTRACT**

The objectives of the study are: to enable a better understanding of the extent, nature and impact of corrupt practices in the healthcare sector across the EU; and to assess the capacity of the MSs to prevent and control corruption within the healthcare system and the effectiveness of these measures in practice. This study focused on three areas of healthcare: medical service delivery; procurement and certification of medical devices; and procurement and authorisation of pharmaceuticals.

On the basis of desk research, interviews (with EC officials and representatives of health professional's organisations, medical device industry, pharmaceutical industry and health insurers), field research in all 28 EU MSs and analysis of a total of 86 corruption cases, six typologies of corruption have been identified: bribery in medical service delivery; procurement corruption; improper marketing relations; misuse of (high) level positions; undue reimbursement claims; and fraud and embezzlement of medicines and medical devices.

The study concludes that corruption in the health sector occurs in all EU MSs and that both the nature and the prevalence of corruption typologies differ across the EU member States. The study shows that there is no single policy in the successful fight against corruption in the health sector. What is needed is a combination of effective generic anti-corruption policies and practices (legislation, enforcement), policies and practices aimed at addressing fundamental health system weaknesses (managerial and financial), a general rejection of corruption by society (including a self-regulation by health sector actors), and specific anti-corruption in healthcare policies and practices.

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Developed by

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## Table of Contents

Executive summary .....	8
<b>1 Introduction .....</b>	<b>12</b>
1.1 Research objectives .....	12
1.2 Research approach .....	12
1.3 Terminology .....	15
1.4 Legal context .....	21
1.5 Structure of this report .....	24
<b>2 Healthcare and corruption .....</b>	<b>25</b>
2.1 Introduction .....	25
2.2 Informal payments .....	31
2.3 Medical devices .....	34
2.4 Pharmaceuticals .....	40
<b>3 Typologies of healthcare corruption .....</b>	<b>47</b>
3.1 Introduction .....	47
3.2 Towards a corruption-in-healthcare typology .....	50
3.3 Bribery in medical service delivery .....	53
3.4 Procurement corruption .....	63
3.5 Improper marketing relations .....	63
3.6 Misuse of (high level) positions .....	83
3.7 Undue reimbursement claims .....	87
3.8 Fraud and embezzlement .....	91
3.9 Misuse of legal rights .....	92
<b>4 Policies and practices .....</b>	<b>97</b>
4.1 Introduction .....	97
4.2 Generic policies and practices .....	99
4.3 Control and sanctioning .....	106
4.4 Bribery in medical service delivery .....	111
4.5 Procurement corruption .....	116
4.6 Improper marketing relations .....	120
4.7 Critical patient, pressure group and media involvement .....	131
4.8 Findings .....	141
<b>5 Conclusions and recommendations .....</b>	<b>144</b>
Annex A 86 cases of corruption in health .....	151
Annex B Eurobarometer perceptions .....	180
Annex C EU 28 MS research .....	181

**Annex D Country reports ..... 184**

Austria .....	188
Belgium.....	194
Bulgaria .....	200
Croatia .....	206
Cyprus .....	210
Czech Republic.....	214
Denmark .....	221
Estonia.....	224
Finland.....	228
France.....	232
Germany .....	237
Greece .....	242
Hungary .....	247
Ireland.....	252
Italy.....	256
Latvia .....	260
Lithuania .....	264
Luxembourg .....	269
Malta .....	273
The Netherlands .....	278
Poland.....	284
Portugal .....	288
Romania.....	293
Slovakia .....	298
Slovenia .....	302
Spain .....	307
Sweden .....	311
United Kingdom.....	315

**Annex E Country profile template ..... 319**

## Preface

Ecorys is pleased to submit this final report for the Study on Corruption in the Healthcare Sector (HOME/2011/ISEC/PR/047-A2) commissioned by the European Commission (EC) Directorate-General Home Affairs.

This report builds upon desk research (December 2012 and January 2013), field research in the 28 EU MS (February and March 2013) and analysis of all information gathered (April, May and June 2013). We thank all contributors for their willingness to cooperate and their time.

The study involved a close cooperation between Ecorys, the European Healthcare Fraud & Corruption Network (EHFCN) and individual country correspondents in 28 European Union (EU) Member States (MSs). The core team for this study consisted of health and corruption experts from Ecorys: Lorian de Boer, Jakub Gloser, Arthur ten Have, Dr. Wija Oortwijn, Dr. Brigitte Slot (team leader), Geiske Tjeerdsma and Kim Weistra, and Paul Vincke from EHFCN. Our network of EU-28 rapporteurs was composed of local Ecorys researchers, EHFCN contact persons and independent health system experts.

## Executive summary

This section summarises the objectives, methodology, key findings, and presents the overall conclusions and highlights recommendations from the Study on Corruption in the Healthcare Sector.

### Objectives

The study serves as input to the first EU Anti-Corruption Report, which is part of the overall anti-corruption strategy initiated by the European Commission in 2011. The main objectives of the study are centred on gaining better understanding on the nature, extent and impact of corruption in the healthcare sector across the whole territory of the EU Member States (MSs) and analysing the capacity and the effectiveness of policies to combat corruption in healthcare.

More specifically, the objectives are to:

- enable a better understanding of the extent, nature and impact of corrupt practices in the healthcare sector across the EU;
- assess the capacity of the MSs to prevent and control corruption within the healthcare system and the effectiveness of these measures in practice.

The focus lies on three areas of healthcare: (i) medical service delivery (various forms of informal payments); (ii) procurement and certification of medical devices; and (iii) procurement and authorisation of pharmaceuticals.

### Methodology

To address the objectives, we used desk research, interviews (with EC officials and representatives of health professionals' organisations, medical device industry, pharmaceutical industry and health insurers) and field research in the 28 EU MSs. The field research included, per MS, 3–4 interviews with healthcare and anti-corruption stakeholders, a description of 3–6 cases of corruption in healthcare and a description of policies and practices to control corruption using national sources. Thereafter, all information gathered was analysed to produce a reasoned set of conclusions and recommendations.

### What we found

It seems from our initial analysis of the 86 selected cases that the various types as they are generally defined in the corruption literature (bribery, kickbacks, conflict of interest, nepotism etc.) are not a useful discriminating criterion for a deeper analysis of the drivers and prevalence of corruption in health. Corruption is a complex phenomenon and single cases often include several types of corruption. To come to an analytically, practically and policy-wise meaningful grouping of corruption in health typologies the cases were grouped on the basis of similarities and common attributes.



On the basis of this study, six typologies of corruption in the selected healthcare areas have been identified:

- bribery in medical service delivery;
- procurement corruption;
- improper marketing relations;
- misuse of (high) level positions;
- undue reimbursement claims;
- fraud and embezzlement of medicines and medical devices.

Bribery in doctor to patient service delivery is the most visible form of corruption in healthcare. In the area of medical devices and pharmaceuticals, procurement corruption and improper marketing relations appear to be the most prevalent types of corruption.

We conclude that corruption in the health sector occurs in all EU MSs and that both the nature and the prevalence of corruption typologies differ across the MSs. Czech Republic, Latvia, Croatia, Slovakia, Romania, Italy, Bulgaria and Greece are considered having a widespread corruption problem and seem to encounter more bribery in medical service delivery, procurement corruption and misuse of (high) level positions. More specifically, bribery in medical service delivery occurs most frequently, and is considered systemic, in (former) transition economies of Central and Eastern Europe. In Western European countries, bribery in medical service delivery is more rare and restricted to specific areas such as isolated cases in pre- and post-surgery treatment. Procurement corruption and improper marketing relations by providing money or sponsoring of conferences, trips and leisure activities occur throughout the EU. Healthcare procurement corruption seems to occur less frequently in countries where public procurement is highly regulated.

Corruption in healthcare may be provoked by weaknesses in the healthcare system (low salaries, relatively low levels of healthcare spending or research budgets, close ties between the industry and healthcare providers) or flaws and loopholes in healthcare supervision, anti-corruption legislation or judicial effectiveness. Integrity violations and misuse of rights and opportunities depend on personal motivations, norms and values.

A general acceptance, or at least tolerance, of corruption is considered one of the main drivers behind widespread corruption in healthcare. This applies to all of the described corruption typologies. Corruption and conflicts of interest will persist as long as it accepted to offer or receive financial or other benefits.

However, we encountered in almost all MSs an overall decline in tolerance of corruption. This applies again to all of the described corruption typologies. Corruption scandals, effective sanctioning, the implementation (and enforcement) of stricter anti-corruption and healthcare transparency regulations, self-regulation initiatives by the industry or healthcare providers, EU accession, increased living standard, and the economic crisis, all have contributed to a general increase awareness and decreased public acceptance of corruption in healthcare.

There is in no single policy in the successful fight against corruption. However, it is clear from our research that all successful policies in the fight against corruption are a combination of strong, independent institutions, and a general rejection of corruption by the society.

## **Recommendations**

### **EU level**

To address drivers of corruption that prevail in all EU MSs, EU-wide policies are needed. It is recommended to:

- a) set clear and effectively enforced general anti-corruption rules (e.g. like the UK Bribery Act and US Foreign Corrupt Practices Act),
- b) introduce independent and effective judicial follow up on corruption cases, and
- c) implement sound and transparent general procurement systems.

General public procurement policies should also apply for the healthcare sector.

Another aspect that can be addressed at EU level concerns self-regulation, for example through a Code of Conduct or Code of Ethics of the industry. Self-regulation should also be organised at a national level.

### **National level**

At national level it is recommended that MSs have structures that specifically deal with fraud and corruption in the healthcare sector. These structures should not only have a mandate to control, but also to sanction violations. In addition, transparency in healthcare systems should be improved, for example by publication of waiting lists (and queuing times). Also, transparency in the relations between the industry and healthcare providers can be initiated by either the sector itself or government policies (such as transparency enhancing initiatives resembling the Sunshine Act). The obligation of physicians to prescribe generic instead of brand medicines is another good transparency enhancing policy that can be stimulated at MS level.

Finally, it is important for national governments to stimulate – independent – media involvement, ‘civil society’ watchdogs and patient groups to identify and report on corruption. Awareness raising campaigns and fraud and corruptions reporting hotlines are good examples of mobilisation of countervailing powers.

### **Research**

As undue reimbursement claims is currently high on the agenda of some MSs, it is recommended to study the actual scale of the issue and possible policies that may form a remedy. In addition, little research has been carried out establishing the scope, scale and actual impact of informal payments in the healthcare sector in higher income countries. To get a full picture of the size of the problem, we recommend to initiate research targeted at those countries.

Finally, we found that policies and practices that work in one country do not necessarily work in another country. As the effectiveness of a policy depends on multiple factors, simply developing policies such as Sunshine Act -like initiatives will most likely prove insufficient. We therefore recommend to systematically evaluating the policies and their effects to enable successful implementation in specific contexts.

# 1 Introduction

The study is part of the overall anti-corruption strategy of the European Commission (EC). Through the anti-corruption package adopted in June 2011, the EC pledged for a reinforced EU policy against corruption. This covers, among other initiatives, the set-up of an anti-corruption reporting mechanism to evaluate the Member States' efforts in fighting corruption. This 'EU Anti-Corruption Report' assesses the situation in the EU regarding the battle against corruption on a bi-annual basis. It focuses on a number of crosscutting and country-specific issues considered most relevant at the EU and national level – of which corruption in the healthcare sector is currently one of the prominent policy issues. As such, the assessment carried out through the study also serves as an input to the first EU Anti-Corruption Report.

## 1.1 Research objectives

The purpose of this study is two-fold and aims to:

- enable a better understanding of the extent, nature and impact of corrupt practices in the healthcare sector across the EU;
- assess the capacity of the MSs to prevent and control corruption within the healthcare sector and the effectiveness of these measures in practice.

Answering the questions underlying the first objective includes, among other things: describing and analysing patterns of corruption in the EU MSs; identifying specific healthcare corruption problems in specific MSs; if possible estimating the extent and depth of various corruption typologies in the EU; and identifying and analysing illustrative cases. For the second objective the aim is to identify good practices that have shown some results – even partial progress – in preventing or controlling corruption in healthcare as well as some unsuccessful policies and practices.

To focus the research it was decided to limit the health sector to three focus areas:

- medical service delivery (various forms of informal payments);
- procurement and certification of medical devices;
- procurement and authorisation of pharmaceuticals.

## 1.2 Research approach

Our research consisted of three phases: desk research, fieldwork in 28 EU MSs and analysis of the findings and reporting. An overview of the main activities, the timeframe and the team involved per phase is presented in table 1.1.

**Table 1.1 Research activities**

Phase I	Phase II	Phase III
Desk research	Field research	Analysis
December 2012 – January 2013	February – March 2013	April – July 2013
Literature analysis Expert consultation Interviews at EU level	Interviews in 28 MS National literature search in 28 MS Case identification in 28 MS	Analysis of field findings Additional research in some MS Reporting (July 2013)
Core team	Ecorys/EHFCN rapporteurs	Core team

Our general approach is presented in figure 1.1. We started with observations on corruption in healthcare and current policies and practices to fight this in all 28 EU MSs. On the basis of these observations, corruption in healthcare ‘typologies’ (patterns) were identified and described in detail. An understanding of the complexities of the problem was needed to identify successful and unsuccessful anti-corruption policies and practices in healthcare. Finally, conclusions and policy recommendations were formulated.

**Figure 1.1 Research approach**

### Phase I. Desk research

In phase I we conducted several explorative interviews with EC officials and representatives of health professionals organisations, medical device industry, pharmaceutical industry and health insurers. The aim was to gain a better understanding and a general picture of the nature and impact of corrupt practices as well as existing policy mechanisms within the EU. We also organised an expert panel meeting in January 2013 and conducted extensive literature research.<sup>1</sup>

Given the wide objectives of this study, the complexity of the corruption phenomenon and the variety of factors influencing it, we decided to follow an inductive research approach (sometimes informally labelled as a ‘bottom-up’ approach). As explicitly formulated in the terms of reference for this assignment, the study is concentrated at practical aspects keeping the theoretical part to a minimum. Moreover, the study did not limit itself to issues that are comparable across the EU MSs, but also focused on the specifics of each MS and on illustrative case studies.

<sup>1</sup> The expert meeting was attended by the core team, including Paul Vinke (President of the executive committee of the European Healthcare Fraud & Corruption Network (EHFCN)); Piotr Mierzewski, EHFCN Poland; Jan Maarten de Vet (director Ecorys Brussels); Prof. Dr. Wim Groot (Professor of Health Economics at the Department of Health Services Research at the Maastricht University, the Netherlands. Scientific coordinator of the ASSPRO project); Prof. Dr. Marcel Canoy (Professor at Tilburg Law and Economics Center (TILEC) University of Tilburg in the field of the economics of healthcare).

## **Phase II. Field research**

In phase II we collected qualitative information and quantitative data in a systematic and coherent manner across all EU 28 MSs by using extensive country reports which were shared with the EC as working documents but are not final outputs of this research. The country reports have been translated into short country profiles for the purpose of inclusion in this final report and can be found in Annex D.

The Ecorys/EHFCN network of rapporteurs, conducted the actual field research. An overview of our EU 28 network of rapporteurs is presented in Annex C. All country rapporteurs received instructions regarding how to conduct the research. This included:

- to conduct 3 to 4 interviews with different healthcare and anti-corruption stakeholders;
- to collect and describe 3 to 6 cases of corruption in healthcare;
- to collect and describe good and negative policies and practices to control corruption in healthcare.

The Ecorys core research team provided support in case of questions and reviewed all interviewees that were suggested (to obtain balance between stakeholder groups as much as possible) as well as all country profile reports.

The country profiles contain the basic observations. They are based on national literature, publicly available data (including official data accessible to the public), policy documents and interviews with key stakeholders.

The interviews focused on identifying prevailing types of healthcare corruption, causes and risks of corruption and policies and practices. The cases were identified through desk research and the interviews. They cover the three areas of our research and should have actually occurred preferably in the last 5–10 years, i.e. are not theoretical, 'invented' cases or examples. Cases should have been based on reliable sources (e.g. actual court cases, cases undergoing criminal investigations, cases described through various sources in the media or academic literature).

Annex D includes an overview of the number of interviews and categories of stakeholders that have been interviewed. The cases are summarised in Annex A.

Taking into account the short time in which the country research was conducted (February–March 2013), the amount of information collected and reported in the country reports is extensive. A few limitations can, however, be identified:

- Despite the same format and instructions to the country rapporteurs, the breadth of the country reports differs. This is understandable taking into account the number of country correspondents. At the same time it is also a reflection of the country specific situation. In a country in which most respondents answer that corruption in the healthcare sector is not a big issue there is much less to report upon than in countries in which it has been identified as a structural issue;
- The topics of authorisation of pharmaceuticals and certification of medical devices do not stand out in the country reports. This may lead to the conclusion that these topics are of less interest for corruption in healthcare. However, this may also be

the result of the rather technical nature of these processes that are known in detail only by a small number of people in each country. This may have influenced the identification of issues and nature of interviewees in several countries.

### **Phase III. Analysis**

The analysis of the EU-28 observations was done by the Ecorys core research team and consisted of three consecutive steps: identification of corruption in healthcare typologies, analysis of policies and practices, and the formulation of conclusions and policy recommendations.

The identification of different corruption typologies is at the heart of our research. A typology generally consists of a systematic classification of cases or types (in our study: corruption types) that have characteristics or traits in common. Every typology is the result of a grouping process. In our study it is based on a collection of 86 corruption cases that our country experts collected in the EU MSs. We grouped the cases on the basis of common or combinations of attributes. Each typology is divided into subtypes.

The typology method enabled us to understand the complexity, mechanisms, risks, and impacts of corruption in the European healthcare sector. It also served as a foundation for our analysis of policies and practices – since different forms of corruption require different policy approaches.

We also constructed a long list of the policies and practices that are identified in the country profile reports and grouped them into main categories. Several policies are described in detail, assessed in terms of effectiveness (if possible), and evaluated in terms of transferability to other MSs. On the basis of the analysis we formulated conclusions and policy recommendations for addressing corruption in healthcare in the EU.

## **1.3 Terminology**

As specified in the terms of reference for this study, the **'healthcare sector'** is defined as 'an economic and social sector concerned with the provision, distribution and consumption of healthcare services and related products'. Healthcare services and related products is a broad concept. It encompasses 'any intervention that may be used to promote health, to prevent, diagnose or treat disease or for rehabilitation or long-term care. This includes pharmaceuticals, medical devices, procedures and organisational systems used in healthcare.'<sup>2</sup>

In Europe the healthcare sector is organised in intricate and country-specific systems in which the MS governments hold competence in the field of health policy. Roles and responsibilities within the healthcare sector are split between regulators, payers, healthcare providers, the industry (suppliers) and patients (consumers).

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<sup>2</sup> Facey, K., edited by Topfer, L.A., and Chan, L. on behalf of the International Network of Agencies for Health Technology Assessment, 'Health Technology Assessment (HTA) Glossary', First edition. Stockholm: INAHTA Secretariat, 2006.

Though all five actors are generally present in each healthcare system, the actual relationships, responsibilities and payment mechanisms vary. An overview of the key healthcare actors is presented in table 1.2 below. All actors can be actively or passively involved in corruption. An introduction to the European healthcare system is presented in Chapter 2.

**Table 1.2 Key healthcare actors**

Category	Subcategories
Patients	Individual patients Patients' organisations and pressure groups
Providers	Individual healthcare providers (doctors, nurses, pharmacists, etc.) Healthcare institutions Healthcare researchers and research institutes
Payers	Public and private insurance Social security and public funding
Industry	Pharmaceutical companies Medical device companies Intermediary companies
Regulators	Non-health (judiciary, procurement regulators) Health (Ministry of Health, standard setting agencies, insurance board, Healthcare authority, Inspectorate)

**'Informal payments'** are generally defined as payments made by patients or their relatives for those services that are to be provided free of charge or at a lower price. Given that they pose extra and non-foreseen costs, they may constitute a barrier to access healthcare, especially for the poorer socio-economic class of the population.<sup>3</sup> Informal payments can take many forms such as: extorting or accepting payments or soliciting payments in exchange for special privileges or treatment.

**'Procurement'** can be defined as the complete process of acquiring goods, services and works from suppliers. It includes identification of requirements, specifications, assessment of risks, management of tendering processes, ordering, contract award and management and monitoring of suppliers' performance. The procurement process takes into account factors such as the cost over the life (whole life costs) of the good or service, and the quality necessary to meet users' requirements. It is distinct from 'purchasing' goods and services, which refers to the specific activity of committing expenditure and which tends to focus on issues of price rather than of value.<sup>4</sup>

<sup>3</sup> Definition derived from: ASSPRO CEE 2007, a recent EU-Funded research project on the efficiency and impact of patient payments policies in six Central and Eastern European (CEE) countries: Bulgaria, Hungary, Lithuania, Poland, Romania, and Ukraine.

<sup>4</sup> <http://help.procureweb.ac.uk/>.



The tender specifications for this study asked that a wide definition of corruption be adopted, namely, 'the abuse of power for private gain'.<sup>5</sup> This definition encompasses 'aspects that go beyond the criminal law aspects, thus including situations such as conflict of interest, favouritism, etc.' Most definitions of corruption stress the involvement of two willing actors – the corrupter and the corrupted. This differentiates corruption from fraud, which can be committed by one single actor.

### ***Paying and receiving bribes***

The United Nations Convention Against Corruption (UNCAC) defines bribery as<sup>67</sup>: '(a) the promise, offering or giving, directly or indirectly, of an undue advantage to any person, for the person himself or herself or for another person or entity, in order that he or she, in breach of his or her duties, act or refrain from acting, (b) the solicitation or acceptance, directly or indirectly, of an undue advantage by any person, for the person himself or herself or for another person, in order that he or she, in breach of her duties, act or refrain from acting.'

Bribery is corruption by definition. Bribes are also called kickbacks, baksheesh, payola, hush money, sweetener, protection money, boodle, gratuity etc. In short, a bribe is a financial or other advantage. This includes:

- Money
- Discount
- Loan
- Donation
- Gifts or entertainment
- Information
- Preferential treatment
- Offers of employment

Efforts have been made in recent years by the international community to distinguish 'active' (or supply side) and 'passive' (demand side) bribery. Active bribery refers to the offence committed by the person who promises or gives the bribe. Passive bribery is the offence committed by the official who receives the bribe.<sup>8</sup>

It is, however, important to note that 'active bribery' does not always mean that the briber has taken the initiative. In fact often the reverse is true. The individual who receives the bribe often demanded it in the first place. In a sense, then, he or she is the more 'active' party in the transaction. Similarly, it

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<sup>5</sup> Commission Communication on a comprehensive EU policy against corruption from 2003 (COM(2003) 317 final), p.6 and Commission Communication on Fighting Corruption in the EU of June 2011 (COM(2011) 308 final, p3, footnote 1. UNCAC has separate definitions for the bribery of public officials, international public officials and bribery in the private sector. The definition provided here uses the word 'person' in order to generalise the definition.

<sup>7</sup> [http://www.unodc.org/documents/treaties/UNCAC/Publications/Convention/08-50026\\_E.pdf](http://www.unodc.org/documents/treaties/UNCAC/Publications/Convention/08-50026_E.pdf)

<sup>8</sup> For example Article 2 of the Criminal Law Convention on Corruption (ETS 173) of the Council of Europe defines active bribery 'the promising, offering or giving by any person, directly or indirectly, of any undue advantage [to any public official], for himself or herself or for anyone else, for him or her to act or refrain from acting in the exercise of his or her functions.' Article 3 of the Criminal Law Convention on Corruption (ETS 173) of the Council of Europe defines passive bribery as 'the request or receipt [by any public official], directly or indirectly, of any undue advantage, for himself or herself or for anyone else, or the acceptance of an offer or a promise of such an advantage, to act or refrain from acting in the exercise of his or her functions'.

must be noted that in reality the relation between the parties involved is by definition symbiotic relation. All actors have interest in secrecy of their operations. In a highly corrupt environment (systematic corruption), corruptor and corrupted change roles frequently.

### ***Paying and receiving kickbacks***

A kickback is a form of negotiated bribery in which a commission is paid to the bribe-taker as a quid pro quo for services rendered. Generally speaking, the remuneration (money, goods, or services handed over) is negotiated ahead of time. The kickback varies from other kinds of bribes in that there is implied collusion between the two parties (rather than one party extorting the bribe from the other). The purpose of the kickback is usually to encourage the other party to cooperate in the illegal scheme.<sup>9</sup>

The most common form of kickbacks involves a vendor submitting a fraudulent or inflated invoice (often for goods or services which were not needed, of inferior quality, or both), with an employee of the victim company assisting in securing payment. For his or her assistance in securing payment, the individual receives some sort of payment (cash, goods, services) or favour (the hiring of a relative, employment, etc.). Kickbacks often occur in relation to corruption in procurement.

### ***Embezzlement (diversion of assets)***

Embezzlement is the outright theft of public funds (in the context of our study: healthcare money). Embezzlement can be defined as the misappropriation of property or funds legally entrusted to someone in their formal position as an agent or guardian. The UN Convention against Corruption (UNCAC) has identified 'embezzlement, misappropriation or other diversion of property by a public official' as a corruption offence. However, embezzlement is not necessarily corruption – it can also be fraud (by one single actor).

### ***Corruption and collusion in public procurement***

In the sphere of public procurement, corruption and collusion are often considered as distinct phenomena. Corruption is a vertical relationship between one or more bidders and the procurement official. Collusion is a horizontal relationship between bidders that restricts competition and harms the public purchaser. Collusion can take many forms such as bid-rigging, price fixing or market division.<sup>10</sup> Collusion and corruption frequently occur in tandem and have mutually reinforcing effects. They are best viewed, according to the OECD, as concomitant threats to the integrity of public procurement.<sup>11</sup> Chapter 3.4 and 4.5 provides more information on this topic.

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<sup>9</sup> Source: [http://en.wikipedia.org/wiki/Kickback\\_\(bribery\)](http://en.wikipedia.org/wiki/Kickback_(bribery)).

<sup>10</sup> OECD, Policy Roundtable on Collusion and Corruption in Public Procurement, 2010.

<sup>11</sup> See publications by the OECD on the drivers and properties of corruption in public procurement. The OECD findings are presented in three major publications: *Fighting Corruption and Promoting Integrity in Public Procurement* (2005); *Bribery in Public Procurement. Methods, Actors and Counter-Measures* (2007); and an extensive report on a Policy Roundtable on Collusion and Corruption in Public Procurement (2010).

### **Conflict of interest**

A conflict of interest involves a 'conflict between the public duty and private interests of a public official, in which the public official has private-capacity interests which could improperly influence the performance of their official duties and responsibilities'.<sup>12</sup> A conflict of interest occurs when an individual or organisation is involved in multiple interests, one of which could *possibly* corrupt the motivation for an act in the other. The presence of a conflict of interest is independent from the execution of impropriety.

Therefore, a conflict of interest can be discovered and voluntarily defused before any corruption occurs.<sup>13</sup> Corruption related to conflicts of interest can be motivated by financial gain but also by non-financial objectives such as the desire for professional advancement and the wish to favour family and friends.<sup>14</sup>

### **Trading in influence, influence peddling, interest peddling**

Trading in influence occurs when a person misuses his influence over the decision-making process for a third party (person, institution or government) in return for his loyalty, money or any other material or immaterial undue advantage.<sup>15</sup> Trading in influence is a highly controversial issue. International conventions call for the criminalisation of this form of corruption but many states are hesitant to establish this form of corruption as a criminal offence under their domestic law.

Trading in influence (or influence peddling) is described in the Council of Europe's Criminal Convention on Corruption ('COE Convention') as early as 1999.<sup>16</sup> Forty-three states have ratified the COE Convention, but one fourth of the COE states have made a reservation against the undertaking to introduce criminal provisions for trading in influence. Among these are the United Kingdom, Denmark and the Netherlands. Many of the ratifying states face difficulties in providing adequate legal instruments in their anti-corruption policies to deal with trading in influence (trading in influence is difficult to investigate and prove). Another argument given is that the provision could affect acknowledged lobbying activities.

<sup>12</sup> OECD, Managing conflict of interest in the public service. OECD Guidelines and country experiences (2003).

<sup>13</sup> [http://en.wikipedia.org/wiki/Conflict\\_of\\_interest](http://en.wikipedia.org/wiki/Conflict_of_interest).

<sup>14</sup> [http://en.wikipedia.org/wiki/Conflict\\_of\\_interest](http://en.wikipedia.org/wiki/Conflict_of_interest).

<sup>15</sup> Slingerland, W. 'Trading in influence: corruption revisited. How a better understanding of the systemic character of trading in influence can help the Council of Europe and its Member States choosing the right instruments to tackle this form of corruption', Saxion University, School for Governance and Law, Enschede, the Netherlands, EGPA Study Group on Ethics and Integrity of Governance, Toulouse, 8-10 September 2010, [http://www.law.kuleuven.be/integriteit/egpa/egpa2010/slingerland\\_trading-in-influence.pdf](http://www.law.kuleuven.be/integriteit/egpa/egpa2010/slingerland_trading-in-influence.pdf).

<sup>16</sup> The COE Convention describes trading in influence in article 12 as: the intentionally, promising giving or offering, directly or indirectly, of any undue advantage to anyone who asserts or confirms that he or she is able to exert an improper influence over the decision making of any person, whether the undue advantage is for himself or herself or for anyone else, as well as the request, receipt or acceptance of the offer or the promise of such an advantage, in consideration of that influence, whether or not the influence is exerted or whether or not the supposed influence leads to the intended result.

***Revolving door corruption***

The term 'revolving door' refers to the movement of personnel between roles as legislators and regulators and the industries affected by the legislation and regulation. In some cases the roles are performed in sequence but in certain circumstances may be performed at the same time. Political analysts claim that an unhealthy relationship can develop between the private sector and government, based on the granting of reciprocated privileges to the detriment of the nation and can lead to regulatory capture.

It is healthy to have an interchange of skills and experience between sectors – this can improve understanding and communication between public officials and business, and allow sharing of expertise. However, a revolving door brings the risk that government officials will be influenced in their policy or procurement decisions by the interests of past or prospective employers.<sup>17</sup>

***Regulatory capture (state capture)***

It is a common phenomenon in all areas of regulation that regulators become 'captured' by the industry they regulate, meaning that they take on the objectives of management in the firms they regulate. They may thereby lose sight of the ultimate objectives of regulation. Regulatory capture is particularly serious in industries such as banking where there is a conflict of interest between the firms' objectives (to maximise profits) and the objectives of the regulation (to provide consumer protection and maintain systemic stability).<sup>18</sup>

The notion of regulatory (state) capture deviates from traditional concepts of corruption, in which a bureaucrat might extort bribes from powerless individuals or companies, or where politicians themselves steal state assets. State capture is recognised as a most destructive and intractable corruption problem, above all in transition economies with incomplete or distorted processes of democratic consolidation and insecure property rights.<sup>19</sup>

***Clientelism, favouritism and nepotism***

Clientelism is an informal relationship between people of different social and economic status: a 'patron' (boss, big man) and his 'clients' (dependents, followers, protégés). The relation includes a mutual but unequal exchange of favours, which can be corrupt.

Favouritism refers to the normal human inclination to prefer acquaintances, friends and family over strangers. When public (and private sector) officials demonstrate favouritism to unfairly distribute positions and resources, they are guilty of cronyism or nepotism, depending on their relation with the person who benefits. Nepotism is usually used to indicate a form of favouritism that involves family relations, and cronyism relates to favouritism towards friends

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<sup>17</sup> <http://www.guardian.co.uk/public-leaders-network/blog/2012/may/30/fix-revolving-door-corruption-government>

<sup>18</sup> H. Benink, R. Schmidt, Europe's single market for financial services: views by the European Shadow Financial Regulatory Committee, *Journal of Financial Stability*, 2004, p. 186. Derived from: Miller, D (July 6<sup>th</sup>, 2009). 'Revolving doors, accountability and transparency', <http://www.oecd.org/gov/43264684.pdf>.

<sup>19</sup> <http://www.u4.no/glossary/>

## 1.4 Legal context

The legal context, including definitions on what constitutes corruption by law, is important for the identification of corruption cases and the policies and methods for combatting the phenomenon. Several overarching initiatives have been developed in international law. The aim of these initiatives is to build a common approach towards corruption, including attempts to develop a common framework for the understanding of corruption. The major International Conventions concerning corruption are:

**United Nation's Convention against Corruption** (December 2005) - 140 signatories, 165 state parties and 30 ratifications.<sup>20</sup> This Convention covers the broadest range of corruption offences, including: the active and passive bribery of domestic and foreign public officials, obstruction of justice, illicit enrichment, and embezzlement. It also includes preventive measures, international co-operation, technical assistance and provisions on asset recovery.<sup>21</sup>

**Council of Europe's Criminal Law Convention on Corruption** (February 2007) - The Convention has 48 signatories and has entered into force in 35 countries.<sup>22</sup> Offences included are the active and passive bribery of domestic and foreign public officials, bribery in the private sector and trading in influence (This Convention is monitored by GRECO- Group of States Against Corruption).<sup>23</sup>

**Council of Europe's Civil Law Convention on Corruption** (November 2003) - The Convention has 47 signatories and 14 ratifications.<sup>24</sup> This is to provide 'effective remedies for persons who have suffered damage as a result of acts of corruption, to enable them to defend their rights and interests, including the possibility of obtaining compensation for damage.'<sup>25</sup>

**OECD Convention on Combating Bribery of Foreign Public Officials in International Business Transactions** (November 1997) - 38 signatories and 34 ratifications.<sup>26</sup> This is a specialised Treaty on the bribery of foreign public officials in international business transactions.<sup>27</sup>

**WTO Government Procurement Agreement** (January 1996). This is not a convention but a legal binding instrument. In September 2011, 42 countries are bound by the Agreement.<sup>28</sup> This agreement is based on transparency,

<sup>20</sup> See UNODC website: <http://www.unodc.org/unodc/en/treaties/CAC/signatories.html>.

<sup>21</sup> OECD Glossaries: Corruption, A glossary of international standards in criminal law (2008) p. 13-14 see: <http://www.oecd.org/daf/briberyininternationalbusiness/anti-briberyconvention/41194428.pdf>.

<sup>22</sup> See OECD website: <http://www.oecd.org/investment/briberyininternationalbusiness/anti-briberyconvention/41194428.pdf>.

<sup>23</sup> OECD Glossaries: Corruption, A glossary of international standards in criminal law (2008) p.13.

<sup>24</sup> Civil Law Convention on Corruption: <http://conventions.coe.int/Treaty/Commun/ChercheSig.asp?NT=174&CM=&DF=&CL=ENG>.

<sup>25</sup> See COE website: <http://conventions.coe.int/Treaty/en/Summaries/Html/174.htm>.

<sup>26</sup> <http://www.oecd.org/governance/ethics/2406452.pdf>

<sup>27</sup> OECD Glossaries: Corruption, A glossary of international standards in criminal law (2008) p. 12.

<sup>28</sup> Briefing note: Government Procurement Agreement (GPA): [http://www.wto.org/english/thewto\\_e/minist\\_e/min11\\_e/brief\\_gpa\\_e.htm](http://www.wto.org/english/thewto_e/minist_e/min11_e/brief_gpa_e.htm)

competition and good governance. The aim is to open up to international competition and conformity of the members. Therefore, the agreement seeks to reduce corruption and bad governance.<sup>29</sup> These Conventions do not give a generic definition of corruption, but they establish and prescribe the offences for a range of corrupt behaviour. In this way they define international standards on the criminalisation of corruption.<sup>30</sup> The signing, ratification and implementation of these Conventions vary across the EU.

## European law

Currently, there is no comprehensive EU legislation on corruption except for some pieces of legislation that provide for the definition of the criminal offences of active and passive corruption in the public and private sectors.<sup>31</sup> Corruption is mainly defined by the criminal law of the various MSs. In its communication COM(2003) 317 final the EC has stated that it will use the following definition of corruption: 'abuse of power for private gain'.<sup>32</sup> This definition has been also used in the most recent Commission Communication on fighting corruption in the EU (COM(2011) 308 final). In this communication the Commission has announced that it intends to put stronger focus on corruption in all relevant EU policies – internal as well as external – through a variety of legal measures and other initiatives, such as: the publication of a bi-annual anti-corruption report, modernisation of EU rules on confiscation of criminal assets, closer collaboration with EU agencies such as Europol, Eurojust, CEPOL and OLAF, modernisation of rules on procurement and on accounting standards, putting a stronger focus on anti-corruption issues within the EU enlargement process and in its neighbourhood policy, and measures to better protect the EU financial interests.

Important to note is that the EC favours the accession of abovementioned International Conventions. In developing its own policies it also takes into account these Conventions, to avoid duplication. The EU has acceded to the United Nations Convention Against Corruption.<sup>33</sup>

The EU has already produced several legal documents on fighting corruption:

- Article 83(1) of the Treaty on the Functioning of the European Union recognises corruption as a 'serious crime with a cross-border dimension.'<sup>34</sup> The article provides the basis to create directives containing minimum rules on the definition of criminal offences and sanctions in the field of corruption;<sup>35</sup>

<sup>29</sup> [http://www.wto.org/english/thewto\\_e/minist\\_e/min11\\_e/brief\\_gpa\\_e.htm](http://www.wto.org/english/thewto_e/minist_e/min11_e/brief_gpa_e.htm)

<sup>30</sup> OECD Glossaries: Corruption, A glossary of international standards in criminal law (2008) p. 22.

<sup>31</sup> New Europe, EU needs common definition of corruption, see: <http://www.neurope.eu/article/olaf-eu-needs-common-definition-corruption>.

<sup>32</sup> EU website [http://europa.eu/legislation\\_summaries/fight\\_against\\_fraud/fight\\_against\\_corruption/l33301\\_en.htm](http://europa.eu/legislation_summaries/fight_against_fraud/fight_against_corruption/l33301_en.htm)

<sup>33</sup> COM(2011) 308 FINAL, Communication from the Commission to the European parliament, the Council and the European Economic and Social Committee, Fighting Corruption in the EU p. 5. See also: <http://www.unodc.org/unodc/en/treaties/CAC/signatories.html>.

<sup>34</sup> COM(2011) 308 FINAL, Communication from the Commission to the European parliament, the Council and the European Economic and Social Committee, Fighting Corruption in the EU p.3.

<sup>35</sup> Idem.

- 'Article 29 of the Treaty on European Union mentions preventing and combating corruption as one of the ways of achieving the objective of creating and maintaining a European area of freedom, security and justice';<sup>36</sup>
- Framework Decision 2003/568/JHA on combatting corruption in the private sector. This Decision obliges MSs to implement measures to ensure that active and passive bribery in the private sector constitutes criminal offences. (These concepts are described in Article 2).<sup>37</sup> This Decision has however not been equally implemented by the MSs;<sup>38</sup>
- Convention on the protection of the European Communities' financial interests (aimed at combating fraud affecting both the revenue and expenditure side of the EU budget);<sup>39</sup>
- The EU Convention on the fight against corruption involving officials of the European Communities or officials of the EU MSs.<sup>40</sup> On the basis of this Convention, MSs must take the necessary measures to ensure that an act of passive or active bribery by officials is a punishable criminal offence. (Also here a description is given of the concepts active and passive bribery);<sup>41</sup>
- According to the Council of Europe's Criminal Law Convention on Corruption, for instance), active bribery of public officials is defined as the 'the promising, offering or giving by any person, directly or indirectly, of any undue advantage ... for himself or herself or for anyone else, for him or her to act or refrain from acting in the exercise of his or her functions'. Similarly, passive bribery is 'the request or receipt, directly or indirectly, of any undue advantage, for himself or herself or for anyone else, or the acceptance of an offer or a promise of such an advantage, to act or refrain from acting in the exercise of his or her functions'.

## National law

As indicated above, legal definitions of corruption and the criminalisation of corruption are mainly a matter of (substantive) criminal law. It is beyond the scope of this report to go into detail on each MS's legal framework. Important to note is that countries use different definitions and that the legal frameworks regarding corruption differ. This means that MSs do not provide an equally effective and efficiently legal protection framework against corruption. This had several implications for our research:

<sup>36</sup> EU website [http://europa.eu/legislation\\_summaries/fight\\_against\\_fraud/fight\\_against\\_corruption/I33301\\_en.htm](http://europa.eu/legislation_summaries/fight_against_fraud/fight_against_corruption/I33301_en.htm).

<sup>37</sup> See Article 2 of the Decision:

Active and passive corruption in the private sector:

1. Member States shall take the necessary measures to ensure that the following intentional conduct constitutes a criminal offence, when it is carried out in the course of business activities:

(a) promising, offering or giving, directly or through an intermediary, to a person who in any capacity directs or works for a private-sector entity an undue advantage of any kind, for that person or for a third party, in order that that person should perform or refrain from performing any act, in breach of that person's duties;

(b) directly or through an intermediary, requesting or receiving an undue advantage of any kind, or accepting the promise of such an advantage, for oneself or for a third party, while in any capacity directing or working for a private-sector entity, in order to perform or refrain from performing any act, in breach of one's duties.

<http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2003:192:0054:0056:EN:PDF>

<sup>38</sup> COM(2011) 308 FINAL, Communication from the Commission to the European parliament, the Council and the European Economic and Social Committee, Fighting Corruption in the EU p.9.

<sup>39</sup> EU website [http://europa.eu/legislation\\_summaries/fight\\_against\\_fraud/fight\\_against\\_corruption/I33301\\_en.htm](http://europa.eu/legislation_summaries/fight_against_fraud/fight_against_corruption/I33301_en.htm) and [http://europa.eu/legislation\\_summaries/fight\\_against\\_fraud/protecting\\_european\\_communities\\_financial\\_interests/I33019\\_en.htm](http://europa.eu/legislation_summaries/fight_against_fraud/protecting_european_communities_financial_interests/I33019_en.htm)

<sup>40</sup> EU website [http://europa.eu/legislation\\_summaries/fight\\_against\\_fraud/fight\\_against\\_corruption/I33301\\_en.htm](http://europa.eu/legislation_summaries/fight_against_fraud/fight_against_corruption/I33301_en.htm)

<sup>41</sup> [http://europa.eu/legislation\\_summaries/fight\\_against\\_fraud/fight\\_against\\_corruption/I33027\\_en.htm](http://europa.eu/legislation_summaries/fight_against_fraud/fight_against_corruption/I33027_en.htm)



- Because of the difference in legal frameworks (and definitions) we lacked a common point of reference for a comparative legal analysis of the countries;
- The evidence we found in the various MSs is not necessarily comparable;
- Countries with a limited legal definition of corruption may have shown less corruption cases than countries that have relatively broader legal definition (encompassing more forms of corruption).

## **1.5 Structure of this report**

This report is structured as follows. We provide an overview of the context in Chapter 2 through a summary of the main findings of the literature on corruption in healthcare. Special reference will be made to ASSPRO CEE 2007, an EU-funded research project on the efficiency and impact of patient payment policies in six Central and Eastern European (CEE) countries: Bulgaria, Hungary, Lithuania, Poland, Romania, and Ukraine. Moreover, we provide an introduction to the main characteristics of the European medical devices and pharmaceutical market.

Our analysis of the observations provided by interviews, desk research and case analysis in the 28 MSs is presented in Chapter 3. First, we identify the main characteristics of the corruption cases that have been selected in the EU MSs. In addition to this, a detailed analysis of the main corruption-in-health typologies is given. These typologies serve as a starting point for the policies and practices that are extensively described in Chapter 4. This Chapter contains a large selection of various policies and practices (successful and some unsuccessful) that we collected across the EU MSs. Our conclusions and policy recommendations are presented in Chapter 5.



## 2 Healthcare and corruption

### 2.1 Introduction

The citizens of the European Union spend more than 1 trillion euro a year on healthcare. This includes 'any interventions that may be used to promote health, to prevent, diagnose or treat disease or for rehabilitation or long-term care such as pharmaceuticals, medical devices, procedures and organisational systems used in healthcare.'<sup>42</sup>

#### Vulnerabilities

The healthcare sector is one of the areas that is particularly vulnerable to corruption. This is mainly due to the following characteristics of the healthcare sector, as has been outlined by the European Healthcare Fraud & Corruption Network and other experts on corruption in healthcare:

- A high degree of information asymmetry between providers of care and consumers exercising demand for services to become healthy;
- Large number of actors which have complex inter-relations;
- The responsibility given to providers in choosing services for their patients;
- Healthcare services that are highly decentralised and individualised making it difficult to standardise and monitor service provision and procurement;<sup>43</sup>
- Unlike consumer markets for more regular goods, where market supply and demand determine 'the right price', in the complex market of healthcare pricing is much more opaque.
- The ethical implications involved in healthcare decisions make it nearly impossible to define the 'right' amount to be spent on healthcare;
- The payer is often not the same as the direct recipient of healthcare services; there is no immediate check on the actual provision of goods and services. The payer has no direct way of verifying that the service was provided and the customer has no way of knowing that the insurance provider has billed for a service the consumer did not receive.<sup>44</sup>

#### Differences between healthcare systems

Transparency International states 'abuses in the health system aimed at personal gain are not exclusive to any particular country or health system. However, the forms of abuse may differ depending on how funds are mobilised, managed and paid.' In the table below, we present the relationship between the different financing mechanisms and the risk of corruption as developed by the World Health Organization.<sup>45</sup>

<sup>42</sup> Facey, K., edited by Topfer, L.A., and Chan, L. on behalf of the International Network of Agencies for Health Technology Assessment, 'Health Technology Assessment (HTA) Glossary', First edition. Stockholm: INAHTA Secretariat, 2006.

<sup>43</sup> Rădulescu, I.G., Alexandru, G., Miu, A. Inside the Core of Corruption from the Health System. BULETINUL Universităţii Petrol – Gaze din Ploieşti, 2008: Vol. LX (No 1): 43-50.

<sup>44</sup> Thomson Reuters, Where can \$700 billion in waste be cut annually from the US healthcare system, Oct. 2009.

<sup>45</sup> [http://archive.transparency.org/global\\_priorities/other\\_thematic\\_issues/health/health\\_systems](http://archive.transparency.org/global_priorities/other_thematic_issues/health/health_systems) (accessed August 6th, 2012)

**Table 2.1 Relation between the different financing mechanisms and the risk of corruption**

Financing <sup>46</sup>	Characteristics	Corruption risk
Taxes	Normally associated with free or almost free service deliveries.	Large-scale diversions of public funds at ministerial level. High risk of informal or illegal payments. Corruption in procurement. Abuses that undermine the quality of services.
Social insurance	Compulsory, not every citizen eligible for coverage, premiums and benefits described in social contracts (laws or regulations). Only applicable for formal employees.	Most common abuses include excessive medical treatment, fraud in billing, and diversion of funds.
Private insurance	Buyer voluntarily purchases insurance (can be done on individual or group basis).	Problem of risk selection (selecting healthy people). Same as for public insurance schemes.
Out-of-pocket payments	When patients pay providers directly out of their own pockets for goods and services. Costs are not reimbursable.	No guarantee that all health services are of value to those buying them. With weak regulatory capacity there is a high risk of overcharging and inappropriate use of services.

Source: [http://archive.transparency.org/global\\_priorities/other\\_thematic\\_issues/health/health\\_systems](http://archive.transparency.org/global_priorities/other_thematic_issues/health/health_systems) (accessed August 6th, 2012).

A healthcare system that is financed and controlled privately (e.g. US, Switzerland, Netherlands) or by the state (e.g. UK, Sweden and former Soviet Union countries, FSU) may give some indication of possible corrupt practices. Transparency International found that 'in private health systems corruption commonly manifests itself in the form of insurance fraud, unethical procurement and distribution of drugs, and low-quality treatment. In state-controlled systems, low pay to health professionals coupled with poor control mechanisms (i.e. regulation) contribute to a high incidence of informal payments, absenteeism and drugs being diverted for resale.<sup>47</sup> The latter also applies to most Central and Eastern European countries that faced similar challenges as FSU in reforming their healthcare systems after the fall of communism.

As described by Tomini (2011), 'these countries moved from a centrally planned economy to a more decentralised model that led to an over-supply of healthcare professionals who were not very well paid. The transition was accompanied by the decline in public health funds and lack of good governance leading to barriers in access to healthcare and high levels of out-of-pocket payments.<sup>48</sup> These findings are underlined in several studies and household surveys conducted in European countries regarding informal payments (e.g. Romania, Lithuania, Bulgaria), which is one the most common forms of corruption in healthcare.

<sup>46</sup> Please note that it is not always clear what EU country can be assigned to what system, since no country follows either system in its pure form.

<sup>47</sup> [http://archive.transparency.org/global\\_priorities/other\\_thematic\\_issues/health/health\\_systems](http://archive.transparency.org/global_priorities/other_thematic_issues/health/health_systems) (accessed August 6th, 2012).

<sup>48</sup> Tomini, S. Informal payments for healthcare services in Albania. Thesis. Maastricht: Boekenplan, 2011.

## Variations among Member States

We further distinguish here between systemic and incidental corruption in healthcare. Corruption risks are not only dependent on the characteristics of the healthcare system (depending on how healthcare funds are mobilised, managed and paid). They also vary from country to country and even region to region, within a country. As Savedoff and Hussmann (2006)<sup>49</sup> have pointed out:

*'Corruption in the healthcare sector is not exclusive to any particular kind of health system. It occurs in systems whether they are predominantly public or private, well-funded or poorly funded, and technically simple or sophisticated. The extent of corruption is, in part, a reflection of the society in which it operates. Corruption in healthcare is less likely in societies where there is broad adherence to the rule of law, transparency and trust, and where the public sector is ruled by effective civil service codes and strong accountability mechanisms.'*

The most commonly used indicator for the perceived levels of corruption of a country is the Transparency International Corruption Perception Index (TI CPI). This index measures the general levels of perceived corruption. A more targeted measure on perceived corruption in the European healthcare system can be found in the Special Eurobarometer survey (374, February 2012) on corruption in Europe.<sup>50</sup>

This survey provides an initial, however incomplete, indication of the perceived extent to which corruption in healthcare is systemic in the various MSs. Across all EU MSs, an average of 41% of the respondents (based on 26 856 interviews of residents aged 15 years and over) agree with the statement that 'giving and taking of bribes, and the abuse of positions of power for personal gain, are widespread among people working in the public healthcare sector.' These perceptions, however, considerably differ across MSs. Over 70% of the respondents in Romania, Hungary, Slovenia and Greece agree with this statement, while at the other extreme, fewer than 20% of the respondents in Luxemburg, the Netherlands, Finland and Denmark think that corruption in healthcare is a problem (figure 2.1).

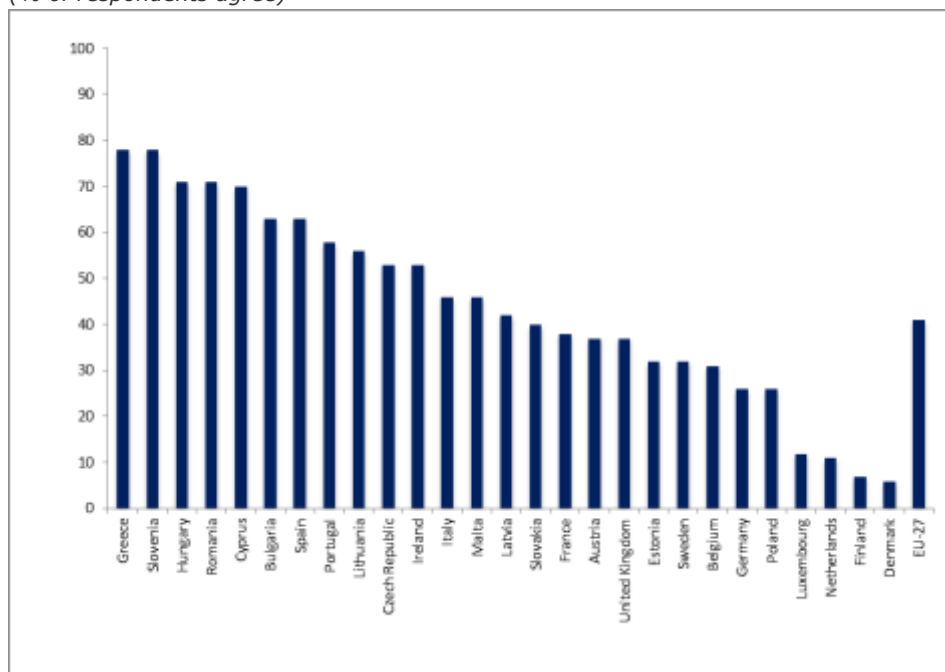
When specifically asked about bribery in medical service delivery, respondents in several MSs indicated that they have not experienced doctors asking or expecting bribes. It seems that the habit to offer or demand patient to doctor under-the-table payments is particular widespread in some Central and Eastern European MSs (figure 2.2). In particular in Romania, Lithuania, Hungary, Slovakia and Bulgaria, Greece, Latvia and Poland people seem to actually have experienced that anyone asked or expected to pay a bribe for his or her healthcare services.

<sup>49</sup> Savedoff, W. & Hussmann, K. (2006). 'Why are health systems prone to corruption?'. Global Corruption Report, Transparency International.

<sup>50</sup> The SPECIAL EUROBAROMETER 374 'Corruption' is part of wave 76.1 and covers the population of the respective nationalities of the European Union Member States, resident in each of the Member States and aged 15 years and over. N = 26.856 interviews. Fieldwork in September 2011, published in February 2012.

**Figure 2.1 Corruption among people working in the healthcare sector**

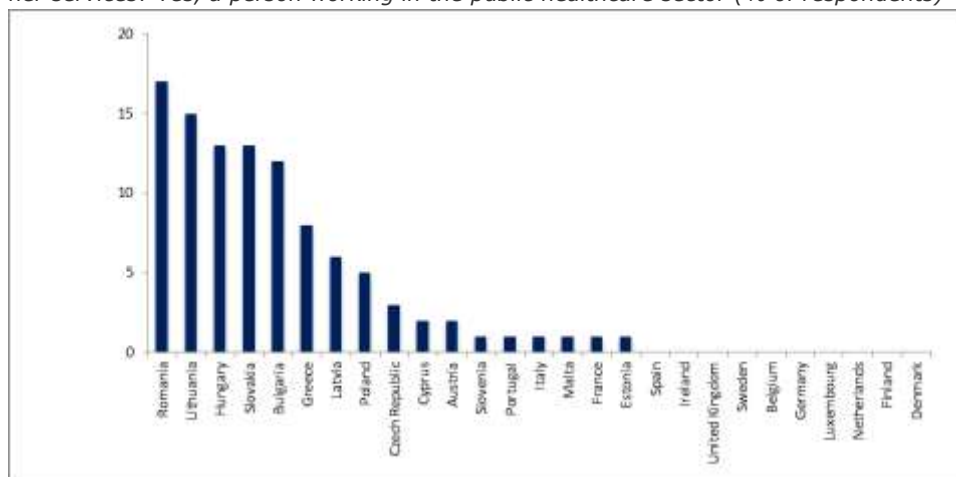
*Do you think that the giving and taking of bribes, and the abuse of positions of power for personal gain are widespread among people working in the public healthcare sector? (% of respondents agree)*



Source: Special Eurobarometer 374, QC1, February 2012. See also Annex B of this report.

**Figure 2.2 Corruption among people working in the healthcare sector**

*Over the last 12 months, has anyone asked you, or expected you, to pay a bribe for his or her services? Yes, a person working in the public healthcare sector (% of respondents)*



Source: Special Eurobarometer 374, QC5, February 2012. See also Annex B of this report.

It is important to note is that the Special Eurobarometer measures *perceptions* rather than actual levels of corruption. When perceptions of corruption are low this does not necessarily mean that corruption levels are also low; it merely indicates that it is not visible. Perceptions about healthcare corruption are more widespread across EU MSs (figure 2.1) than actual experiences with under-the-table payments (figure 2.2).

## Impacts of healthcare corruption

The overall impact of corruption in healthcare on society and on individuals can be (much) larger than the monetary value of the sums involved. We can for example distinguish between direct and indirect impacts, tangible (material, health quality) and intangible (social, psychological) impacts, short term (price and quality) and long term (health system) impacts. There is some general literature on the impacts of corruption in healthcare. For an overview of some key document on corruption in healthcare see box 2.1.

For example Larsson (2010), in a study on informal payments in Lithuania, distinguishes implications for access to healthcare, economic implications and implications for trust in the healthcare system.<sup>51</sup> For example, informal payments not only limit access to healthcare, they also undermine official payment systems, distort health priorities, impede health reforms and can encourage unprofessional behaviour of health providers (such as providing quicker access for patients who can afford to pay).

A list of effects would contain:

- **Impact on price.** Corruption in healthcare may lead to a provision of services or procurement of equipment and drugs at above market prices;
- **Impact on health quality.** Corruption in healthcare may lead to low quality in the provision of healthcare services (when patients do not wish to engage in corrupt practices) and/or a low quality in the provision of medical devices and pharmaceuticals;
- **Impact on access to health.** Corruption in healthcare may threaten the goal of universal health coverage (because as the price of healthcare increases, the accessibility decreases), and increase inequality in health status between socioeconomic groups;
- **Impact on health budget.** Corruption in healthcare may lead to a non-optimal allocation of health budgets;
- **Impact on other public budgets.** Corruption in healthcare may incur costs for prevention, executing anti-corruption policies, and/or costs for law enforcement (detection, prosecution, conviction, incarceration) of involved offenders;
- **Impact on markets (market distortions).** Corruption in healthcare may lead to various market distortions such as bad doctors driving out good doctors, bad suppliers driving out good suppliers, etcetera);
- **Indirect impacts on society.** Corruption in healthcare may cause productivity loss through bad health; distrust in provisions of services by the government; distrust in the health system; and distrust in society as a whole;
- **Cross-border impacts.** Corruption in healthcare may lead to brain drain of medical personnel; increase incentives for parallel trading of pharmaceuticals; and increase incentive for off-label use of pharmaceuticals.

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<sup>51</sup> Larsson, Rickard, 'Informal payments for health care: A threat to human security', Lund University, 2010.

This list illustrates that, as mentioned before, the overall impact of corruption in healthcare on society and on individuals can be (much) larger than the monetary value of the sums involved.

The cases we have collected for this study and presented in Annex A illustrate that this wide variety of impacts can indeed be observed as a consequence of corruption in the European healthcare system.

### **Box 2.1 Previous research**

- ASSPRO CEE (2007), European Policy Brief: *Informal Payments for health care services: policy challenges and solutions*;
- Baji *et al* (2012). The International Journal of Health Planning and Management. *Informal Payments for healthcare services and short-term effects of the introduction of visit fee on these payments in Hungary*;
- Chr. Michelsen Institute, Corruption in the health sector 2008, <http://www.cmi.no/publications/file/3208-corruption-in-the-health-sector.pdf>;
- EHFCN (2005), Comparative Study on Fraud;
- Gee, J., Button, M. and Brooks, G. (2011) *The Financial Cost of Healthcare Fraud*. What the data from around the world shows. London: PKF/CCFS, <http://www.port.ac.uk/departments/academic/icjs/centreforcounterfraudstudies/documents/filetodownload,107171,en.pdf>;
- Gee, J., Button, M. and Brooks, G. (2012) *The Scale of Healthcare Fraud: A Global Evaluation*. In: Security Journal, 25, pp 76-87;
- Hussmann, Karen (2010), Addressing corruption in the health sector, Chr. Michelsen Institute, <http://www.cmi.no/publications/file/3934-addressing-corruption-in-the-health-sector.pdf>;
- Larsson, Rickard (2010), '*Informal payments for health care: A threat to human security*', Lund University;
- Stepurko *et. Al*, Health Services Research 2010. *Empirical Studies on informal payments, for health care services: a systematic and critical review of research methods and instruments*;
- The World Bank (2007), *The Many Faces of Corruption, Tracking Vulnerabilities at the Sector Level*;
- Tomini *et al.* (2012) Health Services Researches. Informal Payments and intra-household allocation of resources for health care in Albania;
- Transparency International, *Global Corruption Report 2006, Special Focus: Corruption and Health*;
- U4 Resource Centre – Corruption and health in developing countries theme: <http://www.u4.no/themes/health-sector/>;
- Vian, Taryn (2011), *La corruption dans le secteur de la santé: méthodes d'apprentissage et d'enseignement*, Bergen: Chr. Michelsen Institute.

## 2.2 Informal payments

Informal payments can take many forms such as extorting or accepting payments for services that are supposed to be free of charge or soliciting payments in exchange for special privileges or treatment. Informal payments are diverse in nature because different people can initiate them at different times for different reasons.

General (interrelated) characteristics of informal payments are:

- **Initiator.** The patient who wishes to express gratitude, the provider (individual or institution) who requests the payment, or both;
- **Nature.** In cash, in kind (e.g. candies, jewellery), or in a form of services(e.g. dinners, trips, and sponsorship);
- **Moment:** Before, during, or after the healthcare service, medical supplies or pharmaceuticals are provided to the patient;
- **Recipient.** The healthcare institution (incl. quasi-official payments that are not official but when the patient receives a kind of receipt), medical staff (incl. physicians and nurses), or the administration of the healthcare institution;
- **Payer.** The patient or the relatives of the patients;
- **Purpose.** Expression of gratitude, fee-for-service, fee-for-commodity, fee-for-access, fee-for-quicker-access, or fee-for-better quality;
- **Amount.** The monetary value of the informal patient payment is usually comparable to the household's income;
- **Views.** Normal behaviour, corruption, illegal behaviour, or tradition (due to cultural perceptions);
- **Attitude.** Negative (especially, if requested) or positive (if an expression of gratuity), usually depending on the moment of payment.

The main reasons for informal payments are expression of gratitude and better quality of healthcare provision and quicker access. By and large, informal payments are observed in all patient groups irrespective of the socio-economic status of the patients.

### Risk factors and indicators for corruption

Informal payments are related to cultural, economic, personal and governmental factors. For example, in some countries informal payments are seen as part of their culture. Economic factors apply to former socialist countries in which public spending on healthcare and the wages of medical staff declined after the turmoil and where there is lack of good accountability systems.

The payment system of physicians can also be a risk factor in the context of informal payments. Physicians that are paid salaries (instead of fee-for-service) are more likely to ask for informal payments to complement their income. Moreover, as physicians that receive salaries may have fewer incentives to provide high quality care, patients might have more incentives to engage in informal payments to ensure a higher level of care. Alongside how the physicians are paid, how much they are paid is also important. When they receive low pay and/or these pays are received irregularly,

physicians have the incentive to ask for informal payments to complement their income.

Another risk factor is the structure of the healthcare system. For example tax-based systems are more prone to informal payments than social insurance systems.

Moreover, the accessibility of a healthcare system can also be considered a risk factor. The more accessible a healthcare system is, the less incentive there is for people to provide their physicians with informal payment for faster or better access. Note however, that this does not mean that informal payments do not occur; it only decreases the incentive to pay for accessibility.

- Indicators of informal payments determined by the European Healthcare Fraud and Corruption Conference include, for example:
- Expenditure of healthcare provider(s) is higher than the actual budget provided (indicating that additional funds are sought through informal payments);
- Number of patients treated more quickly than other patients for the same procedure (which may indicate that the patient has paid to receive treatment and not be placed on a waiting list);
- Acceptance of monetary or non-monetary payments by healthcare providers for referring patients to private services;
- Large reduction in services provided by healthcare provider(s) (indicating that patients are unable to afford the informal payments requested by the provider).

### **Size of the problem**

Despite the fact that the impact of (in-) formal payments is well known internationally, little research has been carried out establishing the scope, scale and actual impact of informal payments in the healthcare sector in higher income countries. Within Europe informal patient payments are mainly associated with healthcare provision in former-socialist countries. Nevertheless, unofficial payments for healthcare services were also identified in a few high-income European countries (i.e. Italy and Greece). Informal payments are made to both medical staff in hospitals and physicians in polyclinics. These payments are mainly reported for services included in a country's basic healthcare package, but services outside the basic package are also affected.

### **Conclusions from the ASSPRO research project**

Informal payments in medical service delivery have recently been studied by ASSPRO CEE 2007, an EU-Funded research project on the efficiency and impact of patient payments policies in six Central and Eastern European (CEE) countries: Bulgaria, Hungary, Lithuania, Poland, Romania, and Ukraine.<sup>52</sup>

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<sup>52</sup> The project started in March 2008 and has been finalised in February 2013. ASSPRO, European Policy Brief, February 2013, p.5.



ASSPRO's concludes that:

- In nearly all CEE countries, informal patient payments were common during the communist regime and transition period, and continued to exist to a greater or lesser extent. Informal payments are widespread in most CEE countries;
- Patients often pay informally to receive better service quality, more attention from medical staff or quicker access;
- Patients can initiate informal payments. Service providers can also request them. Often, informal payments are considered as gratitude payments but their true nature is doubtful;
- Informal payments have various characteristics: payments without receipt; personal and family payments, monetary and non-monetary payments;
- Informal patient payments present a considerable problem in the healthcare sector because they negatively affect the overall functioning of the healthcare system. A mixture of strategies on the demand and supply side of the healthcare market is proposed as a plausible solution to informal patient payments.

Empirical evidence indicates that informal patient payments can represent a significant part of the income of the healthcare providers. In some instances, physicians may earn as much as a full additional salary from informal payments. Furthermore, these payments can also represent a significant part of the total healthcare expenditure.

The ASSPRO estimates on the scale of informal payments in the six CEE countries are (table 2.2):

- Informal payments are more frequent for hospital admissions than for individual physician visits. Informal payments are most frequent in Romania and least frequent in Poland;
- The average informal payments for physician visit range from 8.23 euro (Bulgaria) to 16.16 euro in Lithuania. Informal payments are higher for hospital admissions, ranging from an average of 44 euro (Bulgaria) to 79 euro (Lithuania);
- Informal patient payments for services pour additional resources into the healthcare systems, ranging from 0.1% to 0.3% of GDP depending on the country. In terms of expenditure, the share of informal patient payments ranges between 0.6% and 6.3% of total health expenditure.

ASSPRO concludes that: 'from a macro-level perspective, formal and informal patient payments for healthcare services seem negligible, which can explain the limited policy attention devoted to them. However, these payments have a considerable impact on the individual patients by creating financial barriers to access healthcare services.'<sup>53</sup>

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<sup>53</sup> ASSPRO, European Policy Brief, February 2013, p.5.

**Table 2.2 Conclusions from the ASSPRO research project: magnitude of informal payments**

Informal payments - magnitude indicators					
	Bulgaria	Hungary	Lithuania	Poland	Romania
Informal payments for physician visits (% of adult users)	9.6	20.8	19.8	6.7	28.7
Informal payments for hospital admissions (% of adult users)	19.8	44.2	49.7	16.4	49.5
Average informal payment per physician visit (euro)	8.23	8.75	16.16	13.51	14.73
Average informal payment per hospital admission (euro)	44.11	67.31	79.64	37.88	63.42
Total informal payments for services by adults (% of GDP)	0.10	0.20	0.20	0.04	0.30
Total informal payments for services by adults (% of total health expenditure)	1.50	2.10	2.70	0.60	6.30

Source: ASSPRO, European Policy Brief, February 2013.

## 2.3 Medical devices

As described by the WHO, medical devices include thermometers as well as sophisticated and costly diagnostic imaging equipment<sup>54</sup> and can be classified in different risk classes based on the potential risks to the human body that are associated with the technical design and manufacture of the devices<sup>55</sup>:

- Class I – low risk (e.g. sticking plasters);
- Class IIa – low to medium risk (e.g. tracheal tubes);
- Class IIb – medium to high risk (e.g. X-ray machines);
- Class III – high risk (cardiovascular catheters).

Any medical device that will enter the European market needs to have a CE mark, i.e. comply with the relevant legislation, notably with Directive 93/42/EEC, or with the active implantable devices Directive 90/385/EEC or with the in vitro devices Directive 98/79/EC.<sup>56</sup>

### 2.3.1 Market size

The medical device industry is an important sector for economic growth in the EU. About 6.8% of total healthcare expenditure is spent on medical devices<sup>57</sup>.

In our recent study on medical devices (2011)<sup>58</sup>, we provide the following overview of the medical device sector. 'The global market for 'medical technology' is estimated by the European Commission at 219 billion euro (2007). For 2007, the total turnover for

<sup>54</sup> WHO. Medical devices. Fact Sheet No 346. September 2010.  
<http://www.who.int/mediacentre/factsheets/fs346/en/index.html>. (visited 22 Augustus, 2012).

<sup>55</sup> Based on Directive 93/42/ and Directive 90/385/EEC.

<sup>56</sup> [http://ec.europa.eu/health/medical-devices/faq/market\\_en.htm](http://ec.europa.eu/health/medical-devices/faq/market_en.htm)

<sup>57</sup> [http://ec.europa.eu/health/medical-devices/competitiveness/facts-figures/index\\_en.htm](http://ec.europa.eu/health/medical-devices/competitiveness/facts-figures/index_en.htm).

<sup>58</sup> Volkerink, B., Adamini, S., Meindert, L., van der Wiel, S., Canoy, M. Sectorstudie Medische Hulpmiddelen. Onderzoek naar de structuur en werking van de markt voor medische hulpmiddelen. Rotterdam: Ecorys, 2011.

medical technology was 72.6 billion euro in the EU. Eucomed, which represents the medical technology industry sector in Europe, estimates the total size of the European market higher, at about 95 billion euro in 2009. The largest markets in the European Union are Germany and France, with sales of 22.8 and 19 billion euro respectively.

The European Commission estimates that there are about 11 000 companies in the sector<sup>59</sup>, while Eucomed estimates that about 25 000 companies are active<sup>60</sup>. Both sources estimate that SMEs account for about 80% of the total number. The European (providers) market is therefore a fragmented market with many small or medium-sized businesses. In some (parts of) segments the number of players can, however, be limited. There is a large number of multinationals operating in the European market.

### **2.3.2 Supply chain**

Medical device producers of high-tech devices offer their products all over the world, mainly in countries with a developed healthcare system. Almost without exception these producers come from the EU, the US or Japan. The selling of the products takes place primarily between the producer and the healthcare institution. Some (niche) products are offered through suppliers. Wholesalers do not play any significant part as hospitals generally buy directly. With regard to low-tech devices there are a limited number of links in the chain: from manufacturers (often with production outside Europe) either to wholesalers or direct to customers. Wholesalers mainly have a logistical role (collecting shipments, stock management, etc.).

Corruption in the medical devices sector occurs throughout all stages of the supply chain. This study focuses on corruption in the certification and procurement stages (see coloured blocks in Figure 2.3 next page).

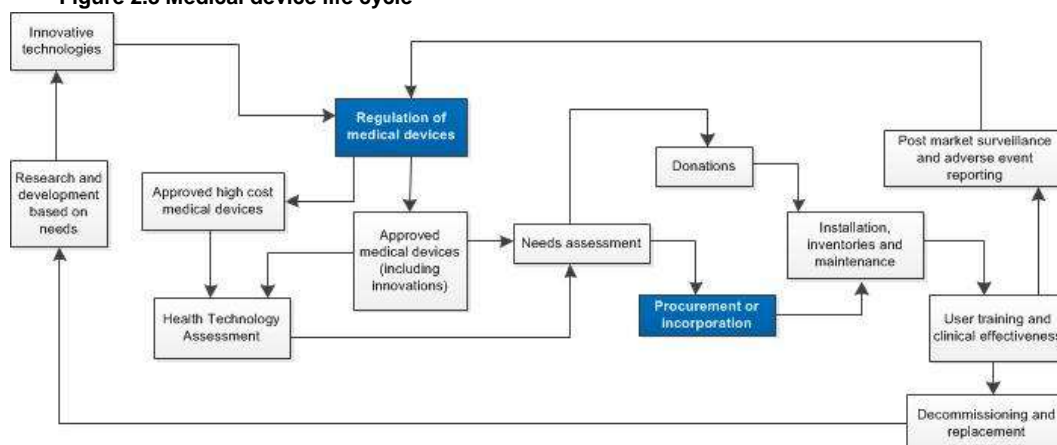
Types of corruption in these stages include for example:

- Bribery/extortion/kickbacks in certification stage;
- Bribery/extortion/kickbacks in procurement;
- Favouritism in procurement (in selection for restricted tender or by direct ordering for example);
- Collusion in procurement (e.g. bid-rigging and market division);
- Awarding contracts to inappropriate suppliers, for example, companies that do not actually provide the services required.

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<sup>59</sup> [http://ec.europa.eu/health/medical-devices/competitiveness/facts-figures/index\\_en.htm](http://ec.europa.eu/health/medical-devices/competitiveness/facts-figures/index_en.htm).

<sup>60</sup> <http://www.eucomed.org/key-themes/value-of-our-industry>.

**Figure 2.3 Medical device life cycle**

Source: WHO: Development of Medical Supply Policies, WHO Medical Device Technical Series.

### 2.3.3 Risk factors and indicators for corruption

The market of medical devices is characterised by a number of potential market failures. One of these market failures is information asymmetry. Manufacturers have the benefit of having much more information than users: they know the functioning (and limitations) of their product; know the cost structure, etc. The demand side of the market (specialists, nurses, buyers, management/board) is very fragmented, both in terms of knowledge of the (sometimes very specialised) use of the devices and also knowledge about what other (substitutable) devices are available. The users of medical devices are therefore strongly dependent on the knowledge, expertise and information provided by manufacturers (for example with specialised operations, with the use of equipment, etc.). The fact that the users share little or no information between themselves (price, quality, etc.) is also a factor.

Another possible risk factor is the presence of market power/advantages of scale in the market for medical devices. For high-tech products, large and sustained research and investment efforts (R&D) are needed that can only be made worthwhile by benefiting from the temporary protection of patents and accompanying market power and higher prices or by such a degree of product differentiation that higher prices can be achieved. High profits attract entry to the market but patents, high investment costs and/or high costs for obtaining a position in the market limit entry.

In the procurement phase, the risk of corruption depends on the level of decentralisation of the procurement process and the method of purchasing that is used:

- Tenders (open tender, restricted tender); or
- Quotation-based methods (request for quotes, competitive negotiations); or
- Direct Ordering.

The risk of corruption increases with the level of decentralisation of the procurement process. Of the different purchasing methods, direct ordering is the least transparent and most open to corruption, while (open) tenders are more transparent and less

open to corruption. Moreover, the smaller the number of suppliers that are part of the procurement process, the higher the risk for collusion.

The prevalence of relatively low quality devices can indicate possible corruption in both the certification and the procurement phase. Other indicators of corruption in the procurement stage are for example a low number of suppliers involved, a low number of bids, relatively high prices, and low number of 'new' suppliers involved in the procurement process<sup>61</sup>.

Moreover, when a contract value is just below the tendering threshold this can also be an indicator of corruption as this might be done deliberately to remove the need for a public tendering process.

It is calculated that 10 to 25% of public procurement spending (including on pharmaceuticals) is lost to corrupt practices.<sup>62</sup> A recent study from WHO (2011)<sup>63</sup> showed that 'most high income countries do not have procurement guidelines and usually do not use national procurement schemes. National procurement guidelines are developed in only 30% of the EU Member States.'

Corruption issues related with public procurement have recently been subject to a study 'Identifying and reducing corruption in public procurement in the EU' conducted by Ecorys, PwC and Utrecht University and commissioned by the European Anti-Fraud Office (OLAF).<sup>64</sup>

#### 2.3.4 Certification of medical devices

Before a medical device can be marketed in the EU, EEA and/or Switzerland, the manufacturer has to acquire a CE marking for the device<sup>65</sup>. This assures that the device is in compliance with the essential requirements, as set-out in three Directives regulating medical devices; Directive 93/42/EEC, the active implantable devices Directive 90/385/EEC and the in vitro devices Directive 98/79/EC<sup>66</sup>. The Directives also outline the appropriate conformity assessment route for obtaining the CE marking<sup>67</sup>.

A Notified Body is involved in the certification of class IIa, class IIb and class III medical devices. For a class I device this is only necessary if it has a measuring

<sup>61</sup> Indicators of performance measures procurement process of medical devices according to WHO.

<sup>62</sup> WHO. Medicines: corruption and pharmaceuticals, Fact Sheet No 335. December 2009.  
<http://www.who.int/mediacentre/factsheets/fs335/en/index.html> (visited 22 Augustus, 2012).

<sup>63</sup> WHO. Fact sheet on health technologies: Selected Results from the Baseline Country Survey on Medical Devices 2010 – European region. Available via:  
[http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0011/140051/Fact\\_sheet\\_HT\\_2011.pdf](http://www.euro.who.int/__data/assets/pdf_file/0011/140051/Fact_sheet_HT_2011.pdf).

<sup>64</sup> [http://ec.europa.eu/anti\\_fraud/documents/anti-fraud-policy/research-and-studies/pwc\\_olaf\\_study\\_en.pdf](http://ec.europa.eu/anti_fraud/documents/anti-fraud-policy/research-and-studies/pwc_olaf_study_en.pdf).

<sup>65</sup> With the exception of custom made devices, devices intended for clinical investigation and in vitro devices intended for performance evaluation as specified in the three main directives regulating medical devices.

<sup>66</sup> All three directives can be found at: [http://ec.europa.eu/health/medical-devices/documents/index\\_en.htm](http://ec.europa.eu/health/medical-devices/documents/index_en.htm).

<sup>67</sup> Note that some devices may also have to fulfil the requirements of other Directives to be CE marked, e.g. the Machinery Directive [http://ec.europa.eu/health/medical-devices/files/guide-stds-directives/interpretative\\_machinery\\_2009\\_en.pdf](http://ec.europa.eu/health/medical-devices/files/guide-stds-directives/interpretative_machinery_2009_en.pdf) and the Personal Equipment Directive: [http://ec.europa.eu/health/medical-devices/files/guide-stds-directives/interpretative\\_ppe\\_2009\\_en.pdf](http://ec.europa.eu/health/medical-devices/files/guide-stds-directives/interpretative_ppe_2009_en.pdf).

function or is placed on the market in a sterile condition<sup>68</sup>. The Notified Body is responsible for the evaluation of all documents and requirements as specified in the Directives. The Notified Body is appointed by the competent authority of a MS and is generally a company in the private sector. When a Notified Body has assessed all relevant requirements and issues the certification, the ID number of that Notified Body has to be affixed to the medical device together with the CE marking. Different Notified Bodies in a MS can provide the same conformity assessment route and are therefore, to some extent, competitors. The fees charged by the Notified Bodies for their involvement in the assessment are not regulated; they can differ between Notified Bodies (also within one MS).

When the CE marking issued, no additional certification is necessary for market access. However, individual countries have the right to demand registration of medical devices or can impose requirements regarding language of product information<sup>69</sup>.

### Revision of the Directives

On 26 September 2012 the EC adopted proposals for revision of the medical device Directives to address several issues such as supervision of Notified Bodies, the lack of transparency and traceability and the management of the regulatory system<sup>70</sup>. The most important changes mentioned (and that are relevant for the certification process) include<sup>71</sup>

- Wider and clearer scope of the legislation;
- Introduction of a classification system with four different risk classes for in vitro diagnostic medical devices, as already in place for other medical devices;
- Stronger supervision of Notified Bodies by national authorities;
- Notified Bodies will receive more power with regard to manufacturers ensuring comprehensive testing and regular checks;
- Introduction of a new scrutiny system: i.e., the obligation for Notified Bodies to inform an expert committee of new applications for conformity assessments for high-risk devices. This expert committee can request a summary of the preliminary assessment report and comment on it before certification is issued.

The expectation is that the new legislation will be adopted in 2014 and that it will come into effect over the years 2015-2019<sup>72</sup>.

With regard to corruption in healthcare, the most important changes are the stronger supervision of Notified Bodies and the introduction of a new scrutiny system. These measures have the potential to mitigate the risks for corruption associated with the involvement of Notified Bodies in the conformity assessment procedure.

<sup>68</sup> [http://ec.europa.eu/enterprise/policies/single-market-goods/cemarking/professionals/manufacturers/notified-body/index\\_en.htm](http://ec.europa.eu/enterprise/policies/single-market-goods/cemarking/professionals/manufacturers/notified-body/index_en.htm).

<sup>69</sup> [http://ec.europa.eu/health/medical-devices/faq/market\\_en.htm](http://ec.europa.eu/health/medical-devices/faq/market_en.htm).

<sup>70</sup> [http://ec.europa.eu/health/medical-devices/files/revision\\_docs/revision\\_ia\\_summary\\_en.pdf](http://ec.europa.eu/health/medical-devices/files/revision_docs/revision_ia_summary_en.pdf).

<sup>71</sup> Proposal for a REGULATION OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL on medical devices, and amending Directive 2001/83/EC, Regulation (EC) No 178/2002 and Regulation (EC) No 1223/2009:

[http://ec.europa.eu/health/medical-devices/files/revision\\_docs/proposal\\_2012\\_542\\_en.pdf](http://ec.europa.eu/health/medical-devices/files/revision_docs/proposal_2012_542_en.pdf).

<sup>72</sup> [http://ec.europa.eu/health/medical-devices/files/revision\\_docs/qa\\_20120926\\_en.pdf](http://ec.europa.eu/health/medical-devices/files/revision_docs/qa_20120926_en.pdf).

### 2.3.5 Corruption in the certification stage

It appears that there are several aspects of/stages in the certification process that are at risk for corruption. First of all there is a risk for corruption when there is no need to involve a Notified Body in the assessment procedure and a manufacturer can thus perform the assessment himself.

When a Notified Body is involved there is the risk for integrity violations such as conflict of interest. For example when someone previously employed in the medical device industry starts working for a Notified Body. Other risks are related to the fact that Notified Bodies may compete with each other, are in general profit-maximising companies, and charge an unregulated fee. This creates a risk for direct corruption (such as bribery and kick-backs). Although Notified Bodies should not be able to compete on time spent on assessment and stringency of requirements, this may happen, tempting manufacturers to choose the 'easy route'. This creates risks for corrupt practices and unfair competition. Note, however, that it is the responsibility of the manufacturer to choose a Notified Body. These risks are all (at least partly) related to the risk of differences in the (quality of the) control by the competent authorities. The lack of uniformity allows Notified Bodies to operate differently. This not only causes risks for corrupt practices, but also for unfair competition.

### 2.3.6 Policies and practices

Over the last few years Notified Bodies have set up initiatives to (self)regulate and harmonise the functioning of Notified Bodies. On the European level there is the NB Med group that comprises of all (currently approximately 80) Notified Bodies. This group has regular meetings on, for example, the functioning of the regulatory system. Next to the NB Med group there is TEAM NB<sup>73</sup> (European Association Medical Devices of Notified Bodies). It is a private organisation and has 30 (large) Notified Bodies as its members. One of the focus areas concerns; in October 2012 the Code of Conduct (CoC) came into effect. This CoC is, amongst other things, a response to the lack of uniformity in control and auditing by the competent authorities and the resulting differences between Notified Bodies. The CoC has already received positive responses. For example, Doctors without Borders (which is a buyer of medical devices) will mention in their tenders that they will only buy products that received CE marking after assessment by a Notified Body that signed the CoC<sup>74</sup>.

Next to the Notified Bodies, the sector has also implemented measures to self-regulate the process. For example, Eucomed has published a comprehensive code of conduct for its members. Another initiative is that during the ENVI meeting on 26-2-2013 a proposal for joint audits was mentioned. This would mean that Notified Bodies would not only be audited by the competent authority of their own country, but also by a representative from another country. This could prove to be a good policy for addressing the differences in control and auditing.

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<sup>73</sup> <http://www.team-nb.org/>.

<sup>74</sup> Source: interview with a Notified Body that is a member of TEAM NB.

In the light of corruption in healthcare, the most important changes are the stronger supervision of Notified Bodies and the introduction of a new scrutiny system as these measures have the potential to mitigate the risks for corruption associated with the involvement of Notified bodies in the conformity assessment procedure.

## 2.4 Pharmaceuticals

Pharmaceuticals (also called drugs, medicines, medications or medicinal products) can be defined as 'any chemical substance intended for use in the medical diagnosis, cure, treatment, or prevention of disease'.<sup>75</sup>

A marketing authorisation is required to place medicinal products on the market in the EU. Marketing authorisations are therefore of crucial importance for producers of medicinal products. They are aimed to safeguard public health.

In Europe, regulations have been partially harmonised by laws of the European Union. This so-called centralised (or community) procedure results in a single marketing authorisation that is valid in all MSs, as well as in Iceland, Liechtenstein and Norway. For a number of categories, the centralised procedure is compulsory: human medicinal products for HIV/AIDS; cancer, diabetes; neurodegenerative diseases; autoimmune and other immune dysfunctions; and viral diseases; medicines derived from biotechnology processes; advanced-therapy medicines; officially designated orphan medicines. Companies have the option to submit an application for a centralised marketing authorisation to the European Medicines Agency (EMA) for medicinal products that do not fall within these categories, as long as the medicine concerned is a significant therapeutic, scientific or technical innovation, or if its authorisation would be in the interest of public health.<sup>76</sup>

In addition, there is a national procedure, which means that each Member State has its own procedures for the authorisation of medicines that fall outside the scope of the centralised procedure. Companies must submit an application to the competent authority of the MS.

There is also an option for companies to apply for simultaneous authorisation in more than one MS with regard to medicinal products that have not yet been authorised in any MS and that do not fall within the mandatory scope of the centralised procedure (i.e. decentralised procedure). Furthermore, there is a so-called mutual recognition procedure in which a medicinal product is first authorised in one MS while further marketing authorisations can be sought from other MS whereby the countries

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<sup>75</sup> Directive 2004/27/EC of the European Parliament and of the Council of 31 March 2004 amending Directive 2001/83/EC on the Community code relating to medicinal products for human use. Article 1. Published March 31, 2004. Accessed 13 December 2012.

<sup>76</sup> See:  
[http://www.ema.europa.eu/ema/index.jsp?curl=pages/about\\_us/general/general\\_content\\_000094.jsp&murl=menus/about\\_us/about\\_us.jsp&mid=WC0b01ac0580028c79](http://www.ema.europa.eu/ema/index.jsp?curl=pages/about_us/general/general_content_000094.jsp&murl=menus/about_us/about_us.jsp&mid=WC0b01ac0580028c79).



concerned agree to recognise the validity of the original, national marketing authorisation.<sup>77</sup>

### 2.4.1 Market size

The pharmaceutical sector is a significant contributor to employment and manufacturing in the EU. Kavanos *et al.* calculated in 2011 that during 2000–2006 an increase of 5.6% in employment for the EU resulted from development of the pharmaceutical sector.<sup>78</sup> Also, the pharmaceutical sector is the highest R&D spending sector in the world. In 2006, approximately 70.5 billion euro was spent on pharmaceutical-related R&D.

From a study that we conducted in 2009<sup>79</sup> it appeared that 'pharmaceutical expenditure (as share of GDP) is rather low in comparison with other components of healthcare expenditure, e.g. hospitals and ambulatory care. Overall across a group of OECD countries with consistent data, all medical goods (including pharmaceuticals) have contributed to around 20% of health spending compared with over 60% from hospital and ambulatory providers.<sup>80</sup>

The OECD average spending on pharmaceuticals was 1.5% of its GDP in 2005 and 2006, but is continuously rising due to the ageing population and access to advanced-therapy medicinal products (ATMPs). The level of per capita pharmaceutical spending varies greatly across the EU: the Nordic countries have the lowest share of pharmaceutical spending as part of their GDP, ranging from 0.7% in Norway to 1.2% in Finland and Sweden. Expenditures on pharmaceuticals as part of GDP are highest in Hungary (2.6%), followed by Portugal and the Czech Republic.

### 2.4.2 Supply chain

As described in our study on pharmaceuticals (2009)<sup>81</sup>, 'the supply chain of the pharmaceutical sector contains several basic features which are almost identical across all EU MSs. It is characterised by two types of suppliers: originator companies and generic companies. The distribution system of pharmaceutical products includes wholesalers, retailers and parallel traders. The wholesale channel is mostly used by community pharmacies, while hospitals buy more often directly from the pharmaceutical companies through tendering procedures. Retailers of pharmaceutical products are typically community pharmacies. Other channels are self-dispensing doctors, hospital pharmacies, and for non-prescription products (e.g. over-the-counter

<sup>77</sup> Marketing authorisations: Types of Application. <http://www.mhra.gov.uk/Howweregulate/Medicines/Licensingofmedicines/Marketingauthorisations/Typesofapplication/index.htm> - visited 13 December 2012.

<sup>78</sup> Kanavos, P., Vandonos, S., Irwin, R., Nicod, E., Casson, M. Differences in costs of and access to pharmaceutical products in the EU. European Parliament. Directorate General for Internal Policies. Policy Department A; Economic and Scientific Policy, 2011.

<sup>79</sup> ECORYS (2009). Competitiveness of the EU market and Industry for Pharmaceuticals. Volume I: Welfare Implications of Regulation.

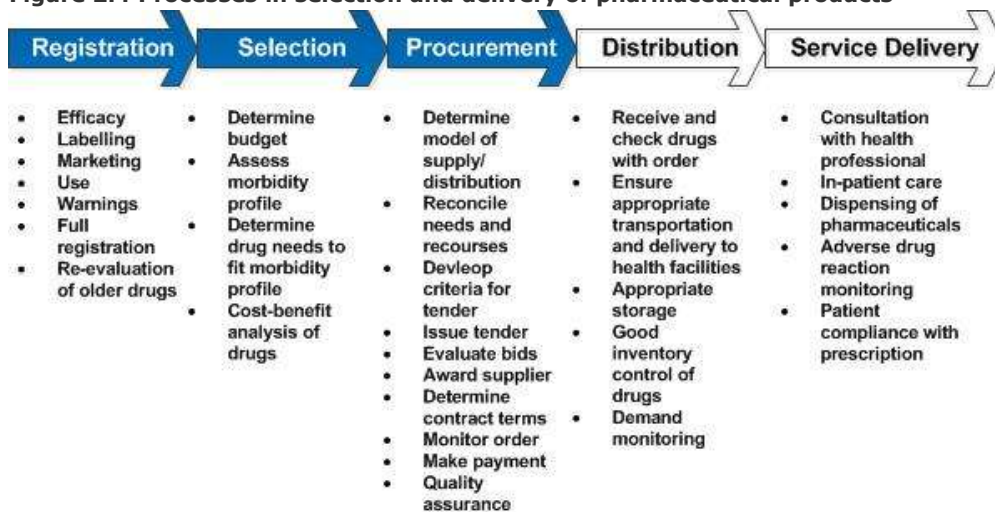
<sup>80</sup> Morgan D, Oxley H, 2008, Improving health-system efficiency: achieving better value for money, introductory presentation: some key features of growth and cross-country differences in health-care spending, OECD and European Commission conference.

<sup>81</sup> ECORYS (2009). Competitiveness of the EU market and Industry for Pharmaceuticals. Volume I: Welfare Implications of Regulation.

products) pharmacy outlets, medicine stores, supermarkets and petrol stations. The demand side consists of a complex interrelation between, amongst others, patients, doctors, hospitals, insurance providers, and reimbursement systems. For prescription medicine a unique market feature is the fact that the consumer (e.g. the patient) differs from the decision maker (e.g. generally the prescribing doctor), and very often also from the bearer of the costs (e.g. generally the health system).'

As for medical devices, corruption in the pharmaceutical sector occurs throughout all stages of the supply chain. This study focuses on corruption in the authorisation (registration), selection and procurement stages (see coloured blocks in Figure 2.4 below).

**Figure 2.4 Processes in selection and delivery of pharmaceutical products**



Source: Cohen J.C. (2006), 'Pharmaceuticals and corruption: a risk assessment'. In Global Corruption Report 2006 London: Transparency International, pp. 77-84.

Types of corruption related to the authorisation and procurement of drugs include:

- Bribery/extortion/kickbacks in authorisation of pharmaceuticals;
- Bribery/extortion/kickbacks in procurement;
- Collusion in procurement (e.g. bid-rigging and market division);
- Favouritism in procurement – conflict of interest/unethical donations (in selection for restricted tender or by direct ordering for example).

### 2.4.3 Risk factors and indicators for corruption

Pharmaceutical markets are characterised by a number of potential market failures such as under-investment for particular diseases, free-riding behaviour concerning the use of R&D, and information asymmetry between professionals and clients on various levels. Therefore the sector is extensively regulated.

As with medical devices, information asymmetry and market power are risk factors for corruption.

Another risk factor in the pharmaceutical market is related to high degree of regulation. Studies on other government sectors indicate that the prevalence of corruption increases when there is a big role for the government<sup>82</sup>.

Furthermore, a low level of governance is a risk factor; according to the WHO countries with weak governance within the medicines chain are more susceptible to being exploited by corruption as they lack appropriate medicines regulation, enforcement mechanisms and conflict of interest management.

Finally, the promotion of drugs with physicians is a risk factor for corruption as this may lead to favouritism in the procurement process.

The indicators for corruption in the procurement stage in the pharmaceutical sector are the same as those in the market for medical devices, i.e. prevalence of relatively low quality, relatively high prices, low number of suppliers involved in procurement, a low number of bids, low number of 'new' suppliers involved in the procurement process and contracts just below the tendering threshold. As stated above, it is calculated that 10 to 25% of public procurement spending (including on pharmaceuticals) is lost to corrupt practices.<sup>83</sup>

#### **2.4.4 Marketing authorisation of pharmaceuticals**

Before a pharmaceutical can be marketed in the EU and/or a specific MS, the pharmaceutical company has to apply for marketing authorisation. There are four different procedures, with different scopes for authorisations. The first distinction we can make is whether the pharmaceutical company wants to apply for marketing authorisation in one or multiple MS.

##### **Marketing authorisation in a single Member State**

When seeking to acquire marketing authorisation in a single MS, the industry has to follow the decentralised procedure at national level. Each EU MS has its own procedures for this kind of authorisation,<sup>84</sup> which can differ across MS.

##### **Marketing authorisation in multiple Member States**

When seeking marketing authorisation in multiple MS simultaneously three possible procedures can apply depending on a) the (class) of pharmaceuticals and b) whether or not there is already a marketing authorisation for the pharmaceutical in another MS: the centralised procedure, simultaneous decentralised procedure or the mutual-recognition procedure.

<sup>82</sup> Cohen J.C. (2006), 'Pharmaceuticals and corruption: a risk assessment'. In Global Corruption Report 2006 London: Transparency International, pp. 77-84.

<sup>83</sup> WHO. Medicines: corruption and pharmaceuticals, Fact Sheet No 335. December 2009. <http://www.who.int/mediacentre/factsheets/fs335/en/index.html> (visited 22 Augustus, 2012).

<sup>84</sup> For list of national competent authorities for authorisation of medicines for human use see: [http://www.ema.europa.eu/ema/index.jsp?curl=pages/medicines/general/general\\_content\\_000155.jsp&mid=WC0b01ac0580036d63](http://www.ema.europa.eu/ema/index.jsp?curl=pages/medicines/general/general_content_000155.jsp&mid=WC0b01ac0580036d63).

### **Centralised procedure**

In the centralised procedure the European Medicines Agency (EMA),<sup>85</sup> is responsible for the scientific evaluation of applications<sup>86</sup>. When an application through EMA is approved, it results in a single marketing authorisation, which is valid in all EU countries and the European Economic Area (EEA) countries Iceland, Liechtenstein and Norway.

The centralised procedure is compulsory for<sup>87, 88</sup>: Pharmaceuticals for the treatment of HIV/AIDS, cancer, diabetes, neurodegenerative diseases, auto-immune and other immune dysfunctions, and viral diseases; Medicines derived from biotechnology processes, such as genetic engineering; Advanced-therapy medicines, such as gene-therapy, somatic cell-therapy or tissue-engineered medicines; Officially designated 'orphan medicines', which are pharmaceuticals used for the treatment of rare diseases.

If a pharmaceutical does not belong to one of the four categories listed above, an application for single marketing authorisation can only be made if the pharmaceutical is 'a significant therapeutic, scientific or technical innovation, or if its authorisation would be in the interest of public (or animal) health'<sup>89,90</sup>.

Important actors in this procedure are: the competent scientific committee of EMA, the Committee for Medicinal Products for Human Use (CHMP), the rapporteur and co-rapporteur designated by the CHMP, the Standing Committee on Medicinal Products for Human Use<sup>91</sup>, and the European Commission. The CHMP and the rapporteurs perform the assessment. Taking into account the response of the applicant to this assessment, the CHMP will formulate an opinion and communicate this to the European Commission that has the ultimate authority for granting single marketing authorisation. The European Commission consults different DGs and sends its draft decision to the Standing Committee. When this committee also formulates a positive opinion, marketing authorisation is granted for five years<sup>92, 93</sup>. When a pharmaceutical is not eligible for the centralised procedure, there are two other procedures that can grant marketing authorisation in multiple countries. Which procedure can be used depends on whether or not a marketing authorisation for any MS is already obtained.

<sup>85</sup> [http://www.ema.europa.eu/ema/index.jsp?curl=pages/about\\_us/general/general\\_content\\_000091.jsp](http://www.ema.europa.eu/ema/index.jsp?curl=pages/about_us/general/general_content_000091.jsp).

<sup>86</sup> For both human and veterinary medicines.

<sup>87</sup> In the case of pharmaceuticals for human use.

<sup>88</sup> [http://www.ema.europa.eu/ema/index.jsp?curl=pages/about\\_us/general/general\\_content\\_000109.jsp&mid=WC0b01ac0580028a47](http://www.ema.europa.eu/ema/index.jsp?curl=pages/about_us/general/general_content_000109.jsp&mid=WC0b01ac0580028a47).

<sup>89</sup> [http://www.ema.europa.eu/ema/index.jsp?curl=pages/about\\_us/general/general\\_content\\_000109.jsp&mid=WC0b01ac0580028a47](http://www.ema.europa.eu/ema/index.jsp?curl=pages/about_us/general/general_content_000109.jsp&mid=WC0b01ac0580028a47).

<sup>90</sup> Note that for some classes of pharmaceuticals that are eligible for the centralised procedure, such as medicinal products for paediatric use, orphan, herbal medicinal products and advanced therapies, there are specific rules: [http://ec.europa.eu/health/documents/eudralex/index\\_en.htm](http://ec.europa.eu/health/documents/eudralex/index_en.htm).

<sup>91</sup> In which each MS has a representative.

<sup>92</sup> [http://ec.europa.eu/health/authorisation-procedures-centralised\\_en.htm](http://ec.europa.eu/health/authorisation-procedures-centralised_en.htm).

<sup>93</sup> [http://www.ema.europa.eu/ema/index.jsp?curl=pages/home/Home\\_Page.jsp&mid=](http://www.ema.europa.eu/ema/index.jsp?curl=pages/home/Home_Page.jsp&mid=).

***Decentralised procedure***

When a pharmaceutical has not yet been authorised in any MS and it is not mandatory to use the centralised procedure, the decentralised procedure can be used to apply for marketing authorisation in multiple countries.

In this procedure, identical applications for authorisations have to be sent to the national competent authorities in the different MS simultaneously. The applicant selects a 'Reference Member State' (RMS) which will prepare a first draft assessment that will be sent to the other MS that received the application, the so-called 'Concerned Member States' (CMS)<sup>94</sup>. The CMS can provide comments regarding the draft assessment after which the RMS will prepare another draft assessment report as well as a summary of product characteristics (SPC) and a labelling and package leaflet. The CMS then decide on accepting the application. In case of acceptance the marketing authorisation is granted and in case of rejection, an arbitration procedure is started. In general the assessment of the RMS will be accepted unless (one of the) CMS has serious concerns concerning public health risks.

***Mutual-recognition procedure***

When a pharmaceutical already has a marketing authorisation in one MS and the company wants to apply for authorisation of the drug in multiple EU countries, it can use the mutual-recognition procedure.

This procedure is in some ways similar to the decentralised procedure as identical applications have to be sent to all MS in which marketing authorisation is sought. Again a RMS is selected (in this case the country where the marketing authorisation has already been granted). The other MS are also in this case referred to as CMS. The RMS sends a copy of the completed assessment together with the SPC and labelling and package leaflet to the CMS. The CMS then have to decide on granting national marketing authorisation. When one or more of the CMS have serious concerns regarding potential severe public health risks, this will be referred to the coordination group<sup>95</sup>, which is composed of one representative per MS and EEA country. If MS fail to reach consensus in the coordination group, an arbitration procedure is started. Hence, the main difference with the decentralised procedure is that the CMS are involved earlier in the mutual-recognition procedure.

***Referral and arbitration procedure***

During the decentralised procedure and the mutual-recognition procedure, disagreements between MS can arise (e.g. on the use of the pharmaceutical or regarding safety concerns). Disagreements are arbitrated through the so-called referral procedure. A referral procedure can be initiated by a MS, the EC or by

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<sup>94</sup> Chavan *et al.* (2011) Marketing Authorisation Procedures in Europe: A Regulatory Perspective': [http://urpjournals.com/tocjnls/24\\_3.pdf](http://urpjournals.com/tocjnls/24_3.pdf).

<sup>95</sup> [http://ec.europa.eu/health/authorisation-procedures-mutual-recognition\\_en.htm](http://ec.europa.eu/health/authorisation-procedures-mutual-recognition_en.htm).

pharmaceutical companies. In the referral procedure, EMA is asked to perform a scientific assessment. Which committee deals with a referral depends on the reason why the procedure was initiated<sup>96</sup>. EMA provides its scientific opinion to the EC that has the final authority for deciding on marketing authorisation. In most cases, the decisions made by the EC reflect the EMA recommendations<sup>97</sup>.

#### 2.4.5 Measuring corruption in marketing authorisation

The procedures for marketing authorisation are highly regulated, especially the centralised procedure. The scope and risk for corruption in marketing authorisation depend on which procedure is followed, i.e. the risk for corruption is low in the centralised procedure. The marketing authorisation procedure is vulnerable to different types of corruption such as direct corruption through for example kickbacks and bribery (especially at other than centralised procedures), corruption through favouring relations (especially in national procedures) and through a variety of integrity violations such as conflicts of interest and revolving doors politics.

There are measures in place to mitigate corruption risks, such as codes of conduct. An example is the EMA policy on handling conflicts of interest.<sup>98</sup> EMA asks all its experts to fill in a declaration of interest each year and it defines risk levels on these declarations. All this information is published on the EMA website.<sup>99</sup> Over the last few years EMA policies have become more strict and pro-active in reaction to incidents related to conflict of interest. An example from 2010 concerns the former Executive Director of EMA. He took up an advisory role in the pharmaceutical sector a few weeks after he left EMA. This is a conflict of interest and several organisations expressed their concerns in an open letter to the EC<sup>100</sup>.

Although EMA strengthened its policy on conflict of interest as a response to this, there has been another incident. This time it concerned chief counsel who left the Agency in June 2012. Only one week after he resigned he was appointed as a counsel at a law firm advising pharmaceutical companies<sup>101</sup>. This example illustrates that there is still scope for corruption through integrity violations. However, last year the European Court of Auditors concluded that EMA is doing better than several other EU agencies in terms of dealing with conflict of interest.<sup>102</sup>

<sup>96</sup> For example in case of a referral related to safety, the assessment is first done by the Pharmacovigilance Risk Assessment Committee (PRAC) and then by the CHMP (in case of the decentralised procedure) or by the Coordination Group for Mutual Recognition and Decentralised Procedures – Human (CMDh) (in case of the mutual-recognition procedure). Other types of referrals regarding pharmaceuticals for human use are solely assessed by the CHMP.

<sup>97</sup> More information of referrals:

[http://www.ema.europa.eu/ema/index.jsp?curl=pages/regulation/general/general\\_content\\_000150.jsp&mid=WC0b01ac05800240d0](http://www.ema.europa.eu/ema/index.jsp?curl=pages/regulation/general/general_content_000150.jsp&mid=WC0b01ac05800240d0).

<sup>98</sup> [http://www.ema.europa.eu/ema/index.jsp?curl=pages/about\\_us/document\\_listing/document\\_listing\\_000178.jsp&mid=WC0b01ac0580029338](http://www.ema.europa.eu/ema/index.jsp?curl=pages/about_us/document_listing/document_listing_000178.jsp&mid=WC0b01ac0580029338).

<sup>99</sup> [http://www.ema.europa.eu/ema/index.jsp?curl=pages/about\\_us/landing/experts.jsp&mid=WC0b01ac058043244a](http://www.ema.europa.eu/ema/index.jsp?curl=pages/about_us/landing/experts.jsp&mid=WC0b01ac058043244a).

<sup>100</sup> [http://www.apha.org/IMG/pdf/24Feb2011\\_letter\\_Commissioner\\_Dalli\\_Lonngren\\_EMA\\_conflictinterest\\_FINAL.pdf](http://www.apha.org/IMG/pdf/24Feb2011_letter_Commissioner_Dalli_Lonngren_EMA_conflictinterest_FINAL.pdf).

<sup>101</sup> <http://www.ft.com/intl/cms/s/0/c597b412-c6b4-11e1-95ea-00144feabdc0.html#axzz2Ijpa80xt>.

<sup>102</sup> [http://www.pharmatimes.com/Article/12-10-17/EU\\_auditors\\_report\\_on\\_EMA\\_conflict-of-interest\\_record.aspx](http://www.pharmatimes.com/Article/12-10-17/EU_auditors_report_on_EMA_conflict-of-interest_record.aspx).

## 3 Typologies of healthcare corruption

As indicated in Chapter 1, the identification of different corruption in healthcare typologies is at the heart of our research. A typology generally consists of a systematic classification of cases or types (in our study: corruption types) that have characteristics or traits in common. The typologies can give us a deeper understanding of the main drivers, complexities and prevalence of corruption in the European healthcare sector.

### 3.1 Introduction

We have asked our 28 EU MS rapporteurs to identify and describe 3 to 6 cases of alleged corruption in healthcare. In each country local reporters used all possible sources from media files, interview tips and possibly court registers to identify corruption cases. The cases cover the three areas of our research (informal payments in medical service delivery; certification and procurement of medical equipment; authorisation and procurement of pharmaceuticals). The cases should preferably be proven. However, since actual convictions of corruption in healthcare are relatively rare in most MS, on-going cases and cases that are not (yet) on trial but have received large media attention, are included. For on-going cases the issue is more delicate since it is not clear yet in a legal sense that there is corruption.

Each case report consists of:

- a factual description of the case (detailed description of the case which includes if possible: facts, main actors, estimated prejudice, type of corruption, activities, detection, and judicial follow-up);
- a contextual interpretation (interpretation of the case, for example if the case is an example of systematic corruption or an exception; risks; impacts etc.).

Rapporteurs were also asked to indicate the relevant healthcare area and the status of the case (is the case a proven court-case or just a suspicion of corruption – either because the case is under investigation, or because the case is derived from media reports). Cases should have actually occurred preferably in the last 5–10 years, i.e. not to be theoretical, ‘invented’ cases or examples. An actual court decision was not required; a suspicion of corruption was sufficient.

It was also established which risk factors were at play in each case. This was based on assessment of the country rapporteurs or, if missing, on the assessment by the research team. In addition, an assessment was made of whether the case represented a systematic issue or was rather incidental in nature.

#### Initial findings

86 cases of corruption covering all EU MS were identified and described. A brief outline of each case is presented in Annex A. 17 cases concern informal payments in medical service delivery, 33 cases pharmaceuticals, 24 cases medical devices and 3 cases



corruption acquisitions related to 'revolving door' job rotations. 9 cases fell outside the scope of our study.

**Table 3.1 Number of cases per area**

Number of corruption-in-healthcare cases	
Informal payments in medical service delivery	17
Pharmaceuticals	33
Medical devices	24
Revolving doors	3
Unclassified	9
<i>Total number of cases</i>	86

Source: Country reports of EU 28 MS.

**Bribes and kickbacks.** Bribery was one of the most frequently mentioned types of corruption, both in the case reports and in the interviews. Bribes (money) are being paid and received in almost all cases in the area of medical service delivery, but also many cases that are related to procurement and purchase of pharmaceuticals and medical devices. Kickbacks (a negotiated bribery) occur in cases that are related to the purchase and procurement of medical equipment and devices.

**Co-occurrence of various types of corruption.** We asked our country rapporteurs to link the cases to the general corruption definitions (see Chapter 1 for definitions). These definitions were explained in an Annex of the country profile instructions. It seemed that in most cases various forms of corruption co-occur. In many cases bribes are being paid or kickbacks are negotiated to influence the procurement process, to promote medicines to 'positive lists' of drugs, and to influence the purchase and prescription and purchase of medicines. Bribes and kickbacks often coincide with other forms of corruption such as, trading in influence, nepotism and conflict of interests.

**Misuse of high-level positions, revolving door corruption and regulatory capture.** In some of the cases we have identified high-level politicians and policy makers are actively involved in the corrupt interactions with the industry and/or healthcare providers. Political and administrative nepotism is considered to be a particular problem in certain EU MS. We will return to this issue in Chapter 3.9.

**Authorisation and certification.** Within the areas of pharmaceuticals and medical devices very few cases have reported concerning the specific issues of authorisation and certification. This may be the result of the rather technical nature of these processes that are only known in detail by a small number of people in each country. This may have influenced the identification of issues and nature of interview respondents in several countries.

**Procurement corruption.** Many cases in the area of pharmaceuticals and medical devices are related to procurement and purchase of pharmaceuticals and medical devices. We have defined procurement as the complete process of acquiring pharmaceuticals (for example vaccines) and medical devices from suppliers. It often



involves large and/or long-term contracts. Procurement is distinct from 'purchasing' goods and services, which refers to the specific activity of committing expenditures.

**Improper marketing relations.** A closer look at the cases that fall under the categories pharmaceutical and medical devices reveals that many of them are not specifically related to procurement. Corruption in the area of pharmaceuticals and medical devices can also be related to the registration of medicines and pharmacies, drug selection for 'positive lists' or the direct or indirect promotion of drugs or medical devices with physicians. We will label this important corruption-in-healthcare category as 'improper marketing relations'. The interview reports support the notion that 'improper marketing relations' is one of the prevailing types of healthcare corruption in the MS. We will describe this in detail in the next chapter.

**Inducement.** Inducement can be defined as a way of influencing by giving 'benefits' with the aim to *indirectly* stimulate a preference to buy or use a product or service, or to promote loyalty to a certain supplier (for example through a conference that is held on a tropical island whereby the trip and accommodation are paid for the pharmaceutical company). As opposed to bribery there is an indirect and long-term causal relation between the benefit provided and the action by the other party. Inducement often occurs in relation to improper marketing.

Note that inducement is not necessarily illegal. Rules and regulations differ across countries and are in some non-existent. Depending upon the country certain limits towards inducement have been agreed upon and crossing these limits may be punishable depending upon the country's legislation (for example in Netherlands and Sweden). In our findings, many cases have elements of inducement. Most of these cases are related to pharmaceuticals. Pharmaceutical companies and doctors are the main actors in these cases, whereby these companies are influencing in an indirect way the prescription of medicines.

**Cross-border cases.** Most cross-border cases concern the sale of legal, illegal or counterfeit medicines in foreign countries. Other cross-border cases are the organ scandal case that caused an unjustified advancement of German patients on the European list for organ transplants (Box 3.4), and several high profile cases that are related to activities of international pharmaceutical and medical device companies, such as recently the Smith & Nephew case (Box 3.1 below), the Philips Poland case (Box 3.8) and the Ratiopharm case (Box 3.10).

**Box 3.1 Bribes to surgeons through a maze of offshore companies**

The US Security and Exchange Commission (SEC) has charged the London-based medical device company Smith & Nephew with violating the Foreign Corrupt Practices Act (FCPA) for bribing public doctors in Greece for more than a decade to win business. The misconduct began in 1997, when Smith & Nephew subsidiaries developed a scheme to pay bribes to Greek doctors through a maze of offshore companies and subsidiaries of the firm, including US and German subsidiaries. Charges alleged that Smith & Nephew has channelled more than 9 million US dollars (about 7 million euro) to persuade Greek surgeons to use its artificial hips and knees. The Greek distributor of Smith & Nephew justified the bribery system, saying that competitors were paying even higher rates at the time. In February 2012 the US subsidiary of Smith & Nephew agreed to pay more than 22 million US dollar (about 17 million euro) to the SEC and Ministry of Justice. Smith & Nephew's chief executive commented: 'These legacy issues do not reflect Smith & Nephew today. But they underscore that we must remain vigilant and let nothing compromise our commitment to integrity.'

Source: Ecorys Country Report 2013; Financial Times, February 6, 2012.

**3.2 Towards a corruption-in-healthcare typology**

It seems from our initial analysis of the cases that the various types as they are generally defined in the corruption literature (bribery, kickbacks, conflict of interest, nepotism etc.) are not a useful discriminating criterion for a deeper analysis of the drivers and prevalence of corruption in health. Corruption is a complex phenomenon and single cases often include several types of corruption. Likewise, it can be questioned whether the distinctions between types of healthcare industry (pharmaceuticals versus medical devices) clarifies the various forms of corruption. The interactions and processes behind procurement, purchase or promotion of medicines and medical devices are very much similar.

In addition to this the initial division in 'procurement and certification of medical equipment' and 'procurement and authorisation of pharmaceuticals' misses one frequently occurring corruption-in-health typology (as highlighted by many interviewees and confirmed with various case examples): improper marketing relations, as we have named it. Improper marketing relations cover all interactions between the industry and healthcare providers and/or regulators that are not directly linked to the procurement process. It includes authorisation and certification but is broader, and sometimes more indirect, than this.

To come to an analytically, practically and policy-wise meaningful grouping of corruption in health typologies the cases were grouped on the basis of similarities and common attributes.<sup>103</sup> In addition we have, wherever possible, defined subtypes for each typology.

<sup>103</sup> Kluge, S. 'Empirically Grounded Construction of Types and Typologies in Qualitative Social Research', Forum: Qualitative Social Research, Volume 1, No.1, Art.14, January 2000.

Our main distinguishing characteristic is based on the actors that are involved (patients, providers, payers, the industry and regulators). A definition and description of the main types of players per category has been presented in table 1.2. The table below presents an overview of the main typologies as we have identified them from the perspective of the actors that are involved.

**Table 3.2 Corruption-in-healthcare-typologies**

Main actors	Typology	
Providers - Patients	Bribery in medical service delivery	Typology 1
Industry - Providers	Procurement corruption	Typology 2
Industry - Providers	Improper marketing relations	Typology 3
Industry - Regulators	Improper marketing relations	
All actors (except patients)	Misuse of (high) level positions	Typology 4
Providers - Payers	Undue reimbursement claims	Typology 5
Providers	Fraud and embezzlement of medicines and medical devices	Typology 6

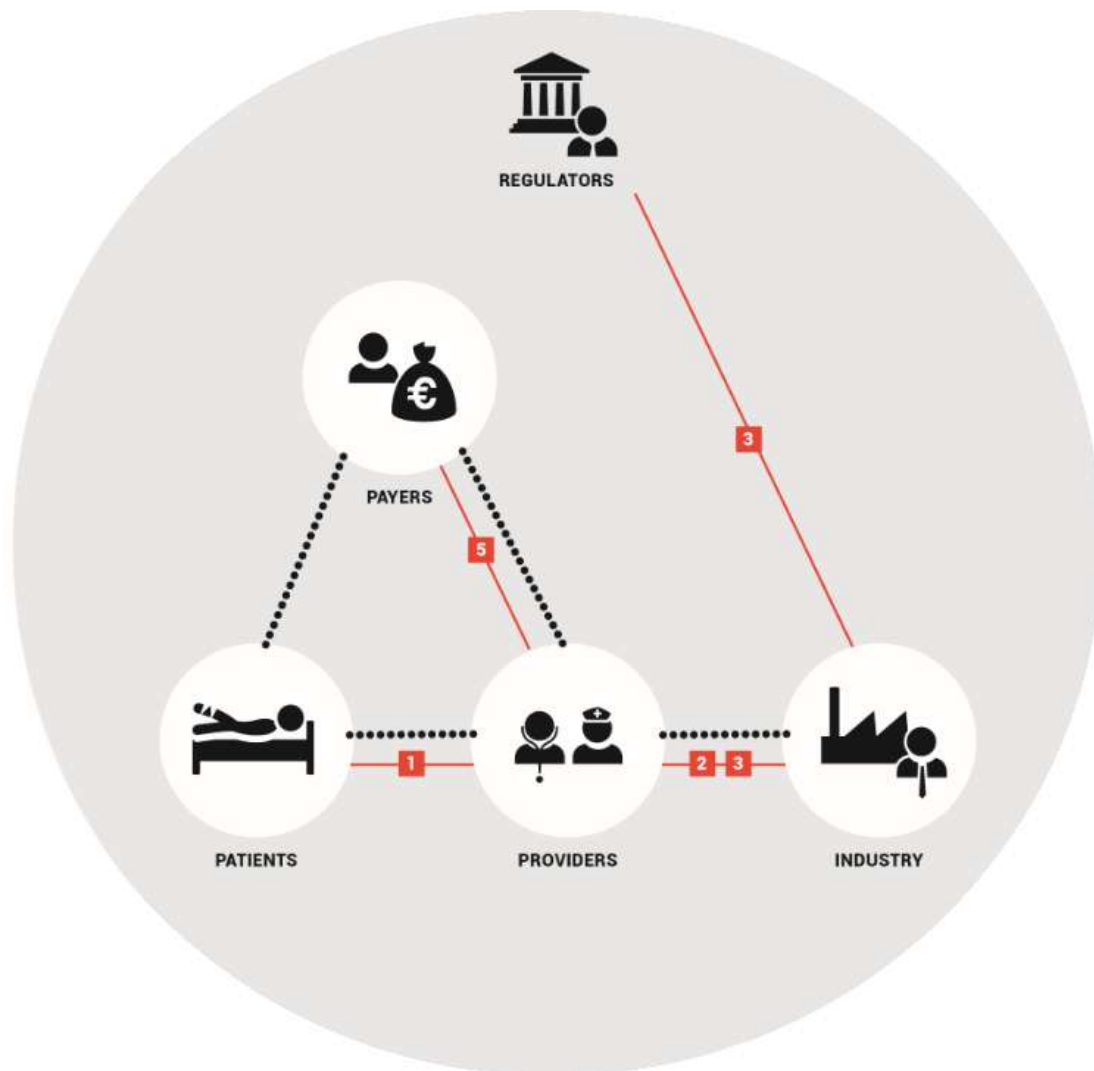
The number of cases in our database gives us an – however incomplete – indication of the relative frequency of each of the areas of corruption (table 3.3). Note that not all typologies fall within the scope of this study. However, we felt that they are worth mentioning in order to complete the picture of the corruption and fraud in the European healthcare system.

**Table 3.3 Number of cases**

Typology	Number of cases
Bribery in medical service delivery	17
Medical devices (procurement, purchase, improper marketing relations)	20
Medical devices (sale of non-certified products)	4
Pharmaceuticals (procurement, purchase)	7
Pharmaceuticals (improper marketing relations)	16
Sale of public medicines for private gain	6
Sale of unauthorised or counterfeit medicines	4
Revolving doors	3
Unclassified cases	9
<i>Total number of cases</i>	86

As stated earlier, the main distinguishing characteristic of the typologies is based on the key players that are involved. In the figure below a simplified model of the major financial relations and corruption typologies between actors in the healthcare system is presented.

Figure 3.1 Corruption in healthcare actors and typologies



#### Corruption typologies

..... FINANCIAL FLOW

— CORRUPTION

- 1** Bribery in medical service delivery
- 2** Procurement corruption
- 3** Improper marketing
- 4** Misuse of (high level) positions
- 5** Undue reimbursement claims

Source: Ecorys / Medamo Data Visualisation

The first three typologies – bribery in medical service delivery (typology 1), procurement corruption (typology 2), and improper marketing relations (typology 3) – are presented in Chapter 3.3, 3.4 and 3.5. For each of the typologies a general description is provided, including an analysis of the main actors, subtypes, characteristics, drivers and – if possible – prevalence (magnitude). The analysis is based on the cases we have identified, the interviews in the 28 EU MS and findings from the literature on corruption in healthcare.

Misuses of (high-level) positions (typology 4) will be described in Chapter 3.6. Note that this typology is intertwined with the previous 3 typologies. This typology applies in particular to often deeply embedded and opaque forms of high-level corruption. Because of the complexity of the issue and the connection with most other typologies, it will be discussed as a separate typology. Undue reimbursement claims (typology 5) and fraud and embezzlement of medicines and medical devices (typology 6) fall outside the focus of our study, but are relevant in the corruption-and-fraud in healthcare debate. We will introduce these typologies briefly in Chapters 3.7 and 3.8.

In this chapter we will analyse each of the typologies on:

- Actors
- Subtypes
- Features
- Drivers
- Prevalence

We were only able to describe the prevalence (size of the problem, geographical prevalence) in a more qualitative way. We have searched for data on the magnitude of corruption in healthcare. However there are very little (almost no) data available. An exception is the ASSPRO research project on informal payments in some Eastern European MSs, however these data are merely perceptions as is the case with most corruption 'data'. A complicating factor is that corruption (in healthcare) also covers a very large 'grey area', where corruption is much more intangible and it is difficult (impossible) to distinguish illegal and legal, ethical and unethical behaviour. This is in particular relevant for typology 3 and 4 (improper marketing relations and misuse of high level positions) and often also for typology 2 (procurement corruption). We have discussed issues related to this grey area separately in Chapter 3.9.

### **3.3 Bribery in medical service delivery**

Bribery in doctor to patient service delivery is the most visible form of corruption in healthcare – and in Central and Eastern European also the most common form of healthcare corruption. It burdens healthcare consumers directly, as they have to pay an extra – informal – fee for services that they are entitled to and which already have been paid through either their insurance premiums or by the state. Paying and accepting bribes for medical services are a major problem from the social point of view, as the effects are usually suffered by the underprivileged. It directly touches upon the universal principle of equal access to healthcare. The main characteristics of this typology are summarized as:

**Table 3.4 Bribery in medical service delivery**

<b>Typology 1      Bribery in medical service delivery</b>	
Actors	Healthcare providers (individual and institutions) versus patients
Subtypes	Bribery to obtain: <ul style="list-style-type: none"> <li>- Access to healthcare</li> <li>- Preferential treatment</li> <li>- Better quality of healthcare</li> <li>- False sick leave statements</li> </ul>
Features	Mainly a transfer of cash from patients to the healthcare practitioner. Informal payments are offered by patients or demanded by service providers.
Drivers	<ul style="list-style-type: none"> <li>- Personal gain or interests, greed</li> <li>- General healthcare scarcity (insufficient healthcare funding)</li> <li>- Scarcity in specific healthcare areas or for specific healthcare services</li> <li>- Low salaries for healthcare providers</li> <li>- Cultural perceptions (presenting 'gifts' are considered as 'normal')</li> <li>- Limited control and accountability</li> </ul>
Prevalence	Mostly widespread and systemic in Central and Eastern European countries and some Southern European countries such as Greece and Italy. Cases that have been identified in some other European countries, such as Austria and Germany, are often more individual and isolated, or related to scarcity in specific types of healthcare (for example organ transplantation). See also: misuse of dual practices.
Relevant policies	See Chapter 4. In particular 4.2, 4.3, 4.4 and 4.7.

### 3.3.1 Cases

We have identified a total number of 17 cases that were reported in the area of bribery in medical service delivery. Most cases concern the payment of bribes to doctors, but also other healthcare providers are involved. The majority of the cases are related to preferential treatment – particular to bypassing waiting lists. Other cases can be characterised as bribery to obtain access to better quality of healthcare – or a combination of these factors. In two cases a bribe was paid in return for a false sick leave certificate. Our rapporteurs classified the majority of the bribery in medical service delivery cases in the area of medical service delivery as 'systemic'.

Below, we present cases that are illustrative for the different subtypes of bribery in medical service delivery that are prevalent in the EU. We have selected some recent cases from a variety of EU MSs. The cases are related to: access to healthcare and better quality healthcare (box 3.2 and 3.3); Preferential treatment (box 3.4, box 3.5); False sick leave statements (box 3.6). A full list of cases is presented in Annex A.

**Box 3.2 180 euro per child**

Two doctors from a Romanian children's hospital in Bucharest were taken into custody after allegedly receiving a bribe to operate three children. The police found RON 6 000 (around 1 360 euro) in their pockets at the time of the search. The surgeon and anaesthesiologist were taken into custody for having taken a bribe and prosecutors are asking the court for a 29-day preventive arrest. According to the prosecutors, the surgeons allegedly received RON 1 800 to operate three children, which is RON 600 (180 euro) per child. Following the search, RON 3 000 (about 680 euro) were found in the pockets of an anaesthesiologist. He allegedly took RON 150 (35 euro) for one surgery and RON 200 for each of the other two.

In Romania, a very good surgeon who works in a state unit can earn a salary of maximum 1 000 euro per month, according to healthcare commentators. Romania has a deficit of healthcare personnel, with many doctors choosing to work abroad, where salaries are around four times higher than those in Romania, according to recruiters.

Source: Ecorys Country Report 2013; Romania Insider, April 9, 2013, <http://www.romania-insider.com/two-romanian-doctors-taken-into-custody-for-taking-bribe-over-three-child-surgeries/79430/>

**Box 3.3 'Facility payment' for a caesarean section in Bulgaria**

A physician was arrested because he requested informal patient payments to perform a caesarean section. When the pregnant woman came to the hospital for an emergency delivery, the physician on duty immediately asked for money. He said to the husband that he would not operate unless he received 400 BGL (about 200 euro). Since the husband did not have the money, the physician agreed that it could be handed over at the follow-up appointment in the physician's private practice when he was supposed to take out the stitches from the surgery. The husband brought the money (marked banknotes that could be identified by the police). The marked banknotes were found on the physician's desk.

Source: Ecorys Country Report 2013; <http://www.segabg.com/article.php?id=585422>. This case of informal payments in maternity care described in a Bulgarian *newspaper* on 18 January 2012.

**Box 3.4 The integrity of the transplant system has been shaken**

Two senior doctors in Leipzig have been suspended after an investigation showed that they had manipulated records to push 38 liver patients up the waiting list for organs. It could not be proven that 'money had changed hands' in exchange. The head of the clinic as well as two senior doctors have been given a leave of absence while the institution conducts an internal probe. Public prosecutors have opened a preliminary investigation. The affair follows revelations in 2012 that other German hospitals engaged in dubious practices with organ transplants, such as the Göttingen and Regensburg university hospitals, which are alleged to have falsified medical records in nearly 50 cases to push patients further up on the Eurotransplant waiting list. The scandal had observers concluding that if the regular system was so easy to manipulate, then bypassing it must be even simpler. The government and the Medical Association have reassured the public that corruption in the transplant waiting list has been eradicated. But the media seems convinced that public confidence in the integrity of the transplant system has been shaken. The *Frankfurter Allgemeine Zeitung* writes: 'The damage done is immense. The number of donor organs began dropping last year just as the first cases of deceit became public. Such cases also hurt transplant doctors, whose own area of specialisation has been plunged into disrepute.'

Sources: Ecorys Country Report 2013; AFP, Organ transplant scandal prompts calls for German reforms, January 3, 2013; BioEdge, German doctors shaken by corruption allegations, by Michael Cook, January 19, 2013; Die Welt/Wordcrunch, In Germany, It is all too easy to skip the organ waiting list, by Johannes Wiedemann, August 9, 2012.

**Box 3.5 Bypassing waiting lists, preferred surgeon, and social status**

In Austria it used to be socially acceptable to give small tips to doctors (20 to 30 euro). Patients also believed that doing so would guarantee them better treatment. These tips were given openly and without embarrassment on either side. However, this is no longer regarded as socially acceptable and if it happens, it happens in secrecy. There are many unconfirmed reports of under-the-table payments in Austria. It is referred to commonly as 'envelope' medicine. The Austrian Chamber of Medicine receives an annual average of 30–40 complaints and internal disciplinary procedures are followed, but these cases and the outcomes of the disciplinary hearings are not published. It is assumed that the vast majority of cases are not reported and it is further assumed that payments are not always insisted upon by doctors, but are offered by patients, and accepted willingly by doctors.

A major issue of waiting lists remains and the continuous pressures from the side of patients to gain advantages over other patients through making payments. For example, for hip repairs there is a 1.5 years waiting period. Patients, particularly the elderly, want treatment sooner rather than later. This creates enormous pressure on doctors to push patients up waiting lists and leads to corruption.

Source: Ecorys Country Report 2013.



**Box 3.6 Sick leave certificates for 1 euro per sick day**

In November 2012 the Press Agency of the Slovak Republic (TASR) reported that in that week a physician (general practitioner) from the city of Nitra was accused in a court by the investigator of the Office of the Fight against Corruption of the Presidium of Police Force, for the crime of taking bribes. The physician took 50 to 100 euro per patient for issuing a sick leave confirmation for healthy patients, so they can take days off work. The media brought up several such accusations in 2008-2012. For example, in 2010 the media ran coverage on court accusations of 4 physicians by the Office of the fight against corruption for issuing false sick leave certificates to healthy patients for a 'fee' (in cash without receipt) of 1 euro per sick leave day. The physicians can be sentenced to up to 8 years of imprisonment. The patients can be sentenced to up to 3 years of imprisonment.

Sources: Ecorys Country Report 2013; [http://www.pluska.sk/krimi/domace-krimi/lekar-z-nitry-mal-falsovav-pn-ky-hrozi-mu-osem-rokov-base.html?forward=sk\\_mobil\\_clanok.jsp](http://www.pluska.sk/krimi/domace-krimi/lekar-z-nitry-mal-falsovav-pn-ky-hrozi-mu-osem-rokov-base.html?forward=sk_mobil_clanok.jsp); <http://www.topky.sk/cl/10/804748/Obvinili-lekara--za-uplatky-mal-podpisovat-PN-ky>; <http://www.minv.sk/?41&sprava=dalsi-lekari-ziadali-a-prijimali-uplatky-za-fiktivne-pn-ky>.

**3.3.2 Actors**

Actors in bribery in medical service delivery are patients and healthcare providers. This is typically a one-on-one relationship.

**3.3.3 Subtypes**

Based on the desk and country research we identified five different subtypes:

- Bribery to obtain access to healthcare
- Bribery to obtain preferential treatment
- Bribery to obtain better quality of healthcare
- Bribery to obtain false sick leave statement

**3.3.4 Features**

Bribery in medical services delivery is most commonly observed to be a transfer of cash between patients and healthcare providers. The bribe can be offered by the patient or asked for by the physician and this can happen both before and after treatment has taken place.

However, as mentioned, it can also take the form of a gift. This usually happens *after* treatment has taken place. It is important to note here that gifts are generally not seen as a bribe. In many cases there is no relation between the quality of treatment and the gifts that have been presented. This type of informal payment should therefore not necessarily be considered as corruption.

We also identified, through our desk and country research, indirect bribery in medical service delivery in the form of misuse of dual practices. This refers to referrals from doctors working in public hospitals to their (own) private clinic. This private care arranged with public hospital facilities can be considered as an indirect form of bribery in doctor to patient service delivery.

### 3.3.5 Drivers

Bribery in medical service delivery occurs for different reasons. From the side of the patients it is apparent that a majority of these bribes are being paid to have access to treatment, receive preferential treatment, either in the area of access to (skipping waiting lists) or for better quality of care. For example in Cyprus journalists revealed that some doctors working in the public sector, in particular specialists, classified patients as emergency cases in exchange for money so that they could skip the waiting list. This notion is confirmed by many interviews: skipping or moving up waiting lists seems to be an important motivation for bribery in service delivery.

It is to a large extent triggered by systemic problems in the healthcare system, in particular scarcity and a lack of funding – either general or scarcity of specific types of healthcare services (for example transplant organs). Countries with relatively low healthcare funding (i.e., where healthcare expenditure as a percentage of GDP is below 7%<sup>104</sup>) include Cyprus, Spain, Latvia, Italy and Greece.

*Interview report Poland: 'Corruption at the line of patient-doctor still takes place and will continue doing so, as long as there are insufficiencies in healthcare financing. Insufficient resources in comparison to the needs are always a corruption-generating factor.'*

Other systemic drivers are:

- Low or irregular salaries for medical personnel. Low salaries, relatively low funding of the healthcare system and corruption are among the main reasons for doctors from Eastern European countries to migrate<sup>105</sup>. Moreover, corruption is considered an important push factor for migration of health professionals<sup>106</sup>. Hence, a lack of resources, low salaries and low prestige for medical profession are push factors in itself and are furthermore enabling factors for corruption; (there is, however, much debate on this issue: it seems that an increase in salaries alone will not solve the problem. More on this in the next chapter;
- Asymmetry of information between the physician and the patient (which is true across the EU);

<sup>104</sup> EU Average is 9%. Source: OECD Health at a Glance Europe 2012, available at: <http://www.oecd.org/els/health-systems/HealthAtAGlanceEurope2012.pdf>.

<sup>105</sup> Diana Ognyanova, Reinhard Busse (2010). 'Chapter 8: A destination and a source: Germany manages regional health workforce disparities with foreign medical doctors' in *Health Professional Mobility and Health Systems, evidence from 17 European countries*. European Observatory on Health Systems and Policies, Observatory studies series 23. Available at: [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0017/152324/e95812.pdf](http://www.euro.who.int/__data/assets/pdf_file/0017/152324/e95812.pdf).

<sup>106</sup> <http://phys.org/news/2013-05-corruption-migration-skilled-workers.html> and Diana Ognyanova, Reinhard Busse (2010). 'Chapter 8: A destination and a source: Germany manages regional health workforce disparities with foreign medical doctors' in *Health Professional Mobility and Health Systems, evidence from 17 European countries*. European Observatory on Health Systems and Policies, Observatory studies series 23. Available at: [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0017/152324/e95812.pdf](http://www.euro.who.int/__data/assets/pdf_file/0017/152324/e95812.pdf).

- Weak controlling mechanisms (e.g. in Spain, Italy, Greece and Portugal<sup>107</sup>);
- Contradictory regulation;
- High out-of-pocket payments for healthcare (e.g. in Cyprus, Bulgaria and Greece<sup>108</sup>);
- Tolerance by the population towards informal medical payments (which is the case in former socialist countries).

Informal payments are often embedded in a culture in which doctors are entitled to receive 'something extra'. This belief is in particular alive in Southern European countries and CEE countries<sup>109</sup> (as informal payments were considered common during the communist and transition period) and makes anti-corruption policies even more challenging as these societies do not perceive informal payments as corruption, but as common practice:

*Interview report Portugal: 'There are also strong underlying cultural conditions, as it is much enrooted in the Portuguese culture (as in many south European countries) that the doctor would be doing a favour to the patient by treating him/her and therefore, it is very common to give presents ('cunhas') in return.'*

*Newspaper article in which a former Romanian medical student reports: 'Later, when I started working as a junior doctor on the wards, I experienced the bribery system from the other side. (...) Many of the older patients, particularly from rural areas, hadn't known anything other than giving gifts. I wouldn't take money from patients and this was quite well known in the hospital, yet many insisted they had to give me something to say thank you. I remember one patient coming for monthly chemotherapy from a village about 12 miles away. Having heard from other patients that I would refuse his money, he brought me a huge chicken and two litres of wine. When I protested, he said, 'I have to give you something!' Most patients would bring me something. If they were from the villages they would bring some vegetables – usually things they had grown themselves.'<sup>110</sup>*

And finally personal gain and greed are always playing a role behind any form of corruption, as illustrated by the following:

*Interview report Czech Republic: 'Greed is an obvious factor. We cannot blame the system and not the doctors who are ultimately responsible.'*

<sup>107</sup> Transparency International (2012). Money, Politics, Power: Corruption Risks in Europe. Available at: [http://www.transparency.org/whatwedo/pub/money\\_politics\\_and\\_power\\_corruption\\_risks\\_in\\_europe](http://www.transparency.org/whatwedo/pub/money_politics_and_power_corruption_risks_in_europe).

<sup>108</sup> Source: OECD Health at a Glance Europe 2012, available at: <http://www.oecd.org/els/health-systems/HealthAtAGlanceEurope2012.pdf>.

<sup>109</sup> ASSPRO, European Policy Brief, February 2013, available at: [http://ec.europa.eu/research/social-sciences/pdf/policy-briefs-assprocee2007-02-2013\\_en.pdf](http://ec.europa.eu/research/social-sciences/pdf/policy-briefs-assprocee2007-02-2013_en.pdf).

<sup>110</sup> Source: *The Guardian*, Bribes for basic care in Romania, March 28, 2008. Romanian medical student Claudia Radu, 33, trained in hospitals in Bucharest and the northern Romanian county of Maramures before coming to work as a junior doctor in Britain in 2004.

### 3.3.6 Prevalence

Demanding and offering informal payments is in particular a characteristic of the healthcare system in *former socialist economies*. The ASSPRO Research Project has assessed patient payment policies and the magnitude of the informal payments problem in Central and Eastern European (CEE) countries. Table 2.2 in section 2.2 of this study summarizes their main results on the magnitude of informal payments.

It appears from our interviews that the custom of demanding and offering informal payments in doctor to patient service delivery is decreasing in some of the Central and Eastern European MS. In Czech Republic for example, a mandatory small doctor fee per visit has changed the habit of informal payments (source: Ecorys interviews in Czech Republic). The necessity to provide under-the-table payments is gradually disappearing from general medical services. What remains are informal payments related to some types of specialist services (child birth, gynaecology, orthopaedics) where people pay to speed up the process or to attain a preferred doctor. In other Central and Eastern European MS, bribery in medical service delivery is still rampant.

Bribery in doctor to patient service delivery is also reported to be a widespread problem in Greece. This concerns both the provision of hospital services and payments to individual physicians, primarily surgeons, so that patients can bypass waiting lists or ensure better quality of service and more attention by doctors. A recent survey using a sample of 4 738 individuals concluded that 36% of those treated in a hospital reported at least one informal payment to a doctor. Of these, 42% reported that the payment was given because of the fear of receiving sub-standard care and another 20% claimed that the doctor demanded such a payment. The probability of making extra payments is 72% higher for patients aiming to 'jump the queue', compared to those admitted through normal procedures. In addition, surgical cases had a 137% higher probability of making extra payments compared to non-surgical patients.<sup>111</sup>

*Interview report Greece: 'Bribes are given to secure access to a hospital, access to surgery or to bypass waiting lists. Even in the midst of the financial crisis these bribes range from 50 euro for admission to the hospital up to 3 000 euro for surgery'.*

<sup>111</sup> Liapopoulos L, Siskou O, Kaitelidou D, Theodorou M, Katostaras T., 'Informal payments in public hospitals in Greece', in: Health Policy. 2008 Jul;87(1):72-81. doi: 10.1016/j.healthpol.2007.12.005. Epub 2008 Feb 4.

**Figure 3.2 Anti-bribery sign in a Greek hospital**

Source: The Wall Street Journal, <http://live.wsj.com/>

From our country research it can be inferred that cases in other MS are in general recorded to be more isolated and exceptional. However, some Western European MS do record systematic but often unconfirmed incidents of under-the-table payments. For example in Austria, cases of under-the-table payments in particular relate to pre- and post-surgery treatment connected to circumventing waiting lists and insisting on treatment by a particular doctor. Sometimes social status can be a motivation to offer under-the-table payments:

*Interview report Austria: 'Patients feel more privileged when they make payment and this is often a matter of social status.'*

Some MS report that bribery in medical service delivery does occur but cannot be said to be an endemic phenomenon in the entire public health system. If it occurs, the phenomenon is restricted to some specialised types of healthcare, such as obstetricians, gynaecologists and surgeons, who incidentally accept informal payments. An example is Cyprus, as illustrated below.

*Publication on healthcare in Cyprus: 'High physician salaries and very strict legislation generally prevent informal payments, although in some cases it may occur. For example pregnant women who want to deliver their child in a public hospital with the gynaecologist or obstetrician of their choice usually offer a gift to their doctor'.<sup>112</sup>*

Scarcity in specific areas of healthcare can provoke (new forms of) bribery in doctor to patient service delivery. As has been mentioned before, informal payments do (incidentally or structurally) occur across all EU MS *in relation to the problem of (too) long waiting lists*. The recent organ transplant scandal in Germany is another example of (presumed) bribery in doctor to patient relations.

<sup>112</sup> Theodorou M, Charalambous C, Petrou C, Cylus J. Cyprus: Health system review. Health Systems in Transition. 2012; 14(6):1-128, page 52.

### 3.3.7 Misuse of dual practices

In addition to this, corrupt practices have occurred in several European MS (including Finland, Austria and Croatia) related to referrals from doctors working in public hospitals to their (own) private clinic. This private care arranged with public hospital facilities can be considered as an indirect form of bribery in doctor to patient service delivery.

There is a financial incentive for doctors working in state hospitals and private practices to steer patients to private institutions. This is considered as an alternative to demand informal payments, in a variety of EU MS, as the following quotes illustrate:

*Interview report Finland: 'Of the three sector focuses, informal, under-the-table payments are not a problem. They are unlikely to occur at all. But there is another somewhat related practice, particularly in big towns: physicians in public health care (specialist care) can recommend private sector follow-up care. They may recommend the facility they work in, or even their own practice.'*

*Interview report Austria: 'Listed doctors in private practice usually also work in public hospitals or hospitals funded with public money. Patients at public hospitals are sometimes steered towards private health care services. The incentive for the patient is often the possibility of quicker surgery. The incentive for doctors is that they are paid by private providers, and as a consequence, charge and receive higher fees in private practice. This also applies to other health care professionals. It happens on a regular basis and is systemic. However, there is no monitoring of this practice and no data, so the extent of it is unknown.'*

Dual practices can also be misused to negotiate favourable conditions for the own private clinic, such as this case from Denmark illustrates. This is a form of procurement corruption (typology 2).

#### **Box 3.7 Rewards for private clinic to negotiations for public clinic**

On May 30th 2007 the Danish newspaper Politiken reported that a senior physician has been reported by the public administration in Jutland to the police for corruption. The location was a regional hospital. The problem was that the physician had two jobs. He was employed at the hospital and at a private clinic. For the hospital he was responsible for procurement of medical devices. He negotiated with the industry, but at the same time he asked industry to come up with special offers for the private clinic. This was considered deeply unethical and the story suggested that the regional administration would formulate new demands for physicians with two jobs, one in the public and one in the private sector.

Source: Ecorys Country Report 2013; *Politiken*, March 30, 2007.

### 3.4 Procurement corruption

We will first look at the procurement process in general and subsequently describe the main features of procurement corruption in pharmaceuticals and medical devices. The main characteristics of this typology are summarized as:

**Table 3.5 Procurement corruption**

Typology 2	Procurement corruption
Actors	Industry (pharmaceutical and medical device companies) versus healthcare providers (specifically procurement departments and officials)
Subtypes	Corruption occurs in all phases of the procurement process: <ul style="list-style-type: none"> <li>- Pre-bidding: corruptive needs assessment</li> <li>- Pre-bidding: circumvention of tender procedures</li> <li>- Pre-bidding: tailored tendering</li> <li>- Bidding: bribery and kickbacks during the bid evaluation</li> <li>- Bidding: favouritism</li> <li>- Bidding: collusion and/or market division in bidding*</li> <li>- Post-bidding: false invoicing*</li> <li>- Post-bidding: changing contract agreements*</li> </ul> <p style="text-align: right;">* not encountered in our research</p>
Features	<ul style="list-style-type: none"> <li>- Bribes to individuals: money, leisure and trips, favouring relatives, offering discounts.</li> <li>- Bribes to medical institutions: money, conference participation, free supply of materials, research funding and other forms of monetary and non-monetary (research facilities) sponsorship.</li> </ul>
Drivers	Markets for medical devices and pharmaceuticals have some special characteristics that influence the functioning of these markets and have an impact on the risks for corruption, such as: patented products, close relationship between industry and providers in the development of new goods, and the high stakes involved taking into account the R&D intensive nature of the industry. The sophistication of the products also influences the degree of control that is possible in procurement procedures and regulatory affairs: few people can judge offers technically.
Prevalence	Worldwide 10–25% of public procurement spending in health (medical devices and pharmaceuticals) is lost to corrupt practices. <sup>113</sup> Healthcare procurement corruption occurs all over Europe. The problem is larger and more deeply embedded in MS that are characterised by weak procurement regulations or are suffering from high levels of (general) corruption such as Czech Republic, Latvia, Croatia, Slovakia, Romania, Italy, Bulgaria, Greece (according to the Transparency International Corruption Perceptions Index 2012 <sup>114</sup> ).
Relevant policies	See Chapter 4. In particular 4.2, 4.3, 4.5 and 4.7.

<sup>113</sup> Source: WHO. Medicines: corruption and pharmaceuticals, Fact Sheet No 335. December 2009. <http://www.who.int/mediacentre/factsheets/fs335/en/index.html> (visited 22 Augustus, 2012).

<sup>114</sup> Countries mentioned have a CPI below 50, which, according to Transparency International indicates that the country has a serious corruption problem, source: <http://cpi.transparency.org/cpi2012/results/>.



### 3.4.1 Cases

More than 20 cases can be grouped under the label of 'procurement corruption'. The majority of the procurement cases cover the relation between the industry (bidders) and healthcare providers (specifically procurement departments and officials). In few cases elements of collusion between bidders have been discovered. An important further observation is that the large majority of the cases concern corruption in the pre-tendering (influencing the tender specifications) and tendering phase, or a combination of these two.

The cases below present two well-known examples of procurement corruption in medical devices and pharmaceutical products, which are both under investigation by the SEC. A full list of cases is presented in Annex A. The Philips Poland case (box 3.8) is a typical case of pre-bidding procurement corruption (influencing tender specifications, making use of a third supplier). The Johnson & Johnson case (box 3.9) is a case of bribery of public healthcare workers.

#### **Box 3.8 Tailored tendering with third party agents**

Royal Philips Electronics was fined 4.5 million US dollar (about 3.5 million euro) by the U.S. Securities and Exchange Commission because of alleged bribery in Poland. The company accepted to pay the fine imposed by the SEC to settle the matter. From 1999 to 2007, in at least 30 bids, employees of Philips' subsidiary in Poland made improper payments to public officials of Polish healthcare facilities to increase the likelihood that public tenders for the sale of medical equipment would be awarded to Philips. Philips would submit the technical specifications of its medical equipment to officials drafting the tenders, who would incorporate these specifications into the contracts. This greatly increased the likelihood that Philips would win the bids. Certain officials involved in these arrangements also made the actual decision of whom to award the tenders. When Philips won, employees of Philips Poland allegedly paid these officials the improper payments. The bribes and kickbacks were 3% to 8% of the contract amounts. Philips Poland employees also kept some of the money for themselves. The employees often utilised a third party agent to assist with the improper arrangements and payments to the officials. The improper payments were falsely characterised and accounted for in Philips's books and records as legitimate expenses and were at times supported by false documentation created by Philips Poland employees and third parties.

A court case against the former Philips workers and 16 hospital directors accused of paying or receiving a total of about 3 million zloty (about 700 000 euro) began in 2011 and is not yet concluded.

Sources: Ecorys Country Report 2013; Bloomberg Businessweek, April 9, 2013; Richard L. Cassin, SEC releases final settlement order with Philips, [www.fcpa.blog](http://www.fcpa.blog), April 9, 2013. SEC Exchange Act of 1934, Release No. 69327 / April 5, 2013. File No. 3-15265.



**Box 3.9 Johnson and Johnson case: bribery of hospital staff**

In this case hospital employees, who were part of the procurement decision process, were bribed by the company Johnson & Johnson to favour tender processes and the purchase of medical equipment to the benefit of Johnson & Johnson (J&J). The investigation revealed that J&J paid a wide array of medical staff, from nurses and midwives, operating theatre chiefs, through to doctors, professors and hospital directors. The proceedings included cases that took place between 2001-2006 in approximately 100 hospitals. Charges were made against 110 persons, both employees of J&J and public healthcare personnel. The bribes were disguised as fictitious services provided by the doctors for employees of J&J (for example, trainings, symposium, and overpaid consults) in exchange for money. In exchange for the bribes the doctors were encouraging other doctors to become interested in purchasing J&J equipment and they tried to qualify the biggest amount of patients for procedures, which influenced the sale of J&J medical equipment. Apart from these activities, J&J sponsored doctors' trips to symposiums and trainings. Many doctors claim that they could not get trainings if not for the financial support of such concerns like J&J, as the under-financed Polish healthcare system does not invest in raising the doctors' qualifications. Moreover, inconsistencies in the tenders were also found. Furthermore, a former vice minister was also suspected for taking bribes of J&J while in the position of deputy director in SKarżysko-Kamienna. He was accused for setting tenders for medical supplies in favour of the company. This case came before court and was proven. It was discovered that J&J was also guilty of corrupt practices in other countries.

Source: Ecorys Country Report 2013.

Tim Mackey and Bryan Liang (2012) point out that over the last years many pharmaceutical and medical devices multinationals, such as Johnson & Johnson, Pfizer, Merck, Eli Lilly and Medtronic, have been accused of violating the USA and UK foreign anti-bribery laws through for example bribery of physicians and health officials. The authors pose that these corrupt practices result from the competition to gain entry to emerging markets<sup>115</sup>.

**3.4.2 Actors**

Procurement corruption concerns:

- The relation between the industry (bidders) and healthcare providers (specifically procurement departments and officials); and
- Collusion between different bidders.

In our research we mainly encountered procurement corruption associated with the first aspect.

<sup>115</sup> Mackey T.K. and Liang B.A. (2012) 'Combating healthcare corruption and fraud with improved global health governance'. *BMC International Health and Human Rights* 2012, 12:23. Available at: <http://www.biomedcentral.com/1472-698X/12/23>.

### 3.4.3 Subtypes

(Public) procurement is a multi-step process. It involves the full cycle from needs assessment through the preparation of the procurement, documentation and awarding of the contracts, implementation and monitoring of goods and services delivered. Numerous authors and institutions, such as the OECD and Transparency International, have made a step-by-step analysis of the procurement process and identified the risks for corruption in each phase.

The procurement processes can be roughly divided into three phases: pre-bidding, bidding, and post bidding. The main activities per phase can be summarized as follows:

**Table 3.6 The procurement process**

Phases of the procurement process	
Pre-bidding	<ul style="list-style-type: none"> <li>- Needs assessment and decision to contract</li> <li>- Definition of contract characteristics</li> <li>- Choice of procurement method</li> </ul>
Bidding	<ul style="list-style-type: none"> <li>- Invitation to bid</li> <li>- Evaluation of the bids</li> <li>- Awarding the contract</li> <li>- Contract award</li> </ul>
Post-bidding	<ul style="list-style-type: none"> <li>- Contract implementation</li> <li>- Contract monitoring.</li> </ul>

Sources: OECD (2007) integrity in Public Procurement Good Practice from A to Z; PwC and Ecorys (forthcoming study in commission of OLAF) 'Development of an EU evaluation mechanism in the area of anti-corruption with a particular focus on identifying and reducing the costs of corruption in Public Procurement involving EU Funds'.

Each phase includes activities that are prone to corruption. As the pre- and post-bidding phases are in general less transparent, and also less regulated, there is significant scope for corruption. Table 3.7 provides an overview of the different subtypes of procurement corruption per phase of the procurement process.

**Table 3.7 Subtypes of procurement corruption per phase**

Subtypes of procurement corruption per phase of the procurement process	
Pre-bidding	<ul style="list-style-type: none"> <li>- The choice for non-competitive purchasing methods (by for example splitting the contract to avoid the requirement for an open tender);</li> <li>- Not objectively determining requirements (motivated by favouritism); and</li> <li>- Providing different time frames for different bidders (by sending out tender invitations/information earlier to some bidders).</li> </ul>
Bidding	<ul style="list-style-type: none"> <li>- Favouritism (for example because of conflict of interest) in invitation to tender;</li> <li>- Bribery and kickbacks during the bid evaluation; and</li> <li>- Collusion and/or market division in bidding*.</li> </ul>
Post-bidding	<ul style="list-style-type: none"> <li>- False invoicing*;</li> <li>- Changing contract agreements (e.g. allowing higher prices)*.</li> </ul>

\* Not encountered in our research.

### 3.3.5 Features

There is a fundamental difference between isolated and systemic (embedded) procurement corruption.

***Isolated procurement corruption*** is a type of corruption that is done on a company-procurement officer basis (or a very limited number of officials involved). In general they tend to be smaller procurements and therefore attract less attention from the control mechanisms and also require smaller number of people involved, thus simplifying the operation. They also tend to be on a regional scale as the corrupted procurement official has to have enough influence to determine the outcome of the process, but not so important as to become very costly to corrupt (since the projects are of lower value). Usually the rather unsophisticated methods of corruption mean that in case that authorities focus on the procurement, corruption is relatively possible to spot as well as prosecute. Often the question is of functioning control mechanisms as most prosecutors and judicial systems are able to cope with such cases due to a lack of political involvement as well as complexity;

***Systemic procurement corruption.*** In some countries, such as Czech Republic, corruption in procurement is deeply embedded in the political functioning of the state. Such political involvement and cover create extensive and complex systems that ensure the smooth operation of the corrupt procedure since every step is covered and controlled by a corrupt individual.

#### **Direct and indirect procurement corruption**

For a good understanding of procurement corruption in healthcare another distinction should be made between direct and indirect procurement corruption. Direct procurement corruption occurs when corruption is used in order for a particular winner to be selected regardless of the offer. Indirect procurement corruption is a more sophisticated method to ensure that the preselected supplier wins the procurement, but technically does not violate the procedure rules and appears to have won out of merit as opposed to the actual corrupt practice.

***Direct procurement corruption.*** In the most common form of direct procurement corruption a company (or appointed intermediary) will approach a public official in charge of the procurement decision and offer him a bribe (in the form of money or other advantages) in exchange that he ensures that the chosen supplier will be awarded the procurement. This most often occurs despite the fact that other competitors have submitted a better or more competitive offer. The company is able to afford this and also profit from this by, most commonly, overpricing their bid or increasing costs at a later stage. Another direct procurement corruption is that of extortion.

***Indirect procurement corruption.*** Indirect procurement corruption can take many forms:

The most common practice in the corruption of procurement of medical equipment and medicine is indirect corruption, in particular by the use of ***tailored terms of reference***. This action requires the cooperation (usually acquired by bribing or applying 'pressure') of a public official in charge of setting the terms of the procurement and the requirements of the product/service that is being sought. The procurement process and requirements are then set in order for there to be only one perfect match of the product/service being offered by the corrupting company. This ensures that the selection committee will declare the predetermined bid as the winner and the process will appear to adhere by all rules and genuine, although it has been fixed beforehand. The popularity of such method is that the public officials can reject personal responsibility or accusations of corruption in pointing out to the correct procedure of the procurement.

For the same reasons of hiding responsibility the ***use of intermediaries*** is another tactic that may be used. The argumentation is that such intermediaries are experts in their field (of say MRI machines) and know the market, therefore will be able to secure a better deal and thus break the information disparity that is a common problem between the buyer and seller. However, there have been several high profile cases where intermediaries have been used in order to corrupt the procurement process. The way in which it works is that the intermediary comes to an agreement with the medical facility to supply it with say a new MRI machine. Already at this phase bribes and kickbacks are offered to the medical supplier in order to be chosen as the intermediary. The intermediary then makes bilateral agreements with the supplier on the product specification, delivery and maintenance. He then adds to the price his 'facilitation' fee and bills the medical facility without it being involved in the process.<sup>116</sup>

Corruption in the later parts of the procurement procedure, especially during the evaluation process is often conducted by ***excluding competitors***. This is done by the responsible public official (in return for a bribe or under duress) declaring that for a very particular reason certain bids have been disqualified. These bids tend to be the more competitive than the predetermined one and therefore are all eliminated until the chosen one appears to be the most beneficial one. In such a way the winning bid appears to have not only met all the requirements, but also appears to be the best deal for the authority, thereby attempting to prevent any accusation of wrong doings to be raised. The disqualified company may appeal, but since almost always there are genuine errors that the disqualification is based on, it is a difficult process and the corrupting official is relatively well covered from accusations.

An indirect practice in illegally influencing public procurement is by ***collusion***. This occurs when companies will divide procurements or geographical areas between themselves (sometime with the help/knowledge of a procurement official). The system works in the way that all the colluding firms will submit a

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<sup>116</sup> This is already after their fees have been counted in and their positive services evaluated.

bid, but only the chosen winner will submit a 'real' bid with what appears to be the most competitive offer (albeit it is already overpriced and the market price is fixed by the fake offers) and win as a result. In the next case the method is repeated only this time with a different 'winner'. Such practices are extremely difficult to prove that in case it is a case of corruption, rather than the reality of the market and open competition. Nevertheless there are strong indications from our research, where suspiciously certain regions are supplied exclusively by one company and a couple of miles further in a different region by another (although both supply a bid in both areas).

### **Methods of corrupting players**

As mentioned earlier there are multiple ways how to corrupt an individual. In fact the definition of corruption is to 'giving someone a financial or other advantage to encourage that person to perform their functions or activities improperly or to reward that person for having already done so':

The most known method is to **bribe with money**. This method remains a frequent method since banks have tight restrictions and monitoring mechanisms to trace money transfers and identify suspicious activity. Hard cash is very difficult to trace and therefore represents an easy and relatively secure way of transferring financial 'rewards' to corrupt players. In fact several recent high profile anti-corruption arrests have been based on arresting the perpetrators in the moment of receiving money as proof, before finding thousands of euros hidden for instance under floorboards in houses. The same method applies when gold, diamonds and other precious 'gifts' (such as expensive famous paintings) are given. Interestingly it appears that during the current economic crisis gold has increasingly been used to give bribes, mirroring the financial markets tendency to invest into gold in times of uncertainty.

More complex method bribery is the **use of kickbacks**. This is when a corrupt official receives a share of the profits or other advantages after the project has been completed, or even at times at a later date. The aim of deferring the bribe is to either ensure that it is paid only upon a successful outcome of the corrupt practice. But at times it is also an effort to hide the act of corruption since if time passes between the procurement and the payment of the kickback they might not be linked together by the authorities or journalists. An example of a kickback is for instance the gift of equity in a company that is associated with the project with the possibility to later sell the corrupt official share and collect the payment. Another example is of the winning company to offer the corrupt official a large discount on house/holidays as a reward, thus bypassing legislation on outright gifts.

Non-monetary kickbacks also include **trading in influence**. This has the same structure of a kickback, in that bribe is collected later, but also it is difficult to put a monetary value on it. In some countries, where organised crime syndicates are particularly influential this can come in the form to arrange that

the public official is re-elected. In procurement where political engagement is present a system is in place where the company rewards the political party by transparent party contribution and the party then rewards the procurement official with promotions or post of higher significance and remunerations (such as boards of directors of state companies).

### **Corruption through extortion**

This is an important aspect of corruption that should not be forgotten. It is the dark side of corruption where at times it is not only the 'carrot' that are offered to people, but also the 'stick' with which they are treated with. There is little corruption literature that considers the relation between corruption and extortion, but at times the perpetrators of corruption are not in complete control of their own fate. One should not underestimate the extent of pressure that in particular the public officials are put under.

This side of corruption complicates the story, but at the same time completes the description of corruption as a complex environment with mere humans at the heart of the issue with both greed and fear playing important parts.

There are two types of corruption through extortions: passive extortion and active extortion. Passive extortion is where the public official informs the bidders that he will award the procurement according to the size of the bribe that is given to him. In this way the public official violates the rules of open competition and sets up an auction of the procurement for his own personal benefit. Alternatively active extortion can take place where the company (or appointed intermediary) apply 'pressure' on the public official to influence the selection process. Such pressure can include threats (for example employment, career progression) or even physical violence against the person, his relatives or his property.

The pressure can also take the form legal attack or the threat of it. For instance in cases of urgent need for the delivery of medical equipment a company (or more commonly through an intermediary) might approach the public official and inform him that in case of losing the bid it will launch continuous legal challenges on the process of the procurement thus delaying the supply of the equipment.

The aim of this practice is to ensure that the targeted person will cooperate in the corrupt practice. It usually occurs in combination with offering incentives (such as bribes or high level positions) to increase the appeal of the deal. It is a very efficient method to illustrate to the targeted person that he/she does not have any other option, but to cooperate, for which they will be rewarded. The alternative is to play a risky game in order to see if the threats (sometimes very violent) are carried out. Such practice puts people into very difficult situations of a struggle between: moral conviction of the targeted people and (at times) self-preservation.

Corruption through extortion is particularly present in places with powerful organised crime syndicates. The prevalence is not quantified.

### 3.4.6 Drivers

One of the drivers for procurement corruption is the limited competition in the market for pharmaceuticals and medical devices, as well as the large sums of money and large profits that are at stake. Markets for medical devices and pharmaceuticals have some special characteristics that influence the functioning of these markets and have an impact on the risks for corruption. In both markets highly sophisticated goods are traded which are often patent protected after introduction. This limits competition and fosters specific bonds between a doctor and a specific medicine that can be used and misused by the suppliers. The development of these goods also requires close relationships between doctors and researchers working for industry. Huge amounts of money can be involved for a specific medicine or piece of equipment making the stakes high. Typically, the sales of only a few medicines determine the prosperity of a large multinational pharmaceutical firm, which sometimes has invested heavily in R&D upfront. Given the public nature of the markets parties often have to follow public procurement regulations, thereby also trying to make use of the opportunities and loopholes of the public procurement regulations. These drivers are valid for all EU MS, but it seems from the interviews that procurement corruption in healthcare is more widespread and embedded in countries where corruption is a more aggravated general and systemic problem in society.

### 3.4.7 Prevalence

Worldwide, 10–25% of public procurement spending in health (medical devices and pharmaceuticals) is lost to corrupt practices<sup>117</sup>. Information on this is not available at the EU level. Our research reveals that healthcare procurement corruption occurs across many different European MS. We have identified serious procurement-in-healthcare cases in a wide variety of European MS. As mentioned, procurement corruption in healthcare appears to be more widespread and embedded in countries where corruption is a more systemic problem in society, such as Czech Republic, Latvia, Croatia, Slovakia, Romania, Italy, Bulgaria and Greece, according to the Transparency International Corruption Perception Index<sup>118</sup>. In MS that are generally less susceptible of corruption procurement cases are more isolated and/or less obvious. Moreover, healthcare procurement corruption seems to occur less frequently in countries where the area of public procurement is highly regulated. A lack of reliable and independent control mechanisms also allow corruption to take place. In a few European MS, such as Czech Republic and Italy, procurement corruption seems to be strongly associated with the financing of political parties.

**Pre-bidding corruption is the predominant subtype.** Procurement corruption mostly occurs in an early stage of the procurement process. An overwhelming majority of the interviewees pointed at the risk of tailoring the tendering specifications to one preferred supplier as the most common or only form of procurement corruption. Procurement corruption is also related to the particular characters of the healthcare sector, where one single supplier may be able to cater to the demands of a

<sup>117</sup> Source: WHO. Medicines: corruption and pharmaceuticals, Fact Sheet No 335. December 2009. <http://www.who.int/mediacentre/factsheets/fs335/en/index.html> (visited 22 Augustus, 2012).

<sup>118</sup> Countries mentioned have CPI below 50, which according to Transparency International indicates that the country has a serious corruption problem.



procurer. We have discovered at least one case in which the decision to purchase new equipment was debatable, but stimulated with strong political backing (corruptive needs assessment).

Many interviewees note that public procurement of pharmaceuticals or medical devices is often designed for a particular supplier:

*Interview report Greece: 'The predominant type is setting up technical standards and specifications in such a way as to favour a single supplier and put obstacles to market competition.'*

*Interview report Hungary: 'The risk of corruption is the highest during the period before the decision is made, as before the decision is made, everything is already settled between the stakeholders, and the tender itself exclude potential applicants.'*

*Interview report Finland: 'If corruption occurs, it must occur at an earlier stage, when it is decided for which drugs or devices offers are asked for.'*

**'Natural' ties between physicians and the industry.** One of the elements in the pre bidding phase is the needs assessment. This is done in close cooperation with physicians.<sup>119</sup> Moreover, it is known that physicians have relations with suppliers of medical devices through for example consultancy contracts, involvement in development of new devices and conferences etc. These kind of ties between the industry and physicians are not illegal, in fact, it is important for R&D, education and post-market surveillance, that these ties exist. It should however not be the case that this influences the choice of treatment by the physician, and thereby the procurement process. Whether or not this is actually happening is difficult to determine, as the only one who can answer this question with certainty is the physician in question.

Personal interaction with a medical equipment company indicated that, in general, the number of people involved in the procurement of medical devices in a hospital is relatively small. Moreover, it is difficult for 'outsiders', such as the hospital management, to intervene in the discussions, as these are often very technical; only few people can therefore judge the nuances between alternatives.

**Bidding and post-bidding corruption.** Corruption in the bidding phase – when the procurement conditions are set – is less likely. However we have identified a few cases where offering bribes to the procuring authorities, during the tendering process, influenced the bidding procedure. In our study there are no cases of post-bidding corruption. Though it must be noted that corruption in the implementation phase (resulting in non-delivery of products or services or delivery against lower quality) is difficult to recognise.

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<sup>119</sup> <http://epub00.publitas.com/zorgmarkt/mei-11/magazine.php?spread=12#/spreadview/12/>, [http://zorgethiek.nu/wp-content/uploads/boonen\\_olthuis\\_zorgmarkt\\_mei2011.pdf](http://zorgethiek.nu/wp-content/uploads/boonen_olthuis_zorgmarkt_mei2011.pdf).



**Intermediary companies.** In some cases procurement corruption was committed with intervention of a third party agents, such as in the Philips Poland case.

Interviewees point at the use of facilitators to assist with the improper arrangements and payments to the officials:

*Interview report Czech Republic: 'One of the ways how this is done is through the use of companies that act as the facilitators of the sale of the equipment. They arrange the price, instillation, and building works for the hospital for a fee. The theory is that these companies have better industry knowledge and can negotiate better prices or conduct EU recognised tenders. In practice however, they arrange a tailored terms of reference for preferred suppliers at an inflated price.'*

*Interview report Hungary: 'A lot of information on procurement is hidden through the intermediary role of so-called 'packing organisations', which are intermediaries that are apply for the tender instead of the manufacturers themselves.'*

**Monetary and non-monetary benefits.** Bribery can involve money and non-monetary benefits, to individuals and to institutions. Bribery to individuals range from monetary benefits, to trips and conference visits, favouring relatives, or offering medical devices for personal (private clinic) use at favourable prices. Benefits to institutions can cover for example, free supply of material, conference participation, research funding and other forms of monetary and non-monetary (research facilities) sponsorship. Parties involved give low salaries and lack of resources for research and education as a justification for accepting the offers made by the industry.

**Costs of procurement corruption.** Corruption in procurement often results in overpricing goods and services, or in delivery of goods and services at inferior quality as compared to the goods and services of competitors that were unduly excluded. Overpricing was the obvious outcome in at least five cases. In some cases money was channelled back in the form of kickbacks (for example through invoicing for fictitious services). Procurement corruption also puts obstacles to sound market competition.

### 3.5 Improper marketing relations

Improper marketing relations between the industry (pharmaceuticals and medical devices) and healthcare professionals, was not explicitly labelled as one of the focus areas of our research. However, we came across many cases that cannot be categorised as procurement corruption nor as bribery in medical service delivery, but would fit into this description. In addition to this, many interviewees across virtually all EU MS pointed to issues related to the relation between the industry and healthcare providers (other than in procurement process) as the major area of healthcare corruption.

*Interview report Austria: 'Procurement as such is less of a problem than for example prescription policies and practices. The focus on procurement obscures the real problem of corruption in healthcare.'*

In general the behaviour of the pharmaceutical and medical devices industry is considered as one of the most problematic areas in healthcare regulation. The relation between the medical industry and medical service providers is a very close one. Money from pharmaceutical companies, and the influence it buys, is integral to the way the healthcare sector functions.<sup>120</sup> At the beneficial extreme, companies collaborate with health professionals to create and test new treatments. They collaborate with physicians to observe the side effects of new drugs. The industry also finances research and research institutions. At the other end of the spectrum, pharmaceutical and medical device producers induce or even bribe health professionals who are all too often willing to prescribe or promote their products.<sup>121</sup> The characteristics of improper marketing relations are summarised as:

**Table 3.8 Improper marketing relations**

Typology 3 Improper marketing relations	
Actors	Industry (pharmaceutical and medical device companies) in relation to healthcare providers and healthcare regulators.
Subtypes	<ul style="list-style-type: none"> <li>- Direct prescription influencing (quid-pro-quo deals)</li> <li>- Indirect prescription influencing (creation of loyalty)</li> <li>- Undue positive list promotion</li> <li>- Authorisation of medicines and certification of medical devices</li> </ul>
Features	Improper marketing relations are created through different channels, such as: <ul style="list-style-type: none"> <li>- Money and (small) gifts</li> <li>- Hospitality (conferences, meetings, dinners, trips)</li> <li>- Sponsorship (research, equipment)</li> <li>- Consultancy contracts</li> </ul>
Drivers	Shortfalls, restrictions or cuts in budgets in healthcare; minor deterrent effects of legal sanctions; lack of legal framework as deterrent, economic power of pharmaceutical and medical device companies; and self-interest and greed.
Prevalence	It is difficult to quantify the prevalence of improper marketing relations as it is often not publicly known. Relationships between healthcare professionals and the industry occur in every country and are often needed and beneficial. They are not necessarily improper, unethical or illegal. Nevertheless, from the fieldwork in all EU28 countries conducted during this study, it can be concluded that improper marketing occurs, with different frequencies and to different extents, in all EU MS. Acceptance of improper marketing relations seems to decline recently – due to various scandals, increased demand to declare conflict of interests, and stricter (international) legislation.
Relevant policies	See Chapter 4. In particular 4.2, 4.3, 4.6 and 4.7.

<sup>120</sup> Source: Edwin A.M. Gale, 'Conflicts of interest in guideline panel members', 11 October 2011, [www.bmj.com](http://www.bmj.com).

<sup>121</sup> Source: The Economist, Doctors and drug companies. Let the sunshine in. New efforts to reveal the ties between doctors and drug firms, March 2, 2013.

### 3.5.1 Cases

A large number of cases can be grouped under the label of 'improper marketing relations'. The cases below represent some examples of subtypes of improper marketing relations. A full list of cases is presented in Annex A.

We have selected as illustrative examples some recent cases from a variety of EU MSs:

- Direct prescription influencing (box 3.10, 3.11 and 3.12);
- Indirect prescription influencing (box 3.13);
- Undue positive list promotion (box 3.14 and 3.15);
- Irregularities with authorization of medicines (box 3.16).

#### **Box 3.10 Doctors paid to prescribe drugs and take part in medical trials**

A representative of an Israeli pharmaceutical company, Ratiopharm was found guilty of corruptive behaviour in business transactions when paying checks amounting up to 18 000 euro to panel doctors in Germany. The pharmaceutical company's bonus scheme foresaw payments of 5% of the manufacturer's price to panel doctors when they prescribed the company's medicaments.

The representative was convicted to pay a fine. This conviction was the first time in the history of the German health system that a representative of a pharmaceutical company was convicted for corruption. It triggered a legal discussion that lasts until today. Prosecutors had spent years investigating doctors and employees of the German pharmaceutical company Ratiopharm. Doctors were allegedly paid to prescribe the company's drugs. However, the Federal Court of Justice can't penalise independent doctors who run their own practices. Panel doctors operate on a freelance basis and therefore cannot be regarded as officeholders (Amtsträger) or as official representatives of health insurance companies when providing healthcare services.

The German Medical Association has investigated just under 1 000 doctors suspected of corruption over the past few years, according to the head of the Association Frank Ulrich Montgomery in Der Spiegel (January 13, 2013). Over half of the investigations concerned doctors accused of accepting bribes from Israeli-owned pharmaceutical Ratiopharm. The Medical Association punished 163 doctors after state prosecutors have made the files available to the Association. The bribery had actually taken place between 2002 and 2005.

Sources: Ecorys Country Report 2013; The Local, [www.thelocal.de](http://www.thelocal.de), Doctors' group admits widespread corruption, January 13, 2013; Der Spiegel, January 13, 2013.

**Box 3.11 Pharmaceutical company paying 350 family doctors**

Croatian authorities arrested more than 26 employees and the management of the pharmaceutical company Farmal on suspicion of paying doctors to prescribe the company's drugs, according to local media reports. 350 doctors were alleged to have received bribes as part of this arrangement. Authorities learned of the bribery operation through investigative reporting by Free Dalmatia reporter Natasha Skaricic, according to an official release by the Croatian prosecutor's office. 'This is proof that this is a widespread phenomenon,' Croatian Health Minister said at the press conference. 'It causes great harm to the profession and destroys confidence in the health system.' The case is on-going.

Sources: Ecorys Country Report 2013; Organised crime and corruption reporting project, 12 November 2012; Dalje.com, 12 November 2012.

**Box 3.12 Trips to Las Vegas and coupons for local supermarkets**

This case concerns an advertising campaign of the company Bauerfeind (orthopaedic equipment and medical products) in Croatia. In this campaign, doctors or pharmacists were promised a 7-day educational seminar for 2 persons in Las Vegas or Los Angeles when they would prescribe their product for an amount exceeding 150 000 kuna (200 000 euro). The trip would be for only 1 person if the total price of the prescribed products were 100 000 kuna (130 000 euro). If the total amount were 75 000 kuna (about 10 000 euro), the reward would be a 4-day seminar in Barcelona. Bauerfeind also offered additional presents, such as gift coupons for a local supermarket chain named Konzum. The Croatian Office for Prevention of Corruption and Organized crime (USKOK) reported the case to the Croatian Institute for Health Insurance for further investigation. The case is now under investigation.

Source: Ecorys Country Report 2013; Poslovni Dnevnik, November 14 2012 (daily newspaper) <http://www.poslovni.hr/hrvatska/bauerfeind-mitio-putovanjem-u-las-vegas-i-barcelonu-221262>.

**Box 3.13 Commercial sponsoring of a study trip**

This case was of particular interest to the national Swedish media. It was the first time the regulations on bribery were applied to the health sector. In August 2003, 42 employees from an orthopaedist clinic went on a sponsored four day study trip to Prague. The group consisted of doctors, nurses, physiotherapists, an occupational therapist and a chef. The trip was initiated by the clinic. The manager of the clinic contacted various medical device and pharmaceutical companies for sponsoring. The cost was 3 400 SEK (about 390 euro) per person, of which the employees themselves paid 250 SEK (about 30 euro).

In this case three doctors were charged with bribery (requesting and accepting bribes). The prosecution also charged representatives from four different pharmaceutical companies. The indictment towards the doctors and representatives of the companies were initially dismissed. The Court of Appeal later took up the case. Finally the operational manager of the clinic was found guilty of bribery and was sentenced to a 60-day custodial sentence. One of the doctors was sentenced to 30 days custody for bribery. The indictment against the pharmaceutical companies was dismissed.

Regulations of the relation between healthcare providers and the industry have only been in place since June 2004 in Sweden. These regulations do include guidelines for sponsoring of activities. However, the regulations were not in place at the time of the trip and all of the defendants stated that such sponsored trips were commonplace at the time.

Sources: Ecorys Country Report 2013; Doctors to court after sponsored trip (Läkare inför rätta för sponsrad resa) Sveriges Radio <http://sverigesradio.se>; Doctors in Jönköping found not guilty (Läkare i Jönköping friade) Läke-medelsvärlden <http://www.lakemedelsvarlden.se/>; Doctors at Ryhov found guilty (Läkare på Ryhov dömda för mutbrott) Jnytt; <http://www.jnytt.se>; Structure of corruption in Sweden (Korruptionens struktur i Sverige) The Swedish National Council for Crime Prevention (Brottsförebyggande rådet – Brå); Jönköpings District Court, case no B 3260-06/2007 and RH 2009:16.

### **Box 3.14 Lobbying members of the National Advisory Committee**

For decades pharmaceutical companies have been sponsoring doctors to attend meetings and conferences in Finland and abroad. This has been considered as necessary and unavoidable, because the hospital districts and hospitals and health centres have limited funding for Continued Medical Education. However, this is considered as a potential risk for conflict of interest in drug procurement decisions. The most important target group of the pharmaceutical companies seem to be national or regional key opinion leaders, who can influence drug selection and procurement decisions. Today the doctors are technically invited through their employers, but it is still usually the key opinion leaders who get to travel. For example, recently 15 Finnish professionals attended a scientific meeting on immunisation of adults. Twelve were either sponsored or employed by Pfizer. The company was lobbying heavily to get the four attending members of the National Advisory Committee on Vaccination to recommend their new pneumococcal vaccine to adults. One member of the committee had actually been sponsored by the company, three had not. The rest of the attending physicians were key infectious disease opinion leaders of their districts. Subsequently they may be involved in procurement of vaccines.

Source: Ecorys Country Report 2013

**Box 3.15 Research or marketing**

In June 2011, the Health Care Inspectorate (Netherlands) fined the pharmaceutical company Allergan with 45 000 euro for providing 'illegal benefits'. These benefits are considered 'gunstbetoon', which roughly translates into inducement. Physicians play an important role in the needs assessment for procurement of medicines. Allergan, located in Eindhoven in the Netherlands, provided the benefits to neurologists for a meeting that took place in March 2010. The case was discussed in the media.

The meeting for neurologists, that took several hours, was held in a hotel in Utrecht. It included a lunch, drink and a luxurious diner. The subject of the meeting was the use of Botox as a preventative treatment for chronic migraines. This is a controversial use of Botox and is not allowed on the Dutch market. Allergan invited the neurologists to this meeting as it hopes that it will be allowed in the future. During the meeting, one of the main topics of interest was the results of Allergan-financed clinical trials. Moreover, it was discussed how these results should be communicated to physicians. Six physicians accepted the invitation and next to the lunch, drink and dinner, they received 1 200 euro for participating. The chairman of the meeting, also a neurologist, was paid 2 000 euro for his contribution to the meeting.

After receiving a tip from a physician who noticed that the focus was more on marketing than on research, the Inspectorate visited the meeting. It was concluded that the fees paid to the neurologists were disproportionate to the efforts of participating in the advisory meeting. Although Allergan claims that the fees they paid to the neurologists were not unreasonable, they paid a fine (a so-called 'bestuurlijke boete'). The neurologists that accepted the invitation were not fined or prosecuted.

Source: Ecorys Country Report 2013

**Box 3.16 Lobbying power of pharmaceutical companies**

The controversy surrounding a diabetics drug known as Mediator is one of France's biggest medical scandals of recent years. Mediator, produced by Servier Laboratoires, France's second biggest pharmaceutical company, was marketed to overweight diabetics but often prescribed to healthy women as an appetite suppressant when they wanted to lose weight. According to the French health ministry, it has killed at least 500 people from heart-valve damage, but other studies put the death toll nearer to 2 000. Thousands more complain of cardiovascular complications that have limited their daily lives. As many as 5 million people were given the drug between 1976 and November 2009, when it was withdrawn in France. This was years after being banned in Spain and Italy. It was never authorised in the UK or USA. Louis Servier, the head and founder of Servier, faces charges of 'aggravated deception', manslaughter and corruption in a related trial. The latter trial has been delayed to May 2014 to allow further judicial investigations. The company has denied the accusations.

Source: Ecorys Country Report 2013; Guardian.co.uk, January 6, 2013; Associated Press, France: trial of drug maker postponed, May 31, 2013.

### 3.5.2 Actors

The main actors are the industry (medical devices and pharmaceuticals) and typically the healthcare providers (individual doctors, doctors' associations, medical institutions, research institutes or individual opinion leaders) or healthcare regulators (ministries of Health, standard setting agencies, insurance boards, healthcare authorities, inspectorates).

### 3.5.3 Subtypes

In the cases of improper marketing relations we can distinguish three subtypes:

- Direct prescription influencing;
- Indirect prescription influencing; and
- Undue positive list promotion.

In the majority of the cases pharmaceutical and medical device companies have provided tangible or intangible gifts to doctors or medical institutions in order to stimulate the prescription of preferred medicines or medical devices to patients, instead of another similar product that is offered by a competing company. Prescriptions influencing takes place either directly by offering rewards to influence the prescription behaviour of doctors, or indirectly by trying to influence the perception or loyalty of medical service providers. The benefits can constitute tangible gifts (money) but mostly intangible gifts, such as, trips or leisure activities, but also sponsoring of research activities.

**Direct prescription influencing.** We have identified several cases where pharmaceutical companies have directly influenced (bribed) doctors to prescribe their medicines. There was a direct causal relation between the gift and desired objective. The instrument of influencing was mostly money. Target groups of direct prescription influencing are mainly individual doctors;

**Indirect prescription influencing.** In some cases there was no obvious or direct causal relation between the gift and objective of the pharmaceutical company. In these cases promotion more takes the form of creating 'loyalty' through sponsorship of 'lavish' conferences, seminars in holiday locations, or offering of holiday trips to doctors (and their families);

**Positive list promotion.** Another subset consist of cases where pharmaceutical companies have made efforts to influence medical service providers or regulators to include of pharmaceutical products on the positive list of drugs that are reimbursed by public funds.

### 3.5.4 Features

It may be misleading to make generalized assessments. However, the following general conclusions appear from a closer look at the cases and the interviews we have conducted in the EU MS:

***Integrity violations but no corruption.*** In some cases it proved to be difficult to draw a clear line between 'normal' collaboration between the industry, research institutes and medical professionals, lobbying and corruption. Lobbying as such is not against the law. For example our interviews in the Netherlands have highlighted that corruption, as it has been defined for this study, occurs mostly in the grey area of integrity violations. 'Hard' corruption cases, which have been proven in court, are rare. The biggest risk is associated with the ties between the medical professionals and the industry. These ties are necessary for the purposes of development and testing. In post-market surveillance it is also important there is contact and these contacts can be rather intensive. However, these ties are also the biggest risk factor for integrity violations in the sector, especially when the contact is intensive. Hence, there exists a tension between the necessity of contact between the industry and the medical professionals and the risk for integrity violations.

***In many cases outright bribes occur in more sophisticated forms than a transfer of cash.*** Fictitious trainings, holidays under the pretext of participating in a symposium, overpaid consults are good forms that allow to hide the dealings and to launder the money. At the one extreme, there are examples of doctors using other names (spouses or relatives) for setting up travel agencies that organize medical conferences with money offered by the industry. There are also cases that pharmaceutical companies transferred cash for providers to offshore accounts, which is almost impossible to detect.

***The industry also supports medical institutions and individual healthcare practitioners.*** Donations in the form of personal computers, libraries, or research funding are often not only tolerated, but also welcomed. Pharmaceutical or medical device producers do also donate or fund medical equipment. In order to use the donated device (or to carry out the act for which the device is intended) more products of the donating companies need to be purchased. Conferences organized by the industry are welcomed by practitioners to collect so called 'credit points', in order to prove the improvement in their qualification.

### 3.5.6 Drivers

In some MS politicians and physicians state that there is not enough public money to assure professional training, which is dramatically needed. As a result of this, the support of **pharmaceutical** and medical device companies is of great value. Shortfalls, restrictions or even cuts in budgets in healthcare combined with and generous offers of sponsorship by large medical suppliers firms lead to acceptance of indirect benefits in exchange for supply contracts. Lack of funding for research and training can be an issue:



*Interview report Finland: 'A special problem is the leading role of pharmaceutical companies in the continuing education of physicians. The problem has been recognised, but the employers still allocate insufficient funding for the training of their employees.'*

In addition to this, the economic pressures on hospitals are immense, as are the pressures on doctors to undertake publishable research. It is undoubtedly the case the external funding for research is coming from suppliers of medications and medical equipment. This in itself is not illegal, and there is no legislation regulating the size or number of grants given by companies to health service providers. What is impossible to measure is the financial impact of quid-pro-quo deals made in this way, as it is clear that the vested interests of suppliers must inevitably lead them to make motivated contributions, even if these contributions come officially with no strings attached.

Some observers are more critical:

*Interview report France: 'One of the causes of the emergence of corruption in the healthcare sector is the lack of moral values that characterise the main stakeholders who are involved in the business of pharmaceuticals and medical equipment. Another cause is the fact that legal sanctions have minor deterrent effects, as the risks related to the possibility of being 'caught' are generally counted in the risk clauses inserted in the business contracts. The risk of being caught is therefore taken into consideration by pharmaceutical companies and is given a financial value. The economic power of pharmaceutical companies is also another important factor. It relates to the productive resources available that give them the capacity to influence (and sometimes make) and enforce economic decisions, such as allocation of resources. Through this economic power, laboratories might be able to influence the decision-making processes and outcomes of public authorities.'*

### **3.5.7 Prevalence**

An observed trend over the last years is the gradual shift in the attention of the industry from (individual) practitioners to opinion leaders. As for the promotion of drugs, in 2006 there was a shift in the strategy of the big pharmaceuticals company decided at an industry congress in Barcelona. They gradually reduced the benefits offered to the individual practitioners for prescribing their products and focused on influencing opinion leaders of the medical community and especially academics. Our interviewees have observed this trend:

*Interview report Greece: 'There are small to medium size pharmaceutical companies producing generics that still bribe doctors to prescribe their products, but big companies don't do this anymore, because they do not consider it being effective.'*

*Interview report Finland: 'The most important target group is national or regional key opinion leaders, who can influence drug selection and procurement decisions.'*

*Interview report Austria: 'Contextual indications are that pharmaceutical companies have withdrawn efforts from the supply side (lobbying doctors directly) and focused efforts on the demand side (with national insurers, making efforts to influence drug and price lists). The efforts by pharmaceutical companies to influence studies, place pressure in various ways (via media, etc.) and through use of lobbyists to determine what drugs or devices get listed and what prices are set, is seemingly a systematic problem and not an isolated case. The great difficulty lies in how to address these issues. Lobbying as such is not against the law and preserving the value of a free media will seemingly always come at the cost of a certain amount of abuse.'*

Many interviewees have confirmed that the consequences of improper marketing relations can be far-reaching, since corruption in healthcare can have effects for both the public budget and for the health of citizens. Improper marketing relations might lead to higher costs for the public healthcare sector as a consequence of higher drug prices or increased drug consumption by the population (through over-prescription, line-extension, or over-medicalization). It can even result in public health issues as result of the promotion for commercial reasons of dangerous, risky products, products of less quality and of questionable medical value.

The current Mediator scandal can be considered an example of this. The scandal sparked a fierce debate about pharmaceutical regulation and the lobbying power of pharmaceutical companies in France. The ramifications for the pharmaceutical industry in France – and indeed across Europe, are significant and set to fundamentally change the way pharmaceutical companies interact with medical service providers. The Mediator case has led to an extraordinary fast tracking of the French Sunshine Act.

Several interviewees have noted a change in attitude and practices. Pharmaceutical companies have been sponsoring doctors to attend meetings and conferences for decades. This has been considered as normal, and often even necessary and unavoidable, as a form of additional funding for continued medical education of health care practitioners. However, this is increasingly considered as a potential risk for conflict of interest, and (extra-territorial) anti-corruption laws and regulations are strengthened and actively enforced.

The practice of pharmaceutical companies paying kickbacks to individual healthcare practitioners, in order to influence drug prescription directly was something that occurred frequently in the past, but has (significantly) reduced in many EU MS. The introduction of electronic prescription has contributed to this reduction. An interviewee in Finland reminded, that in the past the medical students nicknamed marketing of pharmaceuticals 'corruption', but the overall picture has changed significantly (less gifts, less hospitality, transparent systems for prescription and procurement). The case in Sweden in box 3.13 illustrates these changes in attitude.

Although our country and desk research indicate that improper marketing relations are a big problem in many, if not all, EU MSs, it is impossible to quantify the size of the problem and associated costs due to a lack of data and the fact that this typology deals with many grey areas (more information on this in section 3.9).

### 3.6 Misuse of (high level) positions

This typology is strongly connected, and partly overlapping with, the preceding two typologies. However interactions and behaviour are much more opaque, indirect, with sometimes multiple stakeholders involved. There is not always a direct link between the corrupt interaction and the desired outcome. This typology in particular applies to institutionalised forms of high-level healthcare corruption. The main characteristics of this typology are summarized as:

**Table 3.9 Misuse of (high level) positions**

Typology 4	Misuse of (high level) positions
Actors	Regulators Political parties Industry Healthcare providers
Subtypes	Misuse of (high level) positions can cover various types of corruption, such as: <ul style="list-style-type: none"> <li>- Revolving door corruption</li> <li>- Regulatory state capture</li> <li>- Trading in influence</li> <li>- Conflict of interest</li> <li>- Favouritism and nepotism</li> </ul>
Features	Various. See below and definitions in Chapter 1.
Drivers	Mainly (political) power and economic interests.
Prevalence	There is no hard data available on the prevalence of this type of corruption, but it appears that is a problem particular in MS where corruption is deeply embedded in politics and society, such as Czech Republic, Latvia, Croatia, Slovakia, Romania, Italy, Bulgaria, Greece <sup>122</sup> . However some forms also occur in MS that are generally less susceptible of corruption, such as the Netherlands, Slovenia, Belgium, Spain and Finland.
Relevant policies	See Chapter 4. In particular 4.2 and 4.3.

#### 3.6.1 Cases

We came across various cases that are linked to the various facets of this high-level corruption typology. To best describe a deep and systemic corruption environment we will give an example from our research in the Czech Republic, which has recently seen the biggest anti-corruption raid in its history (box 3.17). This police operation and subsequent judicial proceedings have led to the arrest of three MPs, the chief of staff of the prime minister, four other officials, more than 30 house and office searches as

<sup>122</sup> Countries mentioned have a CPI below 50, which, according to Transparency International indicates that the country has a serious corruption problem, source: <http://cpi.transparency.org/cpi2012/results/>.

well as hours of telephone calls, digital correspondence and meetings intercepted by the undercover units.

**Box 3.17 'Richelieu of the Czech healthcare sector'**

During his employment at the ministry of Health (2006–2009), Marek Šnajdr was referred to as the 'Richelieu of the Czech healthcare sector', meaning that he was the eminence-grise, the mastermind and moving force behind Czech healthcare system. Under the ODS government of Mirek Topolánek (2006–2009), Marek Šnajdr was not only politically appointed as a deputy in the ministry of health, but then also as the chairman of the board of directors of the state insurance company (VZP). The VZP is a dominant force on the market with over 65% of the population being insured by it. It is owned and run by the state with the majority of its board of directors appointed by politicians. The VZP essentially operates as a monopolist insurer, with its support a prerequisite to any medical facility attaining the licence to operate and the bilateral fee agreements with VZP determine the financial feasibility of such facilities surviving.

By gaining control of both the ministry, and as a consequence the main insurer, Marek Šnajdr positioned him in the controlling seat of the Czech healthcare system. It is essentially this kind of unspoken agreement by the political elite that shields the corruption activities (in exchange for party donations and political support). The protection under Mr. Topolánek extended to the point that he would interfere with police investigations and appoints a public prosecutor that would give him control over judicial interventions into the operations.

To conduct the corrupt practices these grey eminences first arrange contact and support of local political representatives and with their cooperation ensure, or appoint, a cooperative 'white horse'. These are usually people in the management of the medical facilities or procurement officials, who have the final control over the procurement process. These 'white horses' are then instructed on how to proceed to enact the corruption of the procurement and at times put under various degrees of pressure, including from their superiors or political party. The grey eminences then arrange for themselves to be adequately rewarded through an exceptionally complex system of intermediaries, companies and bank accounts in order to prevent detection. Continuing from the earlier example:

**(box 3.17 continued)**

In 2007 the governor of Central Bohemia was Petr Bendl, who was also the deputy leader of the national ODS. Under his leadership several hospitals in the region were privatised (many with anonymous owners) and one in particular was the hospital in Horovice. This hospital was small, poorly run, close to a large town, but never the less with a large catchment area. The hospital's management, as well as the governor, was keen to prevent the hospital from closing down.

At this point Marek Šnajdr approached at first Petr Bendl, and through him, the hospital itself. Through his influence he arranged exceptionally preferential and good terms between the hospital and VZP, that not only allowed the hospital to remain open, but to prosper (allowing the management to earn large bonuses). In return the hospital signed a contract worth CZK 30 million (1.2 million euro) with a company focused on trainings. The company is completely owned by anonymous shareholders and makes regular donations to the regional ODS. It is also widely rumoured that Marek Šnajdr is the majority secret shareholder of that training company.

With the fall of Topolánek's government, Šnajdr was forced to resign from both posts in 2010 with the new political rearrangement. Nevertheless he was 'rewarded' by his party (who returned to government in a coalition) by being put high on a candidature and becoming an MP. In 2012 he was bribed by the prime minister Petr Nečas and his chief of staff into supporting the government by being given a high profile (and highly remunerated) position on the board of directors of a big public company (ČEPRO).

Source: Ecorys Country Report 2013

### 3.6.2 Characteristics

In the case of misuse of (high level) positions multiple actors may be involved, such as regulators, political parties, the industry and healthcare providers. Misuse of (high level) positions can cover various types of corruption, such as: trading in influence, revolving door corruption, regulatory state capture, conflict of interest, or favouritism and nepotism (for definitions, see Chapter 1). This typology involves a variety of undue high-level interactions with involvement of regulators, political parties, the industry and healthcare providers.

The extent to which misuse of (high-level) corruption is a problem within a MS, largely depends on *the extent to which corruption is embedded in the economy and society*. Various interviewees pointed at the economic power of the healthcare industry and the influence the industry exercises over political decisions makers. This is identified as a problem in many European MS, including MS that are generally less susceptible of corruption

### 3.6.3 Prevalence

In many cases it is difficult to draw a clear line between normal lobbying and unethical forms of trading in influence. Interviewees in for example Croatia, Finland, Lithuania, Romania and France, perceived trading in influence as a prevailing type of corruption in their country.

*Interview report France: 'The lobby of pharmaceuticals is one of the most powerful lobbies in the country, which influence has important consequences on the political decision-making in the healthcare sector, as well as on single Members of Parliament. Infiltrations of people closed to pharmaceutical*

*laboratories into the main health agencies and health administration bodies are very common.”*

Regulatory state capture is said to be a problem in several European MS as political and business elites are strongly intertwined. It was perceived as a prevailing type of corruption by interviewees in for example Finland, Romania, Bulgaria, Spain and Croatia.

*Interview report Spain: 'There is regulatory capture by the big industrial pharmaceutical groups (lobbies) that achieve the authorisation for certain activities through the modification of different laws to favour them.’*

In Hungary, one interviewee considered it to be the main issue in healthcare corruption:

*Interview report Hungary: 'Indeed, we have bribes, we have kick-backs, but the most serious problem state-capture. Interest group has so much power and influence on the legislation, that even kick-backs are not necessary.’*

In some MS public and private roles can be performed at the same time. Simultaneous positions in the industry and in public healthcare institutions create conflicts of interest. Cases involving a conflict of interest have been identified in different EU MS, including the Netherlands, Slovenia, Spain and Belgium. Moreover, in Croatia, Estonia, Latvia and Slovenia all interviewees indicated conflict of interest as a prevailing type of corruption.

*Interview report Bulgaria: 'Another example is of a medical representative of a pharmaceutical company who is simultaneously an employee of the Regional Health Insurance Fund, which obviously creates conflict of interests.’*

Revolving door corruption creates conflicts of interest as well - for example through employment of hospital staff from external companies who are among the hospital's main suppliers. Revolving door cases have been identified in the United Kingdom, Latvia and Czech Republic and it was considered to be a prevailing type of corruption by interviewees in for example Finland, Poland, Lithuania, Hungary and Greece.

*Interview report Poland: 'Often these connections are not direct and there is a chain of connectivity. A particular example is the companies' purchasing hospital debt – sometimes boards of directors of such companies include persons from hospitals. This includes also other (not obvious) connections, such as civil-law agreements with a company purchasing debt and full time employment at a hospital, or previous employment in such company.’*

Political and administrative nepotism and favouritism strongly favour certain circles in society in some MS. Cases on this have been identified in Lithuania and Finland and interviewees in for example Croatia, Finland, Poland and Slovenia consider it to be a prevailing type of corruption in their country.

*Interview report Poland: 'Competitions for attractive positions are completely fictitious and fixed. If a unit is being directed by the Ministry of Health (e.g. science and research institutes) the competition council is dominated by the Ministry in such a way that it is the ministry who decides the competition winner. Therefore, there are pseudo-competitions won by selected staff, which has the full of power. One can track dependencies based on returning favours for 'arranging' a given position. Often, people are 'cross-employed' – director X employs the son-in-law of chief Y, while chief Y employs the daughter of director X.'*

In some MS, such as Czech Republic, the healthcare sector is being used as a source of funding for the political parties, as the healthcare sector is very lucrative and resistant to economic crises:

*Interview report Czech Republic: 'Each corrupt actions needs and has, political backing by the party that is in power. The politicians make an agreement with a specific facilitator that arranges the deal with the supplier and orchestrates for a share of the money to flow into the party's coffers.'*

In the case of political corruption, politically appointed procurement officers or healthcare managers are involved:

*Interview report Czech Republic: 'The party leadership (nation or regional) tells its public procurement office or director of the hospital (the 'white horse'), who are both political appointees, to tailor the terms of reference so that they fit for the desired supplier. All parties involved get rewarded with money from the overpriced value of the procured goods or services.'*

### **3.7 Undue reimbursement claims**

Financing parties such as health insurers or government agencies are paying health care providers for their services. The claims of the insured (the patients) are often directly issued to the insurer by the providers themselves (the insured does not pay or pre-pay the claim). The rules and procedures for filing a claim, actual payment, may or may not also include certain incentives for a health care provider to work efficient, use the cheaper version or generic medicines are generally known as Provider Payment Mechanisms (PPM). The main characteristics of this typology are summarized as:

**Table 3.10 Undue reimbursement claims**

<b>Typology 5 Undue reimbursement claims</b>	
Actors	Healthcare providers versus payers of health care (either insurance companies or government departments purchasing health care).
Subtypes	<ul style="list-style-type: none"> <li>- 'Upcoding' (reimbursement of maximum tariffs)</li> <li>- Reimbursement of unnecessary treatments</li> <li>- Reimbursement non-delivered treatments</li> </ul>
Features	<p>The rules and procedures for filing a claim, actual payment, may or may not also include certain incentives for a health care provider to work efficient are generally known as Provider Payment Mechanisms (PPM). PPM have specific issues:</p> <p>Medical services are not easy to define and most systems that try to define the services end up with very detailed and sophisticated descriptions of individual services that are difficult to understand but also easy to manipulate for informed practitioners and difficult to control.</p> <p>Patients are often not informed and/or not capable to understand the details of a bill for specialized medical treatment. The role of the patient as a consumer who controls what he pay for is often lacking.</p> <p>Financial management systems are not yet very professional in the health sector and not very timely.</p>
Drivers	<ul style="list-style-type: none"> <li>- Complexity and range of medical services and corresponding systems for payment and finance.</li> <li>- Limited attention and investments in physical control of claims.</li> <li>- Asymmetry in information between medical professional, patient and payers for health care such as government agencies and health insurers.</li> </ul>
Prevalence	<p>Misuse of PPM is considered widespread and quoted by many interviewees in this study in particular in Western European countries, such as the Netherlands, Belgium and the UK<sup>123</sup>. The extent of it is unknown but generally believed to be important and potentially of high value. A typical example is the claim based on the higher reimbursement level for a 'live' visit to the doctor whereas the patient in reality only had a telephone consultation with its doctor which has a lower reimbursement level. In particular in those systems where patients do not pay and/or see or verify the doctor's or hospital bills it is difficult and requires substantial surveillance costs to detect such instances of fraud.</p>
Relevant policies	<p>Increase controls on physical delivery of health care services by payers.</p> <p>Involve patients in control of invoices.</p> <p>Limit use of incentives in already complicated payment mechanisms to avoid complexity and corresponding in-transparency in payment procedures</p>

<sup>123</sup> In these countries cases have been identified and/or interviewees perceived it as one of the prevailing types of corruption in the country.



### 3.7.1 Cases

Healthcare providers are being paid for their services by financing parties like health insurers or government agencies. The claims of the insured (the patients) are often directly issued to the insurer by the providers themselves (the insured does not pay or pre-pay the claim). A typical example of misuse of this system in the well-known 'Earwax gate' case in the Netherlands.

#### Box 3.18 'Earwax gate'

A recent example of up-coding from the Netherlands is known in the Netherlands as 'earwax-gate': an ENT (ear, nose and throat) specialist used a code for removing ear wax of approximately 1 000 euro, whereas a year before the same treatments was only 110 euro and when a general practitioner does it its only approximately 10 euro. The ENT specialist in question had used a code that included other procedures, such as removing polyps, which was not actually done. The health insurance company reimbursed the hospital but the patient himself noticed that something had to be wrong and send a complaint to the Ombudsman. As a result of this case the Dutch Healthcare Authority is now communicating with hospitals and medical professionals on these issues.

Sources: Ecorys Country Report 2013;

<http://www.intermediar.nl/vakgebieden/zorg/%E2%80%98oorsmeer-gate-waarschijnlijk-topje-van-de-ijsberg%E2%80%99>; <http://www.volkskrant.nl/vk/nl/2672/Wetenschap-Gezondheid/article/detail/3379464/2013/01/19/Zorgautoriteit-onderzoekt-hoge-declaraties-na-oorsmeer-gate.dhtml>; and <http://nos.nl/artikel/463735-nza-maakt-werk-van-oorsmeergate.html>.

### 3.7.2 Actors

The typology undue reimbursement claims typically involves two actors: the healthcare providers filing the claim and the payers of health care (either insurance companies or government departments purchasing health care) that reimburse these claims.

### 3.7.3 Subtypes

We can distinguish between roughly three subtypes of undue reimbursement claims:

- Up-coding, that is: the use of maximum allowable reimbursement levels for less complicated cases;
- Reimbursement of unnecessary treatments;
- Reimbursement non-delivered treatments.

A typical example is the claim based on the higher reimbursement level for a 'live' visit to the doctor whereas the patient in reality only had a telephone consultation with its doctor which has a lower reimbursement level.

### 3.7.4 Features

Healthcare providers are being paid for their services by financing parties like health insurers or government agencies. The claims of the insured (the patients) are often directly issued to the insurer by the providers themselves (the insured does not pay or pre-pay the claim).

The rules and procedures for filing a claim, actual payment, may or may not also include certain incentives for a health care provider to work efficient are generally known as Provider Payment Mechanisms (PPM). PPM have specific issues:

- Medical services are not easy to define and most systems that try to define the services end up with very detailed and sophisticated descriptions of individual services that are difficult to understand but also easy to manipulate for informed practitioners and difficult to control;
- Patients are often not informed and/or not capable to understand the details of a bill for specialized medical treatment. The role of the patient as a consumer who controls what he pay for is often lacking;
- Financial management systems are not yet very professional in the health sector and not very timely.

Payers for health care services typically use medical advisors to check and control the received claims for their appropriateness on medical grounds, signal improvements for doctor's or providers' professional behaviour and also help detect possible misuse. Separately administrative check and controls are being carried out to make sure that reimbursement of medical services is done efficiently and based on agreed terms.

### 3.7.5 Drivers

PPM are often considered a weak spot in the health financing systems for several practical reasons:

- Medical services are not easy to define and most systems that try to define the services end up with very detailed and sophisticated descriptions of individual services that are difficult to understand but also easy to manipulate for informed practitioners and difficult to control;
- Patients are often not informed and/or not capable to understand the details of a bill for specialized medical treatment. The role of the patient as a consumer who controls what he pay for is often lacking. The professional information asymmetry between patient and doctor plays an important role here;
- Payers of health care tend to load PPM with economic incentives to stimulate or penalize certain professional behaviour. This may add to the complexity of the financial mechanisms;
- Financial management systems are not yet very professional in the health sector and not very timely. E.g. in the Netherlands the claims may take more than a year before they are settled between a hospital and the insurer, thereby limiting the scope for detection and follow-up of mal-practice or fraud.

In particular in those systems where patients do not pay and/or see or verify the doctor's or hospital bills it is difficult and requires substantial surveillance costs to detect such instances of fraud.

### **3.7.6 Prevalence**

Misuse of PPM is apparently widespread and quoted by many interviewees in this study in particular in Western European countries. *The extent of it is unknown but generally considered to be important and potentially of high value.*

*Interview report Germany: 'Existing bonus-systems in the health sector constitute false incentives for medical judgments. In addition, Germany is currently a forerunner in the number of heart- and hip interventions undertaken by doctors, even though there is no apparent need. DRG (Diagnosis Related Group) system vulnerable to up-coding.'*

*Interview report the Netherlands: 'The biggest risks are the rules and regulations that may facilitate a broad interpretation which can lead to people misusing the system for their own personal gain; money that should be spend on healthcare will be spend on something else because people find a way to manipulate the system. Another risk is involved in the system of codes used by specialists; the number of codes a specialist can choose from is relatively high and hence the scope for up-coding is rather big.'*

Although not part of the original terms of reference for this study it is believed that this type of fraud may be very substantial in many countries and would deserve closer attention both determining the actual scale of the issue and possible policies that may form a remedy.

## **3.8 Fraud and embezzlement**

Doctors, pharmacists and other personnel have unique access to medicines and medical facilities that are meant to be used for agreed and professional uses. However, as professionals they also have influence on how and when these drugs or facilities are being used and for whom. During our research several cases have been mentioned of healthcare providers meddling with stocks, numbers of patients, non-existing patients in order to create control over medicines that subsequently were marketed as a private business and/or sold overseas in health systems with other regulations.

In our EU-28 country reports, several cases involve embezzlement of medicines from public hospitals. The following pattern can be identified. Medicines that are funded by the government are purchased and subsequently sold for a higher price (sometimes in third countries). A case on this has, for example, been identified in Romania. The actors are pharmacists, doctors, and (other) hospital personnel. Other cases involve the sale of illegal or counterfeit medicines. In these cases the authorisation procedures

are circumvented. Some of these cases have a cross-border dimension, as the medicines are imported from a foreign country (in and outside the EU).

**Table 3.11 Fraud with and embezzlement of pharmaceuticals and medical devices**

Typology 6 Fraud with and embezzlement of pharmaceuticals and medical devices	
Actors	Healthcare providers.
Subtypes	<ul style="list-style-type: none"> <li>- Sale of public or prepaid medicines for private gain</li> <li>- Sale of counterfeit medicines</li> <li>- Use of publicly owned or financed devices or facilities for private gain</li> </ul>
Features	Doctors, pharmacists and other personnel have unique access to medicines and medical facilities that are meant to be used for agreed and professional uses. However, as professionals they also have influence on how and when these drugs or facilities are being used and for whom. Often involves tinkering with documents and reports on availability of medicines, number of patients etc. In addition, use of publicly owned devices such as diagnostic equipment or lab tests for private practice falls under these categories.
Drivers	Unknown, but reportedly substantial in particular in case of life-style drugs. During our research several cases have been mentioned of health care providers meddling with stocks, numbers of patients, non-existing patients in order to create control over medicines that subsequently were marketed as a private business and/or sold overseas in health systems with other regulations.
Prevalence	Unknown, but reportedly substantial in particular in case of life-style drugs. Cases have been identified in Romania, Ireland, Malta and the United Kingdom.
Relevant policies	Increase physical controls to have higher chance of detection. Make use of better information systems to track goods and medicines (unique identifier systems).

### 3.9 Misuse of legal rights

The definition of corruption that is used for this study does not only include outright illegal behaviour, but also integrity violations and misuse of opportunities. For proper functioning of the healthcare market rules and regulations cannot be too narrow – they should provide room for own initiative and flexibility. However, when there exist loopholes and/or rules facilitate a broad interpretation, this may be misused for the purpose of personal gain. Although in some cases the resulting behaviour may not be illegal per se, it is harmful to society as a whole, and healthcare in specific. Hence, when it comes to setting-up rules and regulations there exists a tension between not making them too narrow –which could hamper the functioning of the market - and not making them too broad – which could result in integrity violations or corruption and fraud.

*Interview report Netherlands: 'The biggest risks are the rules and regulations that may facilitate a broad interpretation which can lead to people misusing the system for their own personal gain; money that should be spend on healthcare will be spend on something else because people find a way to manipulate the system.'*

In some areas it proves difficult to draw an exact line between these kinds of integrity violations that occur within the boundaries of the law and clear-cut corruptive and fraudulent practices. The area where these two things overlap is the so-called 'grey area'. Note that the grey area is context and country specific: both perceptions and legal foundations may differ between countries and sectors.

The country research conducted for this study identified numerous grey areas through interviews and case studies. These grey areas result from ties and interactions between two or more actors within the healthcare system. These interactions can be very important, valuable and even necessary, but they also pose risks for (potential) integrity violations.

A fundamental characteristic of 'grey areas' is that it is not always clear-cut what type of behaviour is considered to be corruption and what is not, also because clear rules / laws (including sanctions) are often missing. The line between what is accepted behaviour and what is not accepted is therefore less clear, which consequently makes the problem less 'tangible' and more difficult to address through clear-cut counter actions. This also means that the individual responsibility of a person becomes key and that integrity violations and misuse of rights and opportunities seem very much dependent on *personal motivations, ethics and values*.

With regard to the corruption typologies identified in this study, *examples* of grey areas include:

### **Bribery in medical service delivery**

Informal payments occur in different ways. One of these is the *expression of gratitude* by presenting your doctor with a gift after treatment has taken place. As there appears to be no direct connection between the treatment received and the gift this may seem harmless. However, it may influence the doctor during future visits/treatments.

*Interview report Finland: 'Doctors sometimes receive gifts from patients, but linkage between the gifts and the treatment provided has not been observed.'*

### **Procurement corruption**

In procurement of medical supplies multiple grey areas exist. For example in the appointment of the evaluation committee: is everybody screened for possible conflicts of interest? Are there risks for favouritism, clientelism or nepotism? Another grey area concerns the influence of opinion leaders on procurement processes (by the government). An example of this concerns the procurement of vaccines during the outbreak of the pandemic influenza. Governments were under pressure to decide within a narrow timeframe which vaccines to purchase and what amount. There was not sufficient time to follow normal procurement processes and governments had to rely on their advisors in making a decision. However, these advisors might have had potential conflicts of interest as they are the experts in this areas and are hence likely to have interactions with the industry concerning for example research and development. Should this exclude these experts or opinion leaders from the process even though they may be the most qualified advisers?

**Improper marketing relations**

In the area of improper marketing relations between providers and the industry many grey areas exist as the distinction between 'normal and necessary' and 'improper' relations is difficult to define. For example, consultancy contracts between individual healthcare providers and the industry are important for many reason, however, they may also create a conflict of interest. This may cause a providers choice for a certain device or drug to appear compromised.

*Interview report Netherlands: 'With regard to medical devices, the biggest risk is associated with the ties between the medical professionals and the industry. These ties are necessary for the purposes of development and testing. In post-market surveillance it is also important there is contact and these contacts can be rather intensive. (...) Hence, there exists a tension between the necessity of contact between the industry and the medical professionals and the risk for integrity violations.'*

Another example relates to inducement. An important difference between inducement and bribery (which is by definition illegal) is that for the latter there is a clear causal relationship between the bribe and the subsequent action. In case of inducement, say through a luxurious dinner, a physician might not exclusively start to use one product, but it might (deliberately or not) bias his prescription / use of devices behaviour.

*Interview report Portugal: 'A particular, also very extended but extremely difficult to prove practice is the doctors receiving presents or sponsorship to participate in congresses etc. by the pharmaceutical representatives, that expect them to prescribe their products in return.'*

**Lobbying and marketing**

Possible grey areas exist when pharmaceutical and medical devices companies aim to influence procurement processes, positive listing, government policies and actual medicine prescription through lobbying and marketing. Efforts to promote products through lobby and marketing are common practice and not illegal. Nevertheless conflicts of interest might occur, as for example lobby or marketing activities may (unconsciously) bias a healthcare provider's decision to purchase certain medicines, compromising the public interest.

*Interview report France: 'There is an important conflict of interest between pharmaceutical companies and medical practitioners. The interviewee sees the lobby of pharmaceuticals as one of the most powerful lobbies in France, which influence has important consequences on the political decision-making in the healthcare sector, as well as on single members of the French Parliament. According to the interviewee, infiltrations of people closed to pharmaceutical laboratories into the main health agencies and health administration bodies is very common.'*

*Interview report Austria: 'Supplies pay a lot of attention and efforts on lobbying to get equipment related treatments onto the official list of treatments reimbursed from the national health insurance bodies.'*

### **Trading in influence**

Persons may misuse their position for a third party to influence decision-making processes (trading in influence). A grey area exists, because it not always clear what can be regarded as justified and unjustified influencing. This also explains the on-going discussions within and between governments on how to criminalise this type of behaviour under (inter)national law.

Decision-making processes are complex as many different actors (including lobby groups as described above) play a role. They all depend on each other's inputs. Parties influencing each other is a crucial and valued part of the decision making process. A conflict of interest might arise, but at the same time influencing a decision is of course not an illegal or undesired act in itself. In such a process it is difficult to determine if someone's really 'misused' his or her position to the benefit of others. In addition, it is not always clear is there is an actual link between the 'undue advantage' and someone's decision or influence.

*Interview report Czech Republic: 'The structure of political integration and implication with corruption is by large managed by powerful individuals in the back ground of a political party, but in fact are the key decision makers. These 'grey eminences' control and influence the front public figures (such as ministers) as well as appoint and then control the executive public officials such as the directors of hospitals (the 'white horses'). They do this most frequently by trading in influence (such as political support in key voting or promising a seat at a prominent and well paid board of directors of a state/municipal company) or alternatively by kickbacks. At the same time they are also the connection with business that channel and realise their ambitions through them (for a reward). In fact these figures are the masterminds of corruption.'*

### **Revolving door corruption**

Grey areas exist when a person occupies several positions at the same time, or when possible conflicting positions are performed in sequence, for example a high level official of the Ministry of Health obtains a key position in the pharmaceutical industry. Such situations might lead to conflicts of interest. However, as also stated in the example below, this practice is hardly inevitable in small communities or when there are a limited number of experts in a particular field.

*Interview report Finland: 'Conflict of interest is a typical problem for a small country; often compromised by the fact that people have double or multiple roles, e.g. as administrators and experts, and the roles may be confounded.'*

The examples related to procurement, improper marketing relations and the misuse of (high-level) positions all include conflict of interest. This appears to be a grey area in

itself and it is often extremely difficult to distil whether decisions were actually compromised because of the conflict of interest or not. Moreover, sometimes it might be inevitable that people in certain roles have a conflict of interest.

### **Undue reimbursement claims**

Up-coding can, in some cases be considered a grey area as the DRG(-type) systems allow providers to choose between different codes for one treatment and there are an abundance of codes. However, some forms of up-coding are clear examples of fraud, such as using an inpatient code for a treatment that is performed in an outpatient setting.



## 4 Policies and practices

The second objective of this study is to 'assess the capacity of the EU MSs to prevent and control corruption within the healthcare system and the effectiveness of these measures in practice'. In order to meet this requirement we have asked our 28 MS rapporteurs to identify good practices that have yielded some results, even partial progress, in combatting corruption in the healthcare sector. The information is collected through interviews, desk research and case analysis. The rapporteurs should also identify unsuccessful policies and practices. This has resulted in a long list of very diverse policies and practices: good policies and practices, negative or failed policies and practices, actual policies and practices, and also suggestions for policies and practices.

### 4.1 Introduction

Policies and practices can be aimed at preventing corruption in the healthcare system (prevention). They can also be aimed at controlling and combatting corruption in healthcare (repression) – or both, since it can be argued that effective repression can have a dissuading effect on corruption. Some of the policies and practices are intended to remove motivations for corruption (for example low salaries in the healthcare sector are generally seen as a driver of bribery in medical service delivery). Other policies are primarily targeted at lowering the opportunities (through stricter regulations or more effective control and sanctioning) for corruption in healthcare. Rationalisation of corruption in healthcare (for example doctors feel that they are justified to accept bribes) is often targeted by a combination of policies and practices that in the end lower the general acceptance of corruption in healthcare within a MS or specific segment of the healthcare sector.

Our analysis of the policies and practices that have been presented to us across the 28 EU MSs, reveals that there are three major categories:

- **Generic anti-corruption policies and practices**, including general judicial effectiveness and general procurement policies and regulations (= non-healthcare specific);
- **Generic healthcare policies and practices**, including healthcare reforms and general healthcare supervision systems (= non-corruption specific);
- **Specific policies and practices** aimed at preventing, controlling and combatting corruption within the healthcare system (= corruption-in-health policies).

Effective generic anti-corruption policies and practices (category I), and generic healthcare policies and practices (category II) are a necessary precondition for successful targeted corruption in health policies and practices (category III). Our main findings with relation to the first two generic categories of policies and practices are briefly presented in Chapter 4.2. Policies and practices related to healthcare supervision systems are discussed in Chapter 4.3. Detailed examples of successful,

and a few unsuccessful, targeted corruption-in-health policies and practices will be given in Chapter 4.4 (policies and practices related to bribery in doctor to patient service delivery), 4.5 (healthcare procurement corruption) and 4.6 (undue marketing and improper relations between the industry and healthcare providers). In Chapter 4.7 the role of the media, patient pressure groups and other civil society organisations is discussed. The country profile reports that were prepared for this study identified multiple good, but also some unsuccessful, practices. This section discusses a selection of these policies and practices. The following policies and practices will be described in more detail in the next paragraphs:

## Prevalence

We will discuss in the subsequent paragraphs the following policies and practices (table 4.1). An overview of the policies and practices per MS is presented in Annex D.

**Table 4.1 Policies and practices addressing corruption in healthcare**

Policies and Practices		
No	Type	Category
4.2.1	Anti-corruption legislation	General
4.2.2	Anti-corruption institutions	General
4.2.3	Anti-corruption-in-health-strategy	General
4.3.1	Fraud in healthcare control I - DGEC	General
4.3.2	Fraud in healthcare control II – CNAMTS	General
4.3.3	Fraud in healthcare control III - NHS	General
4.3.4	Collaboration between competent authorities and the public - IGAS	General
4.4.1	Increase in salaries of healthcare providers I	Medical service delivery
4.4.2	Increase in salaries of healthcare providers II	Medical service delivery
4.4.4	Formalise informal payments	Medical service delivery
4.4.5	Introduce transparent waiting lists	Medical service delivery
4.4.6	Increase penalties for bribery	Medical service delivery
4.4.7	Doctor's initiative against bribery	Medical service delivery
4.5.1	Break the cycle of systemised corruption	Procurement corruption
4.5.2	Include the healthcare sector in general procurement regulations	Procurement corruption
4.5.3	Centralise the maximum price of pharmaceuticals	Procurement corruption
4.6.1	Prescribe main active substances	Improper marketing relations
4.6.2	Code of Conduct for medical devices	Improper marketing relations
4.6.3	Self-regulation of the pharmaceutical industry	Improper marketing relations
4.6.4	Sunshine Act à la Européenne	Improper marketing relations
4.6.5	Conditioned self-regulation in the pharmaceutical sector	Improper marketing relations
4.7.1	Awareness campaign and reporting line	Critical patient involvement
4.7.2	Investigative Journalism database	Critical patient involvement
4.7.3	Civil society reporting website	Critical patient involvement
4.7.4	Transparent waiting lists	Critical patient involvement

Some preliminary remarks:

- This is an overview of policies and practices as presented to us (literature research and interviews in the MSs) in all 28 EU MSs. The policies and practices address various types of healthcare corruption, from different angles. We have selected policies and practices examples that best describe this specific policy and practice. The list does not cover all 28 EU MSs. The fact that a country is not presented with one or more good policies and practices, does not necessarily mean that this policy is not in place;
- As for most of the described policies and practices there were no systematic evaluations carried out. In addition to this, many policies and practices have very recently been adopted. These policies and practices can only be assessed the subjective notion of being 'promising'. It must be noted that in general the assessment of the effectiveness is largely based on perceptions and qualitative experiences;
- The applicability and effectiveness of individual policies and practices is strongly context-dependent. It also has turned out to be difficult to prove the effectiveness of individual policies and practices. Not only because a fairly large number of policies and practices have only very recently been introduced and in general it takes a long time until deeply embedded habits cease to exist. But in particular since single policies and practices won't be sufficient in most cases. In many cases it is a combination of a variety of measures, which is needed.

Finally it must be noted that a general acceptance, or at least tolerance, towards corruption is considered by many of our interviewees as one of the main drivers behind widespread corruption in healthcare. This applies to all of the described corruption typologies. Corruption and conflicts of interest will persist as long as it is accepted to offer or receive financial or other benefits. A change in culture can only indirectly be promoted. For example Edwin Gale, emeritus professor diabetic medicine, ascertains that:<sup>124</sup>

*'Legislation will not change the situation, for the smart money is always one step ahead. What is needed is a change of culture in which serving two masters becomes as socially unacceptable as smoking a cigarette. Until then, the drug industry will continue to model its behaviour on that of its consumers, and we will continue to get the drug industry we deserve.'*

## 4.2 Generic policies and practices

This chapter discusses some generic policies and practices that have an impact on corruption in the healthcare sector. As has been specified before, these policies and practices are a necessary basis for targeted corruption-in-health policies and practices that we will discuss in the next chapters.

<sup>124</sup> Source: Edwin A.M. Gale, 'Conflicts of interest in guideline panel members', 11 October 2011, [www.bmj.com](http://www.bmj.com).

Generic policies and practices that have emerged from our research (interviews, literature, and case analysis) are related to:

- Independence and effectiveness of the judicial system;
- Healthcare system reforms and changes;
- Anti-corruption legislation and strategies.

### **Independence and effectiveness of the judicial system**

Judicial ineffectiveness has repeatedly been identified as one of the major problems in the fight against corruption, including corruption in healthcare. Detecting corruption is an area of activity for the law enforcement authorities. The ministries of health do not have the authority to investigate the details of corruption crimes, and have no investigative authority.

Criticism that we have encountered in our interviews across various EU MSs is:

**Insufficient judicial capacity.** 'A limited number of corruption cases reach final conviction, partly due to a lack of resources. As a result, the deterrent effect is low. (...) The continued lack of financial resources available to the courts jeopardises anti-corruption policies'(interview report Croatia);

**Lack of judicial independence.** 'The judiciary lacks investigative authority, independence and resources. Judges face difficulties in accessing classified documents to investigate cases. Judicial independence is also undermined by the executive's political interference' (interview report France);

**Long and complicated judicial enquiries.** 'The anti-corruption legislation is rather limited, as corruption is hard to detect, with extremely long and complicated judicial inquiries. Overall, it seems that one big hurdle to the effectiveness of anti-corruption measures is that they do not have a sufficiently powerful deterrent effect – the risk to be caught is not high enough' (interview report France);

**Political interventions of court procedures (leading to impunity).** 'The delays of the judicial system in dealing with cases of corruption, the frequent interventions by external actors of the political and economic life, lead in the cover up of the corruption cases' (interview report Cyprus);

**No or few convictions.** 'In some MSs, impunity is considered as a factor that encourages and promotes corruption Lack of confidence in anti-corruption mechanisms because of a lack of convictions - including convictions of doctors and medical staff. People mistrust the justice system' (interview report Bulgaria).

There are also positive developments. Effective prosecution can have a powerful effect:

*Interview report Czech Republic: 'Over the past couple of years there has been a significant shift from within the police and the public prosecution office. (...) The recent arrest of a top Czech politician and doctor by special secret police operations in the act of accepting bribes and his subsequent prosecution have sent a wave across the nation. The capture of such a 'big fish' has signalled that the authorities have grown independent and brave enough to increasingly effectively fight corruption. This development has meant that corruption is beginning to be prosecuted, resulting in increasing the risk of committing corruption.'*

In various MSs successful court procedures (in particular involving high-level politicians or government officials and/or large companies) are said to have had a deterrent effect on corruption in healthcare.

### **Healthcare sector reforms and changes**

If corruption is deeply embedded in the functioning of the healthcare system, major improvements should be found in addressing structural healthcare system problems, such as ineffective managerial structures, inappropriate financing mechanisms, insufficient healthcare capacity, insufficient funding for independent medical research, or unequal allocation of resources.

Interviewees repeatedly stated that weaknesses in the healthcare system should be addressed first:

*'Although institutions have been created and have seriously tried to combat corruption in the healthcare sector, the problem remained and augmented, especially in the last two decades. The main reason for this is the structural problems that the health system faces, easing the development of unethical behaviour'<sup>125</sup> (interview report Greece);*

*'Despite the funds allocated, the healthcare sector is perceived as inefficient, poor and corrupt. People do not trust in the medical act, while doctors leave the country' (interview report Romania);*

*'In my opinion it should not be the main objective to establish measures against informal payments. Informal payments are an inevitable concomitant of the present system, thus comprehensive reforms should be carried out, which will lead to the elaboration of these payments. If we change the system the willingness to pay informal payments and the willingness to accept informal payments will decrease' (interview report Hungary).*

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<sup>125</sup> Economou Ch., Giorno C., 2009, 'Improving the performance of the public health system in Greece', OECD Economics Department Working Paper No 722, Paris. Economou C., 2010, Greece: Health system review. Health Systems in Transition, European Observatory on Health Systems and Policies, WHO/EURO, Copenhagen.

In addition to this, interviewees in for example Italy, France and some Central and Eastern European MSs have identified political influencing of the healthcare system as a major problem:

*Interview report Italy: 'In order to fighting obvious influences of political parties and local organised crime groups, I would advocate stopping the practice of replacing top management in the most of health providing facilities with changed political establishment after every elections.' (...) 'If there are procedures in place according to which the politically appointed administrators can not choose the local health delivery organisation managers discretely (i.e., not transparent), these administrators cannot pursue their corruption objectives. If managers are guaranteed that they are chosen and promoted by merit, they can resist corruption proposals.'*

### **Anti-corruption legislation and strategies**

Many interviewees across a variety of European MSs have highlighted the importance of good national anti-corruption legislation, a compressive anti-corruption strategy and a coordinated national fight against corruption. Compliance with international anti-corruption standards (UN, OECD, GRECO) is considered to be important for the healthcare sector as well. The development of a nation-wide anti-corruption strategy, the creation of an anti-corruption bureau, and collaboration between public agencies and private actors in the enforcement of the anti-corruption regulations, can all have a positive effect on healthcare corruption. Higher penalties for bribery have also been mentioned as having a deterrent effect on the healthcare corruption.

The UK Bribery Act is (along with the US Foreign Corrupt Practices Act) considered to be the current golden standard in anti-corruption legislation (good practice 4.2.1). The example of Austria (good practice 4.2.2) is an illustration of the positive effects of generic anti-corruption legislation and policies in the healthcare sector.

In some countries the anti-corruption bureau explicitly targets healthcare corruption, such as the Latvian Corruption Prevention and Combating Bureau (KNAB), which has prioritised issues of corruption in the healthcare sector. KNAB introduced guidelines for the terms and boundaries for acceptable gifts to physicians; and has set limitations on parallel physician employment in public and private facilities as well as on possibilities for physicians to conduct the second job in companies, which are suppliers of equipment or pharmaceuticals.

The 2012 Action-Plan Anti-Corruption Strategy in Croatia has a specific paragraph on healthcare. The design of the health paragraph in the Croatian anti-corruption action plan is presented below (good practice 4.2.3). Since this plan has recently been adopted we cannot say to what extent it has had any tangible effect. However one of the interviewees from Croatia claims that 'due to strong anti-corruption campaigns, corruption in health in general is decreasing in Croatia. Five to seven years ago corruption was considered the rule, now it is considered the exception.'

#### **4.2.1 Anti-corruption legislation**

##### **What**

UK Bribery Act, United Kingdom

The act passed parliament in 2010. It went into effect on July 1, 2011.

##### **How**

The UK Bribery Act (UKBA) gives the Serious Fraud Office in the UK the power to prosecute bribery anywhere in the world, as long as a company or its employees have a link to the UK. The UKBA is considered as one of the strictest anti-bribery regimes anywhere in the world when it was introduced little more than a year ago. The UKBA defines four main offences: Active bribery; that is, offering, promising or giving a bribe; Passive bribery; that is, soliciting, agreeing to receive or accepting a bribe; Foreign official bribery; that is, bribing a foreign public official to obtain or retain business or gain a business advantage; and Failure to prevent bribery - that is, the failure of a commercial organisation to prevent bribery by someone acting on its behalf. The jurisdiction of the UKBA extends not only to domestic UK concerns but also to non-UK businesses that do business in the UK.

##### **Results**

There are few prosecutions to date. No healthcare related cases yet. However it is considered to have a strong deterrent effect on all companies with links to the UK. The UKBA is considered to put pressure on the pharmaceutical and medical device industry.

## **4.2.2 Anti-corruption institutions**

### **What**

Establishment of the Office for Prosecution for Corruption  
Establishment of a Federal Anti-Corruption Bureau  
Austria, 2008

### **How**

The Austrian anti-corruption legislation of 2008 is an example of a successful policy. The Criminal Law Reform of 2008 and the amendment in 2009, as well as the establishment of the Office for Prosecution for Corruption and the Federal Anti-Corruption Bureau (both new offices the first of its kind in Austria), are viewed by participants to be important developments in the fight against corruption in Austria.

### **Results**

On the legal side, high penalties have had a strong dissuading effect on overt or highly visible types of corruption (cash payments, conference participation). On the psychological or cultural side, interviewees have noted a sea-change in attitudes towards corruption from widespread tolerance 20 years ago to a widespread non-acceptance. Because of the high penalties for taking bribes in the new law (up to 3 years) covering all kinds of perks (conference attendance, libraries, etc. – all gifts over the value of 100 euro), hospitals have made enormous efforts to educate staff and provide regular warnings at meetings. This has reportedly led to a change in attitudes and more cautious behaviour.



### 4.3.3 Anti-corruption-in-healthcare strategy

#### What

Ministry of Justice of the Republic of Croatia  
Action Plan with the Anti-Corruption Strategy, Chapter 10. Health  
Croatia, 2012

#### How

Measures to prevent corruption in the health system are contained in the 2012 Action Plan Anti-Corruption Strategy, which covers:

- Introduction of national waiting list;
- Introduction of e-Scheduling;
- Linking of healthcare sector registers and unification of data;
- Unification of hospital procurement for the public hospitals;
- Continued health institution accreditation;
- Monitoring the implementation of clinical testing of medicines;
- Monitoring of advertising of drugs and orthopaedic aids (Agreement on Ethical Advertising);
- Monitoring of process of inclusion in the List of Orthopaedic and Other Aids;
- Monitoring of the implementation of contract obligations and earmarked spending of funds from obligatory health insurance.<sup>126</sup>

#### Results

The strategy has recently been adopted. It is considered by our interviewees as promising.

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<sup>126</sup> [www.anticorruption-croatia.org](http://www.anticorruption-croatia.org).

### 4.3 Control and sanctioning

Controls such as administrative, financial or broader institutional measures are an important element in preventing and controlling malpractice and corruption. To a large extent the healthcare sector follows regular procedures and frameworks, like any other sector. The nature of the control procedures and frameworks is also very much country specific. For example in France the Audit Office has prosecuting powers of its own, whereas in the United Kingdom the Audit Office can only signal issues but cannot follow-up or sanction by itself. In this study we make a distinction between three main categories of anti-corruption policies and practices:

- **Non-healthcare specific anti-corruption policies and practices.** Ineffective generic control and sanctioning mechanisms, such as overall judicial effectiveness, have repeatedly been identified as one of the major problems in the fight against corruption, including healthcare corruption. This sub-category includes policies and practices such as: the implementation and enforcement of a sound anti-corruption legislation (UK Bribery act 2010 is new gold standard); effective generic anti-corruption policies and practices within a country; and overall judicial effectiveness.
- **Generic healthcare supervision.** The healthcare sector has specific control and audit mechanisms such as Health Inspectorates, pharmaceutical committees, quality control agencies and professional bodies of doctors that may have a mandate to supervise the behaviour of their members, quite often with a specific formal disciplinary mandate. Countries with good healthcare supervision systems seem to have less corruption in healthcare. Healthcare system reforms could therefore also include the establishment of good generic healthcare supervision of the entire performance of healthcare providers: the quality of medical care, the efficiency of use of resources *and* fraud and corruption:

*Interview report Bulgaria: 'Improved and regular – multidisciplinary - control in healthcare establishments is needed. Effective control of the entire performance is only possible through multidisciplinary teams that adequately cover the activities in the social and medical as well as in financial and economic aspects.'*

- **Healthcare specific – targeted anti-fraud and corruption in health control.** It is crucial to set up structures that specifically deal with fraud and corruption in the healthcare sector. These structures should not only have a mandate to control but also to sanction violations. Control and sanctioning should be explicitly connected. However, this does not necessarily mean that separate organisations or bodies need to be set-up. Existing agencies within their existing mandate, but with dedicated resources for the health sector are probably best equipped. The health sector as such is not so special that it would require always separate treatment, as it may increase the risk of regulatory capture of such an agency by the sector. We will discuss hereafter four examples of targeted anti-fraud and corruption in health control practices.

### 4.3.1 Fraud in healthcare control I

#### **What**

Medical Evaluation and Control Department (DGEC)  
Belgium, since 2004

#### **How**

The National Institute for Health and Disability Insurance (INAMI-RIZIV) organises and financially manages health and disability insurance in Belgium. Within the INAMI, the Medical Evaluation and Control Department (DGEC) has developed new systems to broaden the range of their counter-fraud activities; A more proactive counter- fraud strategy has been developed aimed at prevention and more appropriate sanctioning as a deterrent. The starting point was an in-depth analysis of data collected from specific areas in health insurance considered to be 'at risk' of waste, abuse, fraud or corruption. As a result of these evaluations or screenings, people detected as outliers are being informed, warned, monitored or sanctioned. 100 medical-doctor inspectors and 35 nurse-inspectors investigate the explicit anomalies detected, prioritised according to the expected impact for return on investment.

Sanctioning is embedded in a structure of predominantly administrative judicial proceedings within INAMI. Aside from the head of DGEC who has the authority to sanction infringements of up to 35 000 euro, administrative 'chambers' in the first instance deal with cases of evident fraud and corruption above 35 000 euro. Administrative fines can be as high as 200% of the amount that has been fraudulently pocketed. In cases of 'unwarranted services' (unnecessary and/or too expensive care or prescriptions) monitoring and eventually administrative suspension can be decided.

Throughout the entire enforcement process the rights of defence are scrupulously observed as well as the right to higher appeal. The chambers of first instances and appeal are presided by a judge who is assisted by members of health insurance organisations and medical professionals, all equally represented.

#### **Results**

The financial losses measured in sectors such as over- billing of medication and fraudulent abuse of long-function tests, range from some 10,000 euro up to 15 million euro. Circa 8 000 individual investigations have been started with some 1 200 actually sanctioned. An average of 4.5 million euro per year has been claimed back with an additional 1.5 million euro per year as administrative fines imposed by DGEC. A majority of cases resulted in a spontaneous reimbursement, after receiving a warning letter, by individual healthcare providers and hospitals of the money they had appropriated wrongfully due to error or ignorance. The immediate and indirect results of these counter-fraud actions aimed at behavioural change of healthcare providers, are followed up and measured through impact assessments. In some cases the return was as high as 13 million euro over a 3 years period.

### 4.3.2 Fraud in healthcare control II

#### **What**

The Fraud Prevention and Litigation Directorate within CNAMTS (Caisse Nationale de l'Assurance Maladie des Travailleurs Salariés) France, since 2005

#### **How**

Following the implementation of the 2004 health reform, CNAMTS created a new dedicated team in 2005 to prevent and fight fraud and corruption in healthcare: the Fraud Prevention and Litigation Directorate (DCCRF). In order to increase its efficiency in fraud detection and investigation, data mining methods have been implemented by statisticians within regional units and training of medical and administrative staff in charge of investigations have been enhanced.

#### **Results**

In 2010 actions related to fraud and unwarranted services led to litigation procedures that ended up with serious sanctions:

- 219 jail sentences;
- 46,280 days of suspension of the right to practice medicine;
- 240 permanent suspensions of the license to practice;
- 217 notifications of financial sanctions for an amount of 45 million euro and 361 notifications for undue payments for an amount of 36 million euro.

A specific investigation aimed at the unjustified prescription of sick leaves by doctors resulted in almost 400 million euro savings. An amount of 150 million euro of fraud was detected and stopped in 2010, compared to 138 million euro in 2009, 132 million euro in 2008, 126 million euro in 2007 and 91 million euro in 2006.<sup>127</sup>

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<sup>127</sup> European Healthcare Fraud and Corruption Network Annual Report 2010.

### 4.3.3 Fraud in healthcare control III

#### **What**

National Health Service (NHS) Protect - identifying and tackling economic crime United Kingdom, since April 2011

#### **How**

NHS Protect was launched in April 2011 as an intelligence-led, stakeholder-focused service to safeguard NHS resources. Apart from many other types of identified crime such as criminal damage and theft, economic crime such as fraud, corruption and unlawful action (market fixing etc.) are the subject of attention. An organisational structure and business model was introduced that reflects the requirements to provide an effective response to the threat of these crimes within the NHS. Several primary business services were created: The Policy and Standard Unit; the Information and Intelligence Unit; the Deterrence and Engagement Unit; the Local Support and Development Services; the National Investigation Service and the Information Security and Systems Unit.

As part of the work to tackle fraud and corruption, the National Investigation Service provides a centralised enforcement response. A comprehensive forensic computing service has been established to recover digital evidence for use in criminal, civil and disciplinary proceedings. The NHS Protect also supports and administers the NHS Fraud and Corruption Reporting Line, a telephone and online fraud referral service that allows NHS staff and members of the public to report their concerns. Callers may remain anonymous if they wish.

#### **Results**

Over the years 2011-2012, fraudulently obtained payments have been frozen and returned to the NHS for an amount of 2.7 £ million; 172 360 £ have been confiscated for compensation. As a result of NHS bulletins and alerts, and the work of local NHS anti-fraud staff, attempted fraudulent activity totalling more than 3.6 million £ has also been prevented. The NHS Fraud and Corruption reporting Line provided many cases which have been successfully investigated: of the 959 allegations which were reported, 80 % were referred on for further investigative action.<sup>128</sup>

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<sup>128</sup> European healthcare Fraud and Corruption Network; NHS Protect: «Annual report 2011-2012'.

#### 4.3.4 Collaboration between competent authorities and the public

##### **What**

GAS (Inspeção Geral das Atividades em Saúde) is the service within the Portuguese Ministry of Health responsible for inter alia, preventing, detecting and investigating corruption and fraud.

Portugal, since 2007

##### **How**

In 2010, 17 audits have been performed, some of them on a multi-annual basis focusing in particular on the construction of new hospitals, the billing of medicines and the implementation of contracts with the private and social sector. Since the beginning of 2012, the Portuguese Government built up strategies and coalitions in order to reduce corruption risks in the area of pharmaceutical procurement. IGAS, the judicial police and Infarmed (the National Authority of Medicines and Health Products) joined forces aiming at prevention. Improvements in control systems, risk analysis and implementation of uniform methodologies (training of controllers, adoption of new anti-corruption methods) are some of the initiatives that have been undertaken by this coalition. At the same time, awareness is being promoted amongst the public by means of an on line registration system for complaints and suspicion of corruption by concerned citizens (Livro de Reclamacoes, Sugesteos e Elogios).

##### **Results**

Irregularities detected in procurement procedures account in 2010 for 22 million euro reported to and trialled by the Audit Court. In 2011 the Portuguese Minister of Health, estimated the value of the fraud and corruption cases under investigation at around 100 million euro, linked to the more than 366 complaints the IGAS received about possible corruption cases. Two major corruption cases involving doctors colluding with pharmacists and abusing the electronic invoicing and stock management system, still to be trialled, have been detected and investigated.<sup>129</sup>

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<sup>129</sup> European Healthcare Fraud and Corruption Network Annual Report 2010.

#### **4.4 Bribery in medical service delivery**

In our interviews the low remuneration of doctors and health workers active in the public sector have been cited as one of the main risk factors for soliciting or accepting bribes, in particular in relation to informal payments. In addition to this, information asymmetry between the healthcare providers is considered an extra enabling factor for demanding informal payments on top of the official healthcare charges.

A general conclusion is that Informal payments cannot be contested with targeted but isolated policies against the phenomenon as such. In many countries comprehensive system changes are needed. One of the interviewees has formulated this as follows: 'Informal payments cannot be handled as a separate problem to solve. Fundamental changes in the healthcare system are needed. If we change the system, the willingness to pay informal payments and the willingness to access informal payments will decrease. We do not have to address informal payments themselves, but the potential risks of corruption.'

In addition to this, some specific policies and practices that have been implemented in a variety of MSs where bribery in patient to doctor service delivery is, or used to be, a widespread problem include:

- An increase in salaries of healthcare providers (mixed results);
- Formalising informal payments (no positive results);
- Introduction of transparent waiting lists;
- Higher penalties for bribery;
- Collective action by medical professionals against asking or accepting bribes;
- Public information campaigns (to be discussed in Chapter 4.7).

#### 4.4.1 Increase in salaries of healthcare providers I

##### What

Increase in salaries of healthcare providers  
Hungary, 2004

##### How

In 2004 the salary of all public employees was increased by 50%. This measure was not specifically taken to combat corruption, but mainly to prevent an exodus of healthcare workers to countries abroad.

##### Results

An increase of the salaries in the healthcare sector was without any appreciable results. There were no significant changes regarding the magnitude of the informal payments (Baji *et al.* 2012). The reason for the failure of these measures is that the doctor receives the total amount of the informal payments itself, but when the same amount is paid as official fees by the patients, the physician gets only the part of it after taxation.

In addition there are other reasons for prevailing informal payments in Hungary, which might contribute to the failure of this particular policy:

- Existing regulation does not explicitly forbid accepting informal payments;
- Codes of Ethics of the Medical Chamber accept informal payments;
- There is limited access to information (e.g. consumer/patients' rights, service delivery standards, official price schedules, procurement information) for all stakeholders. Patients are not aware what services they are entitled to, or where they can make complaints. The entitlements are also hardly defined in the regulations.

Furthermore, according to official figures, salaries remain among the lowest in Europe and the CEE region. Recent studies also show that the Hungarian population is still rather tolerant towards informal payments (Baji, Gulácsi 2012).<sup>130</sup>

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<sup>130</sup> Ecorys Country Report Corruption in Healthcare 2013.



#### 4.4.2 Increase in salaries of healthcare providers II

##### **What**

Increase in salaries of healthcare providers  
Romania, 2007

##### **Results**

The result of these measures is unknown. The measure did not last long, as the wages were in 2010 again cut by 25% within the austerity measures during crises and got back in 2012 but not up to the same level as in 2010 before cuttings. In addition, the current agreement of Romania with IMF does not allow increases in salaries in the public sector unless significant economic growth is achieved.<sup>131</sup>

#### 4.4.3 Formalise informal payments

##### **What**

Formalise informal payments  
Czech Republic, 2011

##### **How**

The ministry of health has made an attempt in the summer of 2011 at formalising payments to allow for a transfer of a select doctor. The aim was to mimic what already happens in informal payments, but in a transparent and legal way. It also includes the opportunity to pay for better equipment and treatment, for instance a higher quality hip replacement that is considered by the legislator as adequate and is covered by the insurer.

##### **Results**

This plan has not taken off and is not currently being used. The main reason behind this is the limited incentives for the doctors to participate. Since the payments were to be shared with the hospital as well as taxed, they amounted to roughly a fifth of the going rate.<sup>132</sup>

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<sup>131</sup> Ecorys Country Report Corruption in Healthcare 2013.

<sup>132</sup> Ecorys Country Report Corruption in Healthcare 2013.

#### **4.4.4 Introduce transparent waiting lists**

##### **What**

Introduce transparent waiting lists, Austria

##### **How**

Some hospitals have official waiting lists that can be accessed internally (not by the general public); any movement up or down the list has to be accompanied by an explanation. There is a draft amendment under discussion regarding the formalisation of waiting lists and procedures for ensuring that waiting lists for medical treatments are transparently managed. Apart from this, however, there have been independent efforts to improve transparency in this area. In 2008/2009, the Vienna Hospital Association (with the exception of one hospital) introduced a computerised registration system ('OPERA') towards greater transparency in waiting lists. This system is reportedly functioning well.

##### **Results**

Receiving payments for moving up waiting lists at public hospitals is considered to be a thing of the past due to the practice of many hospitals to publish the lists, making any sudden move up a list questionable and subject to scrutiny and justification.<sup>133</sup>

#### **4.4.5 Increase penalties for bribery**

##### **What**

Higher penalties, Austria, since 2008

##### **How**

The new anti-corruption law of 2008 applies heavy penalties on health practitioners who are corrupt. Interviewees suggest that the threat of high sanctions has had a major impact on this practice of receiving cash. An old convention had it that patients should leave a 'tip' for services received.

##### **Results**

The new climate following the law has reportedly completely eliminated this old practice as it is now regarded as illegal, when once it was perceived as polite behaviour. The prevalence of any residual practice of making payments to doctors is perceived to be low. More costly are the semi-legitimate transfer of patients from public to private hospitals. This is semi-legitimate because it is not illegal, but nevertheless perceived to be illegal due to the financial profit by doctors.<sup>134</sup>

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<sup>133</sup> Ecorys Country Report Corruption in Healthcare 2013.

<sup>134</sup> Ecorys Country Report Corruption in Healthcare 2013.

#### 4.4.6 Doctor's initiative against bribery

##### What

Doctor's initiative refusing to take or tolerate bribery: 'Ďakujem, úplatky neberiem'  
Slovakia, August 2012

##### How

In 2012 a Neurosurgeon Milan Mrázik from the Northern city of Žilina began an initiative 'Ďakujem, úplatky neberiem'. This involved doctors signing a public petition declaring that they do not accept bribes or other forms of informal payments. They would declare this by openly wearing, or displaying, a badge symbolising this stance. The initiative quickly spread and got the support of Medical Trade Unions Association (LOZ), before gaining the support of Marian Kollár, the president of the Slovak Medical Chamber (SLK). Both of these institutions say that the campaign should be continued and supported. To this day 412 doctors are actively participating, constituting around 10% of the country's doctor base.



One way to effectively deal with corruption is to break the vicious cycle, where corruption is the norm by both the patients and receiving doctors. The initiative should illustrate to the patients that informal payments are not needed for extra or better care. It also acknowledges that institutional reform is a necessary method in combating corruption, but highlights the fact that it cannot succeed alone. For corruption to truly become eradicated it has to become socially unacceptable. 'Ďakujem, úplatky neberiem' is an attempt to break this cycle of healthcare corruption and not only illustrates that there are alternatives, but also start a wider social discussion about corruption, and its place in Slovakia's modern society.

##### Results

The initiative has at times met the resistance of some doctors, who say that it is demeaning as doctors take an oath that should prevent them from taking bribes or doing favours. They state that the campaign is simply stating the obvious and that the real problem, as well as the solution, lies in the institutional reform and stricter disclosure rules. Undoubtedly this is not the golden bullet, but it is considered as a positive step and a piece of the complex mosaic that is a successful eradication of corruption.<sup>135</sup>

<sup>135</sup> <http://somprotiuplatkom.webnode.sk/>; Rai-see.org; Aktualne.sk.

## 4.5 Procurement corruption

Centralisation of procurement is often promoted as a method to lower the risks of corruption. As one interviewee in Austria noted: 'Procurement has become gradually more centralised, and this has had the effect of lower prices and greater transparency.' Centralisation of procurement, central standards or price setting can indeed reduce the risk of procurement corruption. However in some MSs decentralisation was promoted as a way to prevent corruption in healthcare procurement. Central procurement systems can become very vulnerable as targets for lobbyists and more political inspired types of corruption.

The three examples of good practice that we will discuss are:

- Breaking the cycle of systemic corruption;
- Inclusion of the healthcare sector in strict federal procurement regulation;
- Centralise the maximum price of pharmaceuticals.

### 4.5.1 Break the cycle of systemised corruption

#### What

The police and public prosecutor became independent and peruse suspect and corruption practices, regardless of the person's wealth, influence or political function. Czech Republic, June 2013

#### How

The last three years have seen a significant shift in the fight against corruption. The initial step was taken by the current government to actively distance themselves from the activities of the police and the public prosecutor's office in order to create their true independence. This has been the first time that politicians actively refused to interfere with investigations. The police as a consequence became braver and willing to investigate even more prominent members of the establishment. Importantly they have improved their techniques and prevented previous information leaks about on-going investigations (facilitated by a relaxation of pressure and demand for information by the politicians).

In the summer of 2012, a new chief public prosecutor was appointed with the political support to operate independently in the interest of the nation. She has supported the police and pushed several high profile cases in front of the courts. One high case, that she participated in, was that a doctor, member of parliament for CSSD (social democrats), an ex-Minister of Health and at the time of his arrest a Governor of Central Bohemia. He was widely considered as one of the most influential politicians in the country. In May 2012 he was arrested, together with four other people, during the act of receiving a large cash bribe after a 6 month undercover police operation. He remained in custody and is due to stand trial in the summer of 2013.

The fact that such a high profile politician was arrested, stripped of his immunity (since then a new law has been passed stripping all politicians of criminal immunity) and charged, was a defining moment in the country's fight against corruption. It signalled a new era, where such action by the judiciary and the police was possible.

However, what confirmed and definitely cemented such a momentous shift was the unprecedented police operation of June 2013. In the early hours of Thursday 13th June the biggest police operation in modern Czech history begun. During that one day 400 police offices conducted several raids in private homes, businesses, public companies, Prague's city council and even at the seat of the Czech government. They seized computers, files, money and even gold. In total they arrested and charged the MPs, the chief of staff of the Prime Minister, two high ranking officers of the military secret services and an ex-minister. On top of that they called for questioning several high profile people including the PM and the Minister of Finance. They were charged with abuse of power and corruption.

## **Results**

The fact that such high profile people and those of real power have been arrested and are awaiting trial has been a momentous event. Investigation is underway with the seized documents being reviewed in order to build a concrete case between the eminence-grise of corruption and their political enablers. In breaking the vicious cycle of embedded and systemic corruption, the authorities are attempting to establish an environment where the rule of law is above political power and where corruption is prosecuted for the acts and irrespective of the person committing it.<sup>136</sup>

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<sup>136</sup> Ecorys Country Report Corruption in Healthcare 2013; iDnes; iHned; Lidove Noviny; NFPK.

#### 4.5.2 Include the healthcare sector in general procurement regulations

##### **What**

Extending general public procurement requirements to the supplies and services procured by public hospitals  
Belgium, 1 July 2013

##### **How**

On 1 July 2013, the new regulatory framework for public procurement came into force. This is the date that had already been put forward by the Public Procurement Commission in January 2013, when the provisions of several Royal Decrees and the Law of 15 June 2006 will enter into force. What is new is that the application of the new regulatory framework for public procurement will be extended to public hospitals. Until now, public hospitals were in fact excluded from the rules applying to procurements of supplies and services, which were not exceeding the European thresholds.

The regulatory framework introduces a series of new thresholds and requirements for the use of the different procurement procedures, such as:

- New thresholds for the use of a negotiated procedure without publicity (a general threshold of 85 000 euro, 193 000 euro for services);
- New, stricter requirements to make use of a negotiated procedure without publicity for the procurement of supplies;
- New thresholds to make use of a negotiated procedure with publicity (6 000 000 euro for works; 193.000 euro for supplies and services);
- Establishment of a new negotiated procedure: the direct negotiated procedure with publicity, according to which any supplier or service supplier can present an offer as soon as the tender is advertised;
- Specific restrictions aimed at combating conflicts of interests;
- Obligation to keep records of all procurements launched in the previous five years.

##### **Results**

This law is only in force since July 2013.<sup>137</sup>

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<sup>137</sup> Interview report n°2 of the Belgium country study, Law of 15 June 2006, Royal Decree of 15 July 2011, Royal Decree of 14 January 2013.

### 4.5.3 Centralise the maximum price of pharmaceuticals

#### What

The State Institute for Drug Control (SÚKL) sets maximum prices  
Czech Republic, Since 2008

#### How

The State Institute for Drug Control (SÚKL) has a long history as an independent scientific institute that certifies pharmaceuticals and medical equipment and ensures their safe and proper use. As of 1st of January 2008 (pursuant to Act no. 48/1997 Coll., on Public Health Insurance) SÚKL has been given the competence to determine the maximum prices of pharmaceuticals and to determine the level and conditions of reimbursement of medicinal products.

The maximum prices are set by following a procurement procedure (which adheres to all relevant EU standards on public procurement). Each medicine is judged on its:

- Usefulness (how effective is it in curing ailments compared to available medicines);
- Safety (does it have any unwanted side-effects, are there any patients in danger, etc.);
- Price of the medicine (calculated by the average production price in a basket of 8 similar EU countries, or by the average of three EU countries with the cheapest price, or the production price of the closest alternative);
- Price efficiency (is the power-to-price ratio correct, or is the effect too small for the large price).

The analysis is subject to rigorous scientific examination and consultation with not only stakeholders (insurance companies/pharmaceutical companies) but also with other expert scientific bodies and research institutes.

According to its type the new medicine is placed into a category and according to the conducted analysis allocated a maximum price, within that category, that the insurers are allowed to reimburse upon the use of this medicine. This means that hospitals and medical facilities can procure the medicine at the set maximum price or cheaper, preventing space for corrupt deals and overpriced medicine. A corresponding action has been to encourage doctors to review the mix of medicine for the elderly and seriously ill, to try to determine a smarter combination that results in the same or better effects with fewer medicines.

#### Results

This system has had significant results that have, according to some sources, led to a price reduction of medicine expenditure for the insurer and medical facilities, as well as increasing patient's access to the best medicine. The system is well protected from undue influence and has eliminated the motivation to corrupt public procurement in pharmaceuticals. A similar system is currently being created for medical equipment.<sup>138</sup>

<sup>138</sup> Ecorys Country Report 2013; SÚKL.

## 4.6 Improper marketing relations

The attitudes, policies and practices with regard to the improper marketing relations between the industry and healthcare providers differ across countries. While some countries have lax rules on marketing relations, other countries have much more strict regulations.

In Sweden recently a tough stance has been taken including the prosecution of doctors joining a foreign educational trip organised by a pharmaceutical company. In the Netherlands a company was sentenced to a fine for organising a seminar for physicians with the aim of discussing the possible expansion the medical use of Botox to new treatment areas. Participating doctors were not prosecuted. Another case concerns the purchase of large quantities of Tamiflu, an antiviral, during the epidemic of the avian flu. In several countries (e.g. Netherlands, Belgium, Bulgaria) 'normal' procurement procedures were waived at the time. In those countries the decision-making has been questioned or is being investigated currently.

Regulations not only differ across countries, but also across sectors; in general the pharmaceutical sector is more strictly regulated than the medical devices sector. With regard to medical devices different cases came to light over the last years. For example, cases involving orthopaedic implants and scams that were aimed at higher prices and preferred use by physicians and hospitals. Such cases have been reported in the Netherlands, Greece, Romania and Poland.

Measures to regulate and monitor the marketing relations between healthcare providers and the industry can be broadly divided into two categories: formal regulation through legislation, and self-regulation through for example a Code of Conduct (CoC) or Code of Ethics (CoE). Self-regulation can either be organised at a national or supranational level. Industry organisations at the European Union level, such as EUCOMED and EFPIA, in general have CoCs or CoEs in place for their members.

The following examples of good practices will be presented below:

- Prescribe main active substances;
- Code of Conduct for medical devices;
- Self-regulation of the pharmaceutical industry;
- Sunshine Act à la Européenne;
- Conditioned self-regulation in the pharmaceutical sector.

Note that policies discussed in other sections of this chapter might also have the potential to reduce the opportunities for or mitigate the effect of improper marketing relations. Note also that this section discusses a selection of policies and practices regarding improper marketing relationships between the industry and providers. The fact that a country is not mentioned in the discussion of a policy does not mean that this policy is necessarily not in place.



## **General observations**

We present, before discussing the policies and practices in detail, some general observations:

**Differences across countries.** From the policy descriptions in this section it is clear that while a policy may be effective in one country, a similar policy can be considered unsuccessful in another country. This can be related to a multitude of factors such as the present control and enforcement mechanisms, legal foundations, longstanding traditions of self-regulation and (dis) trust towards to industry.

**Role of healthcare providers.** It is also important that policies acknowledge the importance of reciprocity, that is, it should not only focus on regulating the industry, but also the healthcare providers.

**Generic brand names.** The description of the policies on prescribing generic instead of brand name pharmaceuticals illustrates the importance of control and enforcement for such as policy to be successful; in Estonia the policy became (more) effective after control and enforcement by the Patient Fund was introduced. The fact that the country report on Spain indicates that physicians simply keep prescribing brand names after the introduction of the policy suggests that that control and/or enforcement are lacking.

**Awareness.** With regard to self-regulation it is interesting to see that only the Netherlands highlighted for medical devices industry's CoC as a good practice, whereas, according to the EUCOMED website, many countries have such a code in place. This can imply that people are simply unaware of these codes or that they do not take them seriously, i.e. do not consider them viable options for regulation of this sector. This notion is confirmed by the discussion on self-regulation in the pharmaceutical industry in which it is for example mentioned that in Austria such codes are not considered cynical.

**Distrust.** There appears to be distrust to both the medical devices and pharmaceutical industry in several countries, most likely due to the different cases that have been discussed in the media. This distrust might lead to the perception that self-regulation in these industries cannot be effective. This does not imply that that is true. Self-regulation measures could also be used to take away this distrust. For example, in the Netherlands it was mentioned that one of the reasons for setting up the new CoC for medical devices was the bad image the industry was getting due to several cases coming to light. Of course awareness is not the only factor to making self-regulation successful.

**Control and enforcement.** Control and enforcement, and the way in which this is organised, also plays an important role. When there is for example an independent committee evaluating complaints, or there are legal foundations for the regulation, success of (and trust in) the self-regulation is likely to increase. Moreover, some countries have longstanding traditions of self-regulation, such as the UK and the Netherlands, where for other countries this is relatively new.

**Transparency.** Countries also differ on the level of transparency and the way in which this is promoted. Traditionally Anglo-Saxon countries have always highly valued and encourage transparency. For other countries, where this has been done to a lesser extent over the years, implementation of Sunshine-Act-like initiatives might be much more challenging. Moreover, the scope of such policies can substantially differ between countries. The fact that EFPIA is implementing an EU-wide transparency policy as of 2016 is very interesting in that sense as some countries have to come in long way.

**Systematic evaluations.** Hence, it can be concluded that what works in one country does not necessarily work in the other. As the effectiveness of a policy depends on multiple factors, simply developing policies such as Sunshine Act-like initiatives or self-regulation measures will most likely prove insufficient. Carrying out systematic evaluations of policies and their effects (including the reasons behind this) is important in establishing the conditions for successful implementation.

#### 4.6.1 Prescribe main active substances

##### What

Policy on prescribing main active substances rather than brand names of pharmaceuticals

Estonia & Lithuania (good practice), Slovakia and Spain (unsuccessful policy)  
2005 (Estonia), 2010 (Lithuania), 2011 (Slovakia and Spain)

##### How

In all four countries the policy basically entails the same thing: physicians prescribing the main active substances rather than the brand name of pharmaceuticals. Additional measures/features in the different countries are described below.

In **Lithuania** an additional measure, related to this policy, has been introduced: pharmacies are required to present comparative information regarding relevant pharmaceuticals and their prices on monitors. This has the goal of informing patient who walk in with a prescription and need to make a choice between different drugs containing the same active substances.

In 2011 Act Nr.362/2011 Coll. on medicines and medical aids was adopted in **Slovakia**. This Act states, amongst other things, that physicians are only allowed to prescribe the generic name of a drug. In essence, the Act shifted the competence on deciding which (brand) medicine is to be handed out from the physicians to pharmacists and patients themselves.

According to Royal Decree Law 9/2011 in **Spain**, the prescription of medicines should be done on the basis of their active chemical composition. Pharmacists are also obliged to sell the lowest price (unlabelled) medicine.

## Results

In **Estonia** it was thought that the introduction of this policy might shift the risk of corruption from physicians to pharmacies. However, up until now there is no solid evidence on this. In 2012, a report of the National Audit Office revealed that in the first years after the introduction of this regulation many physicians were still prescribing brand names instead of active substances. After the requirement became an integrated part of the physician contract with the Patient Fund the situation improved significantly. Penalties for violating the requirement are listed.

During his visit to **Lithuania**, the managing director of EHFCN was familiarised with the requirement of comparative information on monitors in pharmacies and deemed this a good practice. Moreover, the interviewees in the country report for Lithuania (carried out in 2013 for this study) indicated that this policy can be considered a good practice. However, as systematic monitoring and/or evaluations of the regulation are lacking, it is difficult to say something about the actual effect of the policy.

In **Slovakia** a policy reducing the influence of pharmaceutical companies was long asked for. However, the submission of the draft of the new Act was by public opinion linked to one of the most influential and strongest financial groups: Penta. Penta owns one of the pharmacy chains in Slovakia. This raised the concern that the pharmacists lobby would replace the physicians in receiving the (financial) perks by pharmaceutical companies. After a lot of debate and comments in and from the media and the National Council, the Act was amended by comments of several members of parliament and then adopted. One of the amendments changed the Act substantially; although physicians now have to prescribe generic medication, they may still suggest a brand name in between brackets. This raises ethical concerns as the decision maker is now not clearly defined and the indication between brackets may strongly influence the patient and/or pharmacy. A thorough and systematic evaluation of this policy is needed to clearly identify all the effects.

One of the objectives of the new policy in **Spain** was to stimulate the sale of generic medication. This has not been achieved as many of the brands adjusted their price to the prices of the unlabelled medicines with the same active ingredients. Moreover, according to the country report written for this study, physicians keep prescribing brand names in many cases.<sup>139</sup>

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<sup>139</sup> [http://rahvatervis.ut.ee/bitstream/1/5404/2/Riigikontroll2012\\_Inglk\\_kokkuv%C3%B5te.pdf](http://rahvatervis.ut.ee/bitstream/1/5404/2/Riigikontroll2012_Inglk_kokkuv%C3%B5te.pdf); <http://www.riigikontroll.ee/tabid/168/amid/557/ItemId/643/language/en-US/Default.aspx>; Ecorys Country Report Corruption in Healthcare 2013.

#### 4.6.2 Code of Conduct for medical devices

##### What

Code of Conduct - Medical devices  
The Netherlands (good practice), 2012

##### How

On 1 January 2012 the 'Code of Conduct Medical Devices'<sup>140</sup> (GMH) came into effect in the Netherlands. This code has been set-up by the organisation SOMT, who has as its members 6 professional organisations for medical devices that together represent over 400 suppliers. Before the GMH came into effect, the industry was using different CoCs such as those set up by the industry organisations EUCOMED, COCIR (medical equipment) and EDMA (diagnostics) or national versions of these. In the fall of 2010, in cooperation with the Ministry of Health, Welfare and Sports, it was decided that it was important to develop one uniform code for the whole sector. At that time, the perception of biased medical professionals as a result of inducement by the industry was increasing due to media attention for several cases (e.g. the one on Metal-on-Metal hip implants).

Within the GMH there are two different procedures in place: (i) Advice (ex-ante) and (ii) Complaint (ex post). Both procedures are handled by the independent Code Committee, which is installed by the Foundation GMH. This Committee comprises of approximately 15 people (including e.g. lawyers, people from the medical field, experts). All issued advices and complaints are available on the Foundation's website. The code has specified sanctions that can be enforced in case of violations. The important next step for the GMH is to establish reciprocity. The professional organisations for physicians, medical students and specialists in the Netherlands, KNMG and OMS, have expressed their intention to sign the code. They would like hospitals to sign as well and therefore GMH also started a dialogue with the professional organisations for hospitals in the Netherlands, NVZ and NFU.

The GMH is pure self-regulation; it has no legal foundation and thus, the Inspectorate for Healthcare (Inspectorate) is not formally involved. However, it would be helpful if the Inspectorate would assist the industry and the medical professionals to get to one common framework and a common understanding of it. Concerning some topics the Code differs from the European code set up by Eucomed. In case a company is member of both organisations, the stricter rules (which are in general the Eucomed rules) apply.

##### Results

As the CoC has only been introduced in 2012 in the Netherlands there is no indication of its effectiveness yet. The effectiveness will be partly dependent on whether or not reciprocity will be established.<sup>141</sup>

<sup>140</sup> <http://www.gmh.nu/images/pdf/Gedragscode%20GMH%20-%202012%20english.pdf>.

<sup>141</sup> <http://www.gmh.nu/>;  
<http://knmg.artsennet.nl/Nieuws/Nieuwsarchief/Nieuwsbericht-1/Een-stap-dichter-bij-de-regulering-van-relaties-in-de-medische-hulpmiddelensector.htm> <http://knmg.artsennet.nl/Dossiers-9/Columns-5/column/Gedragscode-Medische-Hulpmiddelen-is-het-voldoende.htm>;  
Interview with Stitching GMH.

### 4.6.3 Self-regulation of the pharmaceutical industry

#### What

Self-regulation - Pharmaceuticals

Lithuania (2003), Malta (2012), Sweden (2007, amended in 2011) & (good practice)  
Austria (2009) & Finland (2008) (unsuccessful policy)  
European Union (EFPIA)

#### How

In **Lithuania** a substantial number of pharmaceutical companies adhere to the Lithuanian Medicines Marketing and Ethics Code, which was adopted in 2006 and amended in 2012. It provides rules and guidance on transparency in contacts between the industry and medical providers and/or patients' organisations and on the sponsoring of scientific events. Hence it is concerned with both the governance of pharmaceutical marketing as well as the relations between healthcare professionals and pharmaceutical companies in general.

In **Malta** the Pharmaceutical Research Based Industry Malta Association (PRIMA) has developed a CoE, which was adopted in 2012. Moreover, it set-up a compliance board that promotes good policies and practices by pharmaceutical companies and aims to ensure compliance to the CoE.

The trade association for research-based pharmaceutical industry in **Sweden** (LIF) has combined all regulations on ethical conduct in a single code: 'The Ethical Rules for the Pharmaceutical Industry'. This Code came into force in 2007 and was last amended in January 2013. It aims to ensure that the pharmaceutical industry follows ethical rules. Agreements on different forms of collaboration and cooperation with healthcare professionals and/or organisational/interest groups are also included in the Code. The LIF's Compliance Officer has the authority to, on his own initiative, decide whether planned arrangements are acceptable given the Code. Moreover, the Swedish Pharmaceutical Industry Information Examiner (IGM) and the Information Practices Committee (NBL) are involved in the self-regulation. The IGM, a qualified doctor, is on continuous basis looking into marketing activities by the pharmaceutical industry. The IGM can refer issues to the NBL (which consist of 12 members that represent different stakeholders). The NBL also deals with appeals to decisions and can give general recommendations.

**EFPIA** adopted in 2007 the EFPI HCP Code, which is the Code on the Promotion of prescription-only medicines to, and interactions with Healthcare Professionals. This code aims to ensure that interactions and promotion are done in a non-deceptive manner that avoids (as much as possible) potential conflicts of interest with healthcare professionals. All members of EFPIA have to adhere to, at minimum, the ethical standards as described in the Code. Moreover, associations must include provisions in national regulations. Whenever the national regulations and the EFPIA code differ on a specific issue, the strictest provision will apply.

In both Austria and Finland self-regulation with regard to advertising for pharmaceuticals is in place. In **Austria** self-regulation by pharmaceutical companies takes the form of official ethics policies. In **Finland** the pharmaceutical industry has set-up its own CoE, even though both the Medicines Act and Decree include provisions on marketing of medicinal products

## Results

The fieldwork conducted for this study in **Malta** suggests that the Code is starting to reduce the prevalence of improper marketing relations. There are no known official evaluations of this policy. The perception is that because the Medicines Authority does not have the role of regulator of ethical conduct and not all pharmaceutical companies are a member of PRIMA (only approximately 9 out of 30), it is likely that not all companies adhere to the ethical standards.

We did not come across official evaluations of the effects of the Codes in **Sweden** and **Lithuania**. This makes it difficult to determine the actual effect of these practices.

For the **EFPIA** Code we also did not come across an official evaluation. However, because all member associations must adopt provisions that are at least as rigorous as those in the EFPIA code, it can be expected that this Code has a positive impact. In **Austria** the public generally regards these self-regulation policies as cynical. Moreover, they consider these policies only to be set-up for the purposes of public relations.

In **Finland** the implementation, control and enforcement of the CoE is considered to be weak. Face-to-face meetings with physicians still take place. Moreover, a number of prescription drugs, particularly vaccines, are marketed to the general public, although this is forbidden by the legislation. The laws are technically circumvented by not mentioning the trade name, but only the indication. Note however, that the disease context makes the product obvious. Patient support programs are growing rapidly and represent a new form of marketing. This works as follows: the manufacturer of a new drug, which requires complicated follow-up or administration, creates an internet based teaching program with various additional services such as reminders via telephone. First, the prescribing physicians are familiarised with the program and then they are asked to provide their patients with the URL of the website and patients register to the system. Subsequently, both the physicians and the patients are more or less tied to the product.<sup>142</sup>

<sup>142</sup> [http://www.farmaindustria.es/idc/groups/public/documents/c%C3%B3digo%20documento/farma\\_110039.pdf](http://www.farmaindustria.es/idc/groups/public/documents/c%C3%B3digo%20documento/farma_110039.pdf); [http://www.efpia-e4ethics.eu/Farma\\_EFPIA/index.htm](http://www.efpia-e4ethics.eu/Farma_EFPIA/index.htm); <http://transparency.efpia.eu/countries/>; [http://www.farmaindustria.es/idc/groups/public/documents/c%C3%B3digo%20documento/farma\\_110039.pdf](http://www.farmaindustria.es/idc/groups/public/documents/c%C3%B3digo%20documento/farma_110039.pdf); <http://www.efpia.eu/topics/building-trust>; [http://www.lif.se/Publik%20webb/Sidnehall/Publik\\_Dokument/Etik%20och%20regler/%C3%96verenskommelser%20o%20etiska%20regler/Ethical%20rules%20130301.pdf](http://www.lif.se/Publik%20webb/Sidnehall/Publik_Dokument/Etik%20och%20regler/%C3%96verenskommelser%20o%20etiska%20regler/Ethical%20rules%20130301.pdf); <http://www.lif.se/default.aspx?id=40897>; [http://www.efpia-e4ethics.eu/idc/groups/public/documents/c%C3%B3digo%20documento/farma\\_111069.pdf](http://www.efpia-e4ethics.eu/idc/groups/public/documents/c%C3%B3digo%20documento/farma_111069.pdf); <http://www.mcpgnet.org/publications/ISSUE14-6.pdf>; Ecorys Country Report Corruption in Healthcare 2013.

#### 4.6.4 Sunshine Act à la Européenne

##### What

Transparency enhancing initiatives resembling the Sunshine Act  
France, the Netherlands & European Union wide (EFPIA) (good practice)  
2013 (publication of Decree in France, implementing the French Sunshine Act into law), 2012 (Foundation for the Transparency Register in the Netherlands initiated), 2016 (EFPIA policy to be implemented)

##### How

In the **United States** (US), Section 6002 of the Patient Protection and Affordable Care Act is referred to as The Physician Payment Sunshine Act. This Act was signed into law in March 2010 and sets out the requirement for manufacturers of drugs, devices, biological, and medical supplies that are covered by Medicare and Medicaid to annually report payments or other transfers of value made to physicians and teaching hospitals. Manufacturers are also obliged to report any information concerning ownership or investment interests of physicians and their immediate family members in such companies. The purpose of the Act is to increase transparency with regard to the ties between medical professionals and the industry. Manufacturers and Group Purchasing Organisations are responsible for the data collection and reporting, while physicians can voluntarily review and dispute the data before it is publicly posted. Data collection will start from 1 August 2013 and the first reports have to be submitted by 31 March 2014. The majority of the data will be made available on a public website that is currently under development.

In December 2011 **France** adopted legislation similar to the Sunshine Act, known as the Bertrand Law. On 22 May 2013, the Decree implementing the Bertrand Law was published by the Ministry of Health. This Law requires that companies that produce, market or provide services associated with products listed in a particular section of the French Code of Public Health (including companies that make drugs, devices and blood and tissue products) to report information on the following two issues:

- Contracts entered into with French healthcare providers, excluding commercial sales agreements for goods and services (reporting within 15 days of execution of the contract); and
- Benefits with a value of 10 euro (including tax) provided, in cash or in kind, to French healthcare providers (reporting in general twice a year: in August for first six months of the year and in February of the next year on the last six months of a given year).

Companies have to start complying with the Law as of 1 June 2013 and the reporting will in the first year be retroactive to 1 January 2012. All reported information will be published on a public website which is currently under development. When companies do not comply with the Law they will face fines and/or other sanctions. Note that this new Act is broader in scope than the pre-existing French 'Anti-Gift Law' that also governs interactions between health products companies and healthcare providers.



In 2012 the Foundation for the 'Transparency Register Healthcare' was established in **the Netherlands** by the CGR Foundation (the Foundation responsible for the supervision of self-regulation with regard to advertisement of pharmaceuticals). The Transparency Register Healthcare is a database that facilitates financial disclosure by registering the financial ties that exist between the pharmaceutical industry and the medical professionals and can thus be considered the Dutch version of implementing the Sunshine Act. The database specifies how much a medical professional received from whom and for what. Note that not all financial relations are included, e.g. clinical research is not included. Relations have to be disclosed within 3 months following the year in which it took place and will stay in the Register for 3 years. The Foundation Transparency Register Healthcare is financially supported by the Ministry of Health, Welfare and Sports, has an independent secretary and the CGR Foundation is responsible for the enforcement. As of 25 April 2013 everyone has been able to access information on the financial ties between the pharmaceutical industry and medical professionals in the Netherlands.

Note that while in the US and France the Acts apply to manufacturers of both pharmaceuticals and medical devices, in the Netherlands it only for pharmaceutical companies.

Other countries within the European Union may not have adopted Sunshine Act like initiatives; however, this does not mean that there are no other rules and or regulations on transparency in place or that the possibility to introduce something like it is not being discussed. For example, in the United Kingdom (UK) they are also calls for a version of the Sunshine Act. Actually, in January 2013 the Royal College of Physicians, the Association of the British Pharmaceutical Industry and the Ethical Standards in Health and Life Sciences Group launched a public consultation period. The aim of this was to collect views and ideas of different stakeholders on how disclosure should take place. The responses to this consultation are currently being analysed.

There are also initiatives for more transparency on a European Union wide level: **EFPIA** has announced that as of 2016 all its members will have to start the process of disclosure.

## Results

As all of these initiatives are very recent. There is not yet any evidence on the results.<sup>143</sup>

<sup>143</sup> Shantanu Agrawal, M.D., Niall Brennan, M.P.P., and Peter Budetti, M.D., J.D. (2013). 'The Sunshine Act — Effects on Physicians'. The New England Journal of Medicine, 368:2054-2057; Meredith B. Rosenthal, Ph.D., and Michelle M. Mello, J.D., Ph.D. (2013). 'Perspective: Sunlight as Disinfectant — New Rules on Disclosure of Industry Payments to Physicians'. The New England Journal of Medicine, 368:2052-2054: <http://www.nejm.org/doi/full/10.1056/NEJMp1305090> <http://www.arkansasbusiness.com/article/91851/sunshine-act-to-shine-light-on-pharmaceutical-dollars-paid-to-doctors?page=all> <http://lifesciencesnow.com/2013/06/13/french-sunshine-act/>; Michael J. Wagner, Dr. Frank Pflueger, Roberto Cursano, Cecilia Pastor, Catherine Ó Súilleabháin (2012). 'Can the French Sunshine Act Push Transparency so Far?'. Legal Alert, Baker & McKenzie, 13 April 2012: <http://www.bakermckenzie.com/alparisfrenchsunshineactapr12/>, <http://cmecoalition.org/content/physician-payment-sunshine-french-sunshine-act-and-disclosure-rules-european-countries>, <http://www.lexology.com/library/detail.aspx?g=cafa9ecd-6e95-488b-9ce2-efac074d53d6>, [www.transparantieregister.nl](http://www.transparantieregister.nl), <http://medischcontact.artsennet.nl/nieuws-26/archief-6/tijdschriftartikel/125610/niks-te-verbergen.htm>,



#### 4.6.5 Conditioned self-regulation in the pharmaceutical sector

##### What

Conditioned self-regulation in the pharmaceutical sector

The Netherlands, United Kingdom

Since 1994 conditioned self-regulation and as of 2007 the new Pharmaceutical Law came into effect (The Netherlands). In 1993 establishment of Prescription Medicines Code of Practice Authority (UK)

##### How

In *the Netherlands* there exists a system of conditioned self-regulation related to the advertisement of pharmaceuticals targeted at medical professionals, i.e. self-regulation is used and enforced within the boundaries set by the government. The self-regulation is arranged through the 'Code Pharmaceutical Advertising' (Code Geneesmiddelen Reclame). This code exists parallel to the Pharmaceutical Act<sup>144</sup> (Geneesmiddelenwet) and the supervisory rules (beleidsregels) on inducement. Market supervision and enforcement are the tasks of the Healthcare Inspectorate<sup>145</sup>. When the code is violated, a complaint can be filed with the Foundation Code Pharmaceutical Advertisement<sup>146</sup> (CGR) and is dealt with by the Code Committee.

In the *United Kingdom* the regulation on advertisement of prescription pharmaceuticals is a combination of self-regulation and regulation by the Medicines and Healthcare products Regulatory Agency (MHRA), which administers UK law. The legal base is contained in Part 14 of the Human Medicines Regulations 2012<sup>147</sup>. Self-regulation is organised in the form of the Code of Practice of the British Pharmaceutical Industry (ABPI) and this Code is administered by the Prescription Medicines Code of Practice Authority (PMCPA). The PMCPA is a not-for-profit self-regulatory body that was established in 1993.

When a complaint is filed, self-regulation is the first means of dealing with it. The MHRA steps in when the complaint addresses an issue not covered by the code, when the companies involved are not a member of ABPI and/or when they do not want to accept the jurisdiction of the PMCPA. Moreover, the MHRA deals with pre-vetting. In dealing with complaints the PMCPA and the MHRA use similar sanctions. The way in which the two systems of regulation on advertisement of prescription medication exist next to each other and work with each other is described in a memorandum of

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<http://knmg.artsennet.nl/Nieuws/Nieuwsarchief/Nieuwsbericht-1/Financiele-afspraken-tussen-artsen-en-farmacie-openbaar-vanaf-2013.htm>; [http://www.efpia-e4ethics.eu/Farma\\_EFPIA/index.htm](http://www.efpia-e4ethics.eu/Farma_EFPIA/index.htm), <http://social.eyeforpharma.com/sales-marketing/pharma-and-physicians-call-uk-sunshine-act>, <http://www.abpi.org.uk/media-centre/newsreleases/2013/Pages/Payments-to-HCPs-consultation.aspx>, <http://efpia.eu/topics/building-trust/codes-of-practice>.

<sup>144</sup> <http://wetten.overheid.nl/cgi-bin/deeplink/law1/title=Geneesmiddelenwet>.

<sup>145</sup> Source for this section is: ZonMW (2008) Evaluatie Reclamebesluit Geneesmiddelen [http://www.gezondescapsis.nl/images/stories/downloads/zonmw\\_evaluatie\\_reclamebesluit\\_gm\\_2008.pdf](http://www.gezondescapsis.nl/images/stories/downloads/zonmw_evaluatie_reclamebesluit_gm_2008.pdf).

<sup>146</sup> Which roughly translates to 'Foundation Code Pharmaceutical Advertising'.

<sup>147</sup> <http://www.mhra.gov.uk/Howweregulate/Medicines/Advertisingofmedicines/Thelegislativeframework/CON2023602>.

understanding<sup>148</sup>. Each year the MHRA publishes an annual report which discusses, amongst other things, the number and source of complaints, the number and types on investigations and the outcomes of these investigations.

## Results

Several evaluations and inquiries have looked into the effectiveness of the **Dutch system** of conditioned self-regulation:

- In 2008 the predecessor of Chapter 9 in the Pharmaceutical Law<sup>149</sup>, the 'Advertisement Decision Pharmaceuticals' (Reclamebesluit Geneesmiddelen), was evaluated. One of the conclusions was that the system with conditioned self-regulation was working well and should be maintained. Points for improvement included a more active approach by the Inspectorate on the norms for advertisement of prescription medication and the need to increase the awareness of medical professionals about the norms and rules on inducement;
- In 2010 Gezonde Sceptis analysed the complaints filed with the CGR and the resulting case law<sup>150</sup>. These results illustrated that the filing of complaints lead to extensive case law in the Netherlands. However, as in some areas of advertisement the number of complaints was very limited (e.g. in the area of inducement), case law has not developed evenly over all the different areas. Also note that the number of cases that were actually prosecuted in court were very low. Recommendations include, amongst other things, more active education and creation of awareness of inducement;
- In 2011, Foundation CGR send out a questionnaire to pharmacists and medical professionals to inquire whether pharmaceutical companies were respecting the Code and Pharmaceutical Law<sup>151</sup>. The results indicate that in general this is the case and that the guidance document on the CGR that was issued in October 2010 was important in achieving this.

From both documents and the inquiry by the Foundation CGR it can be concluded that the system of conditioned self-regulation is working well and should be maintained, but that there are some areas that need more attention. In the **United Kingdom**, we did not come across an official evaluation. Nevertheless, during the fieldwork for this study it became clear that the system as it is in place is considered a good practice in which the two types of regulation complement each other and create synergistic arrangements. Moreover, the system is considered transparent because all complaints are listed on the website of the PMCPA and because the MHRA publishes annual reports.<sup>152</sup>

<sup>148</sup> <http://www.pmcga.org.uk/aboutus/Documents/Memo%20of%20understanding%20final%203%20Nov.pdf>.

<sup>149</sup> In the evaluation it is noted that Chapter 9 would replace the Advertisement Decision Pharmaceuticals but that in practice this would mean only minor changes.

<sup>150</sup> [http://www.gezondesceptis.nl/images/stories/downloads/rap\\_gs\\_analyse\\_cgr\\_uitspr\\_20100625\\_s.pdf](http://www.gezondesceptis.nl/images/stories/downloads/rap_gs_analyse_cgr_uitspr_20100625_s.pdf).

<sup>151</sup> <http://www.nefarma.nl/nieuwsberichten/website/2011/08/farmabedrijven-leven-reclameregels-na>.

<sup>152</sup> [www.nefarma.nl](http://www.nefarma.nl), [www.cgr.nl](http://www.cgr.nl), [www.gezondesceptis.nl](http://www.gezondesceptis.nl), [www.transparantieregister.nl](http://www.transparantieregister.nl), <http://medischcontact.artsennet.nl/nieuws-26/archief-6/tijdschriftartikel/125610/niks-te-verbergen.htm>, <http://knmg.artsennet.nl/Nieuws/Nieuwsarchief/Nieuwsbericht-1/Financiele-afspraken-tussen-artsen-en-farmacie-openbaar-vanaf-2013.htm>, <http://knmg.artsennet.nl/Publicaties/KNMGpublicatie/Code-ter-voorkoming-van-oneigenlijke-beïnvloeding-door-belangenverstrengeling-2012.htm>,

## 4.7 Critical patient, pressure group and media involvement

Civil society involvement is seen as a necessary element in fighting corruption. 'Civil society' can be defined as individuals and organisations, which are independent of the government. This includes, among others, consumer organisations and pressure groups, non-governmental organisations and the media. It is the 'third sector' in society, distinct from government and the business sector. A strong participation of civil society can function as a barrier to corruption as it enhances the control and accountability of the government, other organisations or individuals. Within the healthcare sector, patients, media and pressure groups can take up this role.

This chapter will describe ways to activate these actors and how they actively contribute in the fight against corruption in healthcare. Ways to foster their participations include sound complaints procedures, watchdog organisations, general awareness raising campaigns, information systems, the introduction of fraud and corruption hotlines.

*Interview report Bulgaria: 'Successful anticorruption policies require an increased awareness of all stakeholders.'*

*Interview report Bulgaria: 'Increasing awareness of patients regarding their rights can be successful policy to prevent corruption. The role of patient organisations has to be increased. The role of patient organisations is to work towards the promotion of patients' rights.'*

*Interview report Austria: 'Civil society involvement is cost-effective and effective.'*

### Governmental and public awareness

Civil society can play an active role vis-à-vis all actors in the healthcare sector: governments and regulators, the industry, healthcare providers and patients. For example, the OECD has pointed at the importance of civil society groups in fight against corruption, as 'the third sector' (such as non-governmental organisations and the media) has helped in many countries to generate political will to criminalise bribery of public officials and to pressure governments to maintain their commitments under OECD international agreements.

In addition to this, non-governmental pressure groups, patients groups and the media can help to raise public awareness on corruption in the healthcare sector by raising general knowledge on corruption. They can play a role in creating norms, promoting certain standards of behaviour and disapproving other forms of behaviour. They can also help identifying actual corruption cases and occurrences (through media reports, independent research and patient corruption hotlines). Non-governmental

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Contact by phone with Michel A. Dutrée MD PhD, Director general Nefarma,  
<http://www.mhra.gov.uk/Howweregulate/Medicines/Advertisingofmedicines/index.htm>  
<http://www.pmcpc.org.uk/aboutus/Pages/default.aspx>, <http://www.pmcpc.org.uk/thecode/interactivecode/Pages/Default.aspx>,  
<http://www.abpi.org.uk/Pages/default.aspx>.

organisations can also increase the awareness of patients (or others) on their rights that can empower them to stand up against corruption.

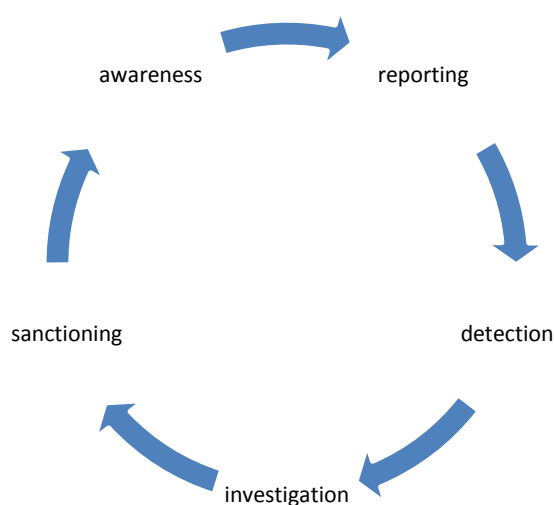
### Reinforcing effects of actual follow-up

The effects of critical non-governmental activities, media involvement and awareness campaigns are strongest in combination with other measures. For example, in the end the judicial follow-up of reports coming from civil society is crucial. In turn, high awareness on corruption or anti-corruption measures can enhance the effectiveness of other policies and practices.

The NHS anti-fraud and corruption policy (described below) is a good example of a successful combination of anti-corruption measures reinforcing each other's effect. The diagram flow below describes the link between the various links in the anti-corruption chain. Awareness not only eventually contributes to sanctioning, the actual sanctioning helps to raise awareness as well (NHS publishes on sanctions being taken, as part of their awareness campaign).

Accordingly, civil society plays a role in informing and enforcing anti-corruption policies and practices. Their involvement is a way to complement and strengthen other measures.

**Figure 4.1 The anti-corruption cycle**



### Disclosing corruption

Civil society organisations, for example watchdogs, help to identify cases by continuously reporting on and investigating corruption. As already mentioned above, they channel and publish the voice of groups they represent. In order to identify cases of corruption, it is important that people speak out when they witness corruption. Therefore, other mechanisms to encourage reporting are key, such as clear (internal) reporting channels whereby the protection of whistleblowers and anonymity is being guaranteed. A crucial element for success is that reports are actually being followed up by investigations and sanctions.

In addition to this, independent media plays a special role in the fight against corruption. We have come across surprisingly many cases that were initially identified or exposed by the media. Two examples are presented in box 4.1. Exemplary is the observation from one of our interviewees:

*Interview report Austria: 'The story was uncovered by an investigative journalist and would almost certainly have gone unnoticed but for the tireless efforts of the journalist.'*

#### **Box 4.1 Corruption cases identified by journalists (some examples)**

##### **Cyprus**

'Following an investigation made by the TV program '60 minutes' of the 'Sigma Channel', it was shown that some doctors of the public sector, and especially those of specific specialties, are frequent recipients of informal payments made by patients. According to the TV reportage these doctors usually ask and receive systematically informal payments, which in some cases exceed the amount of 500 euro, in order to make a surgical operation, bypassing long waiting list for the patient. In these cases, patients are classified by the doctors as emergency incidents, and are led to the operating theater without any delay, while the doctor 'asked' for his own 'reward' in the form of informal (envelope) payment for the facility he offered to the patient.' Effect of the TV show: The police started investigations, nevertheless until now no one has been convicted, and the case never reached court. Unofficial sources claim that this affair is covered up, as usually occurs in such cases.

##### **Latvia**

In May 2010 a journalist revealed through a hidden camera recording that a physician (trauma-orthopaedic speciality) asked for an illegal payment of 50 lats (about 30 euro) for the conducted surgery. Effect of the publication: The physician was fired from the hospital and the case came before court where he was sentenced to 140 hours of public work.

Source: Ecorys Country Report Corruption in Healthcare 2013.

There are various tangible ways in which journalism can be a barrier to corruption, for example: the launch of investigations and/or legal proceedings by official bodies as a result of media reports; exposing corrupt officials and office holders (for example officials losing their jobs); reinforcing the work and legitimacy of the state's anti-corruption bodies by reporting on the work and finding of these bodies; influence public opinion and create public hostility towards corruption practices (for example electoral defeat of politicians); pressure for changes in laws by reporting on their weaknesses.<sup>153</sup>

<sup>153</sup> Stapenhurst, Rick, The media's Role in Curbing Corruption (2000) The World Bank Institute, p. 2-7.

Journalism has also a more intangible, less visible deterrent effect on corruption, which can be described as: 'The checks on corruption which arise from the broader social climate of enhanced political pluralism, enlivened public debate and a heightened sense of accountability among politicians, public bodies and institutions that are inevitably the by-product of a hard hitting independent media.'<sup>154</sup>

## Risks

Knowledge about anti-corruption initiatives, such as a reporting line, is also crucial in order for people to really use it. In Romania for example, a website was set up to report corruption in the healthcare sector. The initiative failed as professionals and patients were not aware of the opportunity and patients also still feared repercussions when issuing complaints.<sup>155</sup>

The dangers of relying too much on the media to uncover corruption should be taken into account as well. Information can be incomplete and even biased. Suspects are innocent until proven guilty. Journalists may have strong political ties or can be paid by companies to express their message.

*Interview report Slovakia: 'Another serious issue is that media are paid for to write in a certain way to portray a politician, company, or person - or not to write about a certain case.'*

*Interview report Austria: With vaccinations (swine flu epidemic), civil society uncovered the processes of procurement to prevent extreme expenditures and battle against the corrupt boss of the Social Medicine Association; promoting more involvement of civil society leads to lower corruption.*

Finally opinions may differ. With respect to media involvement, two contradicting opinions were given:

*Interview report in Romania: 'Stopping urgently the media campaign (of journalists) for producing hysteria among people by highlighting only negative cases, and supporting the public sector for generating financial resources and regulatory support necessary for development.'*

*Interview report Germany: 'Finally, good practices in Germany relate to the attention of the media to (alleged) case of corruption. As can be witnessed by the reference list, German media (also the quality media: Frankfurter Allgemeine, Die Zeit, Sueddeutsche, Der Spiegel) drew much attention to the cases listed in this report as well as to the BGH ruling. According to interviewees, the media are strong instruments to trace cases of corruption and to call account of those involved.'*

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<sup>154</sup> Idem p. 8.

<sup>155</sup> Ecorys Country Report Romania.

#### 4.7.1 Awareness campaign and reporting line

##### What

NHS (National Health Service) - Counter awareness campaign and Fraud and Corruption Reporting Line, United Kingdom  
Fraud and Corruption Reporting Line since 2001; awareness raising campaign since 1998.

##### How

The National Health Service has about 1.2 million employees and an annual budget of £70 billion. The anti-fraud and corruption activities of NHS currently fall under NHS Protect, which exists since 2011. NHS Protect, replacing the NHS Counter Fraud Service (1998–2011), has the task to protect NHS staff from crime, including fraud and corruption. The organisation's work covers three main objectives: (i) to educate and inform those who work for or use the NHS about crime in the health service and how to tackle it; (ii) to prevent and deter crime in the NHS by removing opportunities for it to occur or to re-occur; (iii) to hold to account those who have committed crime against the NHS by detecting and prosecuting offenders and seeking redress where viable.<sup>156</sup>

Besides detection, investigation and sanctioning, it aims to realise these objectives by focusing on 'changing public attitudes'. Therefore, NHS Protect has launched a large awareness raising campaign aiming at reaching the largest possible number of NHS staff, professionals and patients with key-anti crime (including fraud and corruption) messages.<sup>157</sup> An important focus of NHS is to *mobilise the honest majority* through presentations and awareness sessions for staff and patients.<sup>158</sup> NHS believes that 'awareness of and involvement in counter fraud work should become a general responsibility of all professionals'.<sup>159</sup>



<sup>156</sup> NHS website, see: <<http://www.nhsbsa.nhs.uk/3349.aspx>> accessed July 2013.

<sup>157</sup> 'Countering Fraud in NHS' (October 2001) – NHS document available at: <[http://www.nhsbsa.nhs.uk/CounterFraud/Documents/countering\\_fraud\\_nhs.pdf](http://www.nhsbsa.nhs.uk/CounterFraud/Documents/countering_fraud_nhs.pdf)> accessed July 2013.

<sup>158</sup> Transparency International Report 2006, page 47.

<sup>159</sup> 'Countering Fraud in NHS' (October 2001) – NHS document page 9, available at: <[http://www.nhsbsa.nhs.uk/CounterFraud/Documents/countering\\_fraud\\_nhs.pdf](http://www.nhsbsa.nhs.uk/CounterFraud/Documents/countering_fraud_nhs.pdf)> accessed July 2013.



In line with this, the NHS has established a Fraud and Corruption Reporting Line (FCRL). FCRL is a hotline where NHS staff can anonymously report suspicions of fraud and corruption to an experienced and trained team that deals with these reports.

To spread awareness not only internal communication tools are being used, but also extensive national, regional and local media coverage (including written press, radio and television) is being sought.<sup>160</sup> Through the media NHS tries to 'deter the dishonest minority by publishing actions taken'.<sup>161</sup> As part of the awareness program, NHS has also collaborated with a BBC television series to raise awareness on more uncommon fraud cases in the healthcare. According to NHS raising awareness is crucial to strengthen the antifraud culture, as it changes public attitudes and behaviour.

In sum the awareness policy encompasses the following key points:

- 'The use of publicity to deter crime affecting the NHS;
- The proactive management of media coverage in relation to fraud, corruption and security incidents;
- The positive promotion of the benefits of the work that NHS Protect undertakes;
- on-going engagement with stakeholders;
- Liaison with the Department of Health on anti-fraud and security briefing, parliamentary and media issues.<sup>162</sup>

## Results

In general, NHS anti-fraud and corruption policy is renowned as a good practice. Although it is difficult to assess the exact effect of the NHS awareness raising campaign in particular, it can be considered successful because of its large reach. In 2005 it was reported that about 400 media articles are being published each year. In the subsequent years this number has gone up and according to NHS figures: 'in 2010-2011, there were 1285 media articles that referred to NHS fraud work. Media analysis of this coverage shows that it led to over 17 million opportunities to see the NHS CFS's message, with an advertising value equivalent of over £3 million.'<sup>163</sup> According to the NHS it reaches hundreds of thousands of staff and millions of patients with awareness raising activities.

The campaign has also been an opportunity to promote the FCRL and increase reporting on fraud. Since its existence the FCRL has been collecting many complaints. Only in the years 2011-2012 a total of 959 allegations were reported of which 80% were referred on for further investigative action.<sup>164</sup> Contributing to its success is the fact that the reporting line is backed by a team of professionals, ensuring professional follow-up of the complaints.

In the Transparency International report of 2006, it is stated that the detection rates of fraud (including corruption) within the NHS 'have risen with several hundred percent,

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<sup>160</sup> NHS Protect Annual report 2012, page 6.

<sup>161</sup> NHS Protect Performance Report 10/11 page 8.

<sup>162</sup> Transparency International Report 2006, page 47.

<sup>163</sup> NHS Protect Performance Report 10/11 page 2.

<sup>164</sup> NHS Protect Annual report 2012, page 18.



with a 96% success in prosecution, alongside extensive use of civil law to freeze and recover assets.’ According to the NHS there have been four keys to this success: ‘(i) Accurate identification of the nature and scale of the problem; (ii) Comprehensive action to tackle the problem (not limited to traditional policing); (iii) Professional agency staff with the right skills to reduce losses to corruption permanently; (iv) successful mobilisation of the honest majority and the deterrent effect this has had on the dishonest minority.’<sup>165</sup>

The NHS approach is an example in which different type of anti-corruption measures are combined. Although its success cannot be attributed to one single component, the example does show the importance of the awareness-raising component in activating healthcare professionals and patients in the fight against corruption.<sup>166</sup>

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<sup>165</sup> Transparency International Report 2006, page 47.

<sup>166</sup> NHS Protect Annual Report 2012; Transparency International Report 2006; Counter Fraud measures NHS; NHS Performance Report 2011/2013; <http://webarchive.nationalarchives.gov.uk>.

#### 4.7.2 Investigative journalism database

##### **What**

Pro Publica Investigative Journalism 'Dollars for Docs' database  
United States, since 2010

##### **How**

Pro Publica is an independent, non-profit newsroom that produces investigative journalism in the public interest. One of their investigations is the 'Dollar for Docs' projects. This project investigates and reveals the financial ties between the medical community and the drug and device industry in the United States. In order to reveal these ties, ProPublica has created a database on payments that drug companies make to doctors, physicians, other medical providers and healthcare institutions. ProPublica has only included 15 companies in their database which are the ones who have published their payments on their website. Through the database, persons can look up their doctors or medical centre and receive a list of payments matching the name of this person and / or centre. One can also search the database by state or company.

Because only 15 companies are included in the database (meaning several dozens of other companies are not included), the data is not entirely representative for the industry. Nevertheless these companies do represent a large market share: the combined prescription drug sales is about 47% of the US market in 2011.

##### **Results**

The initiative has gained a lot of media attention and has reached many people in the US:

- The project is tracking payments of more than a quarter billion dollars to 17 000 doctors nationwide (updates now include 2 million records and payments of more than \$2 billion);
- Users of the database have recorded more than 5.75 million page views;
- The research has gained large media attention in the US and stories have appeared in the more than 170 media outlets.

Some of the nation's top medical schools (including University of Colorado Denver and Stanford University) have sanctioned professors who were given paid promotional talks for pharmaceutical companies after ProPublica revealed these cases. In addition, some companies have been cutting back on such spending as a result of negative publicity. Furthermore, ProPublica investigated university policies regarding the subject matter. It found out that these policies were hardly enforced. As a result, a number of schools have now indicated that they want to begin using the payment database to check for rule-breakers.<sup>167</sup>

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<sup>167</sup> Pro Dollar Docs website (<http://projects.propublica.org/docdollars/>).

### 4.7.3 Civil society reporting website

#### What

Edosa Fakelaki – website (<http://www.edosafakelaki.org>)

Greece

#### How

Edosa fakelaki means 'I gave an envelope' whereby the envelope refers to a bribe. The website is a private initiative of Ms Kristina Tremonti. She set up the website after she after her family had to pay a bribe of 300 euro in order to ensure the urgent treatment of her grandfather. Similar initiatives have been set up in Indonesia, India, Kenya, Zimbabwe, Pakistan and the Philippines. People can share their experiences on corruption on this website. The website collects reports on all kinds of corruption, not only limited to the field of healthcare. Both people who have been paying bribes report and have asked for bribes report on the website.



#### Results

The website gained a lot of media attention and spurred the public debate. So far, the website has already received over 1 600 anonymous reports on corruption amounting to more than five million euro in bribes. Most reported bribery cases relate to healthcare service delivery (34%).<sup>168</sup> In this way the website has collected evidence on corruption and insight in the scale of the problem.<sup>169</sup>

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<sup>168</sup> <http://www.againstcorruption.eu/articles/online-initiatives-collect-reports-of-bribery-in-greece/>

<sup>169</sup> <http://www.againstcorruption.eu/articles/online-initiatives-collect-reports-of-bribery-in-greece/>.

#### 4.7.4 Transparent waiting lists

##### **What**

Publish Waiting Lists

Croatia, 2004 -2005

##### **How**

Long waiting lists in Croatia are considered to be a large risk for corruption, as one of the main forms of corruption is paying bribes in order to skip these long waiting lists. Therefore, in 2004 the Ministry of Health in cooperation with Transparency International Croatia encouraged the publication of waiting lists of two major hospitals in Zagreb.

##### **Results**

'A hotline run by TI Croatia to monitor the effectiveness of the initiative received 90 calls about the Dubrava Hospital waiting list within the first few months starting in October 2004. In one case, a patient had waited two years for heart surgery but, after lodging a complaint with TI Croatia, was operated on within two weeks. The pilot initiative is set to become a precedent in curbing corruption in healthcare delivery by making it more open and transparent.' (TI report 2006).<sup>170</sup>

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<sup>170</sup> Transparency International Report 2006 - Hospital Waiting Lists open for Scrutiny in Croatia', Global Corruption Report Box 3.2, p55- See more at: [http://archive.transparency.org/global\\_priorities/other\\_thematic\\_issues/health/tools\\_health#sthash.mZtiTwMV.dpuf](http://archive.transparency.org/global_priorities/other_thematic_issues/health/tools_health#sthash.mZtiTwMV.dpuf).

## 4.8 Findings

The second objective of the study is to assess the capacity of the MSs to prevent and control corruption within the healthcare system. The EC has expressed its explicit interest in a diversity of policies and practices that have been explored in various EU MSs and that have proven to be successful – or have showed even some partial progress in the fight against healthcare corruption.

The following policies and practices have proven to be successful is the fight against corruption in the healthcare sector:

### **Generic anti-corruption:**

- Independent and effective judicial system;
- Designated office for prosecution of corruption;
- Increase penalties for bribery;
- Forceful anti-bribery legislation (such as the UK Bribery Act and the US FCPA);
- Press freedom and sufficient investigative journalism countervailing power.

### **Generic anti-corruption in healthcare:**

- Address structural healthcare problems (such as: management, supervision, capacity, funding, salaries);
- Coherent anti-corruption-in-healthcare strategy;
- Anti-fraud /corruption in healthcare control mechanism.

### **Bribery in medical service delivery:**

- Transparent waiting lists;
- Doctor's initiatives against bribery (for example Slovakia);
- Public information campaign and reporting line (government);
- Patient pressure and reporting line (civil society).

### **Procurement corruption:**

- Procurement regulation;
- Centralised maximum price setting.

### **Improper marketing relations:**

- Sunshine Act like initiatives;
- Prescribe main active substance;
- Code of conduct (industry and between the industry and healthcare providers);
- (Conditioned) self-regulation.

### **Independence and effectiveness of the judicial system**

An independent and effective judicial system healthcare (legal provisions, implementation, and enforcement) are by many interviewees identified as key in fighting corruption. This has in particular been highlighted in the interviews with stakeholders in most of the Eastern European MSs. Setting up a designated office for prosecution of corruption and an increase of the penalties for bribery is said to have had an effect on corruption in healthcare in for example Austria.

**Anti-bribery legislation**

Good practices are also the UK Bribery Act or the US Foreign Corrupt Practices Act, which have set the international standards for anti-bribery legislation. Forceful enforcement of anti-corruption provisions will also have an impact. Convictions of (high-profile) corruption cases are considered as having a deterrent and norm-setting effect.

**Press freedom and investigative journalism**

The importance of active – independent – media involvement and pressure from ‘civil society’ watchdogs and patient groups cannot be underestimated. We came across many corruptions in healthcare cases that initially were identified and uncovered by the media.

**Address structural healthcare system weaknesses**

With respect to for example bribery in medical service delivery, a general conclusion is that this problem cannot be contested with targeted policies against the phenomenon as such. In many countries comprehensive healthcare system changes are needed to root out the problem. Weaknesses that should be addressed – and do have an impact on corruption – are among others: ineffective managerial structures, inappropriate financing mechanisms, insufficient healthcare capacity, insufficient funding for independent medical research, or unequal allocation of resources. It seemed in several MSs that raising salaries as an isolated policy do not have significant preventive effect on bribery in medical service delivery.

**Coherent anti-corruption-in-healthcare strategy**

Some countries have recently adopted a specific anti-corruption in healthcare strategy (for example Croatia and Greece), which covers and integrates various aspects of the problem.

**Anti-fraud/corruption in healthcare control mechanism**

It follows from our research that structures should be in place that specifically deal with fraud and corruption in the healthcare sector. These structures should not only have a mandate to control but also to sanction violations. This does not necessarily mean that separate organisations or bodies should be set-up. Existing agencies within their existing mandate, but with dedicated resources for the health sector are probably best equipped. Some EU MSs have successfully set up control mechanisms that have the power to control (and sometimes sanction) corruption and fraud in healthcare, such as: the Medical Evaluation and Control Department (DGEC) in Belgium; The Fraud Prevention and Litigation Directorate within CNAMTS in France; NHS Protect in the United Kingdom; and Inspeção Geral das Atividades em Saúde (IGAS) in Portugal.

**Transparent waiting lists**

Transparency is important in preventing corruption in healthcare. The introduction of transparent waiting lists has had a positive effect on healthcare bribery in some MS (for example Austria and Croatia).

**Prescription rules**

Prescription of generic names of medicines instead of brand names of pharmaceuticals is another good transparency enhancing policy in many EU MSs (such as Estonia, Lithuania, Slovakia and Spain).

### **Self-regulation**

Self-regulation can be organised both between players (such as joint initiative from the industry and healthcare providers) and among players (such as within the pharmaceutical industry or among doctors). The good practices in the Netherlands and the United Kingdom illustrate that (conditioned) self-regulation can be an effective way of regulation a sector. Governments should strike the right balance between government regulation and self-regulation and clearly define how the two functions complement each other. In Slovakia the campaign by doctors themselves to refuse accepting bribes, is considered as a positive step in the complex problem of corruption.

### **Public information campaign and reporting lines**

Awareness raising campaigns and fraud and corruptions reporting hotlines are another good example of mobilisation of countervailing powers. Governments can play a role in stimulating the mobilisation of such countervailing powers. In the UK the fraud reporting hotline by NHS protect can be considered successful example of both awareness raising and actually collecting complaints and investigating these. The Edosa Fakelaki website in Greece is a good example of a private initiative.

### **Procurement regulation**

Centralisation of procurement is often promoted as a method to lower the risks of corruption. However central procurement systems can become vulnerable as target for lobbyist and more political inspired types of corruption. What counts is that general public procurement policies should also apply for the healthcare sector and procurement systems should be transparent.

### **European Sunshine Act initiatives**

Transparency in the relations between the industry and healthcare providers can be initiated by either the sector and/or government policies (such as transparency enhancing initiatives resembling the Sunshine Act). Initiatives to introduce legislation that is inspired by, or resembles the US Sunshine Act have been initiated in France (2013, publication of Decree in France, implementing the French Sunshine Act into law), the Netherlands (2012, (Foundation for the Transparency Register), and by EEPIA (to be implemented in 2016).

## 5 Conclusions and recommendations

### Introduction

The fight against corruption is currently one of the priority areas for the European Commission (EC). The EC has adopted a comprehensive anti-corruption package in June 2011, which includes, among others, the publication of a bi-annual anti-corruption report, which evaluates the MSs' efforts against corruption. The healthcare sector is one of the areas where particular vulnerabilities to corruption are noted.

This study focused on three areas of healthcare: medical service delivery; procurement and certification of medical devices; and procurement and authorisation of pharmaceuticals. The methods used are desk research, interviews (with EC officials and representatives of health professionals organisations, medical device industry, pharmaceutical industry and health insurers) and field research in the 28 EU MSs. The field research included, per MS, 3–4 interviews with healthcare and anti-corruption stakeholders, a description of 3–6 cases of corruption in healthcare and a description of policies and practices to control corruption using national sources.

### Corruption in healthcare typologies

On the basis of this study, six typologies of corruption in the selected healthcare areas can be identified:

- bribery in medical service delivery;
- procurement corruption;
- improper marketing relations;
- misuse of (high) level positions;
- undue reimbursement claims;
- fraud and embezzlement of medicines and medical devices.

The latter two typologies fall outside the scope of this study. Bribery, procurement corruption and improper marketing relations appear to be most prevalent types of healthcare corruption in the EU MSs. Out of a total of 86 corruption cases identified through this study, 24 cases are related to medical devices, 17 to pharmaceuticals and 33 cases to bribery (medical service delivery). In addition, bribery in doctor to patient service delivery is the most visible form of corruption in healthcare – and in Central and Eastern European countries also the most common form of healthcare corruption.

The extent, nature and impact of corrupt practices in the healthcare sector is a widespread problem across the EU. In 2009, European MSs spend between 3% and 11% of their GDP in healthcare. Gee, Button and Brooks calculated in 2011 that approximately 56 billion euro is lost annually to fraud and corruption in this sector – though this estimate is considered to be highly speculative.



### **Bribery in medical service delivery**

Bribery in medical service delivery is often loosely labelled as 'informal payments' or 'under-the-table-payments'. It must be noted that informal payments are not always perceived as corruption (bribery). Informal payments can be offered as a form of gratitude (mostly after the medical treatment). We speak of 'bribery' in medical service delivery if money or other advantages are demanded or offered with a special objective such as preferential treatment, getting access to healthcare, better quality healthcare (e.g., treatment by a specific physician) or for example to obtain false sick leave statements. The majority of the 17 cases of bribery in EU MSs are related to preferential treatment – particular to bypassing waiting lists.

A related type of corruptive behaviour by healthcare providers versus patients observed in a the MSs, including Finland, Austria and Croatia, considers misuse of dual practices. Healthcare providers can charge higher fees by referring patients from public practices to their own private practice (sometimes even by utilising publicly funded healthcare facilities).

Although specific EU figures on prevalence of bribery are overall not available, we conclude that bribery in medical service delivery occurs most frequently in (former) transition economies (Central and Eastern Europe) where it is systematic ('seen as common practice'). There is, however, a trend that this practice is slowly decreasing and is sometimes restricted to specific types of healthcare (such as obstetrics, gynaecology, orthopaedics). Bribery is also widespread in southern European MSs, such as Greece and Italy. In Western European countries, bribery in medical service delivery is rare and restricted to specific areas such as isolated cases in pre- and post-surgery treatment. The recent organ transplant scandal in Germany illustrates that shortages can motivate patients and physicians to circumvent the rules.

The main obstacles in countries in which bribery is widespread include scarcity of health care services (e.g. organ transplants), relatively low level of healthcare funding (i.e., where healthcare expenditure as a percentage of GDP is below 7%), weak controlling mechanisms, high out-of-pocket payments for healthcare, self-interest and greed from the side of the healthcare providers.

A general conclusion is that informal payments cannot be contested with policies targeted against the phenomenon as such. In many countries comprehensive system changes are needed. Increased healthcare funding, together with increasing resistance from health practitioners (for example doctors in Slovakia who publicly decided to jointly refuse taking bribes) and pressure from patient organisations (for example the Edosa Fakelaki website in Greece) have reduced the tolerance vis-a-vis bribery.

### **Procurement corruption**

Procurement corruption is a complex process, in which intermediary companies can be involved, conflicts of interest occur, competing companies collude and intangible bribes are being paid in the form of sponsorship of medical equipment, education or research facilities. It mostly occurs at an early stage of the procurement process. The

risk of tailoring the tender specifications and/or the tendering phase to one preferred supplier is the most commonly observed form of procurement corruption.

Worldwide 10–25% of public procurement spending in health (medical devices and pharmaceuticals) is lost to corrupt practices; European figures are not available. Healthcare procurement corruption occurs all over Europe and we encountered a fundamental difference between isolated and systemic corruption in the area of public (healthcare) procurement. The problem is larger and more deeply embedded in EU MSs that are characterised by weak procurement regulations or are suffering from high levels of (general) corruption such as Czech Republic, Latvia, Croatia, Slovakia, Romania, Italy, Bulgaria, and Greece.

Good, reliable and independent control mechanisms will lower the risks of healthcare procurement corruption. In addition, centralised procurement or national standards or price setting can reduce the risk. However, in some MSs decentralisation is promoted as a way to prevent corruption in healthcare procurement. Central procurement systems can become very vulnerable targets for lobbyist and more political inspired types of corruption. In addition, pharmaceuticals may be more suitable for more centralised procurement policies than medical devices.

### **Improper marketing relations**

Improper marketing relations concern the promotion of pharmaceuticals and medical devices by the industry towards individual healthcare practitioners, healthcare institutions, medical research institutions and positive list committees. The objective is to promote products or create loyalty (indirect promotion).

This practice is considered as one of the most problematic areas in healthcare regulation as it might lead to higher costs as a consequence of higher drug prices or increased drug consumption by the population (through over-prescription, line-extension, or over-medicalization). It can even result in public health concerns as result of the promotion of products that are dangerous, risky, of less quality or of questionable medical value. For example, increased use of antimicrobial agents inevitably leads to increased antimicrobial resistance in microbes, which in turn leads to increased use of more expensive antimicrobials.

The instrument of corruption can be money, travel or leisure activities. It also includes sponsoring of medical equipment or research facilities and activities. This type of sponsoring is often welcomed – in particular if funds for research and education are limited. Reciprocity plays an important role in the context of improper marketing relations.

It is difficult to quantify the prevalence of improper marketing relations. Relationships between healthcare professionals and the industry are ubiquitous and are often necessary and beneficial. They are not necessarily improper, unethical or illegal. Nevertheless, it can be concluded that improper marketing occurs, with variable frequency and to different extent, in all EU MSs.

Inducement (influencing by giving 'benefits') is something that is much discussed and considered a systematic problem in the relation between industry and healthcare providers. The pharmaceutical industry is increasingly focussing on opinion leaders in the medical community (often academics) instead of individual practitioners. The habit of sponsoring meetings and conferences has been considered as normal and even a necessary element regarding how the health system functions. Nonetheless, this is increasingly considered as a potential conflict of interest.

Acceptance of improper marketing relations seems to decline around the world, including EU MSs. This is due to various scandals, increased demand to declare conflict of interests, and stricter (international) legislation. Measures to regulate and monitor the marketing relations between healthcare providers and the industry can be broadly divided into two categories: formal regulation through legislation and self-regulation through for example a Code of Conduct or Code of Ethics of the industry. Self-regulation can either be organised at a national or supranational level. High profile cases, such as the Mediator case in France, have initiated self-regulation and the introduction of legislation that is inspired by the American Physician Payments Sunshine Act.

### **Misuse of (high-level) positions**

Misuse of (high-level) positions is a cross-cutting typology which covers various kinds of corrupt practices by high level political and administrative officials, healthcare providers, and the healthcare industry. This typology in particular applies to institutionalised forms of healthcare corruption.

The extent to which misuse of (high-level) corruption is a problem within a MS, largely depends on the extent to which corruption is embedded in the economy and society. There is no hard data available on the prevalence of this type of corruption in Europe, but it appears that is a problem particular in MSs where corruption is deeply embedded in politics and society, such as Czech Republic, Latvia, Croatia, Slovakia, Romania, Italy, Bulgaria, Greece. However, it is in many cases difficult to draw a clear line between normal lobbying and unethical forms of trading in influence.

Conflicts of interest might arise from 'revolving doors' between government positions or the healthcare sector and the private healthcare industry. It is often difficult to determine whether individual career switches between the public and private sector, should be considered as normal and even desirable (from the society's perspective) or if this will ultimately foster unethical practices.

Although undue reimbursement claims, fraud and embezzlement of medicines and medical devices are not part of the original terms of reference for this study it is believed that this type of fraud may be very substantial in many countries. Hard data on its existence in MSs, is however, hard to find.

## **Policies and practices**

Three categories of measures to address corruption can be distinguished in the EU MSs: (i) Generic anti-corruption policies and practices, including general judicial effectiveness and general procurement policies and regulations (= non-healthcare specific); (ii) Generic healthcare policies and practices, including healthcare reforms and general healthcare supervision systems (= non-corruption specific); (iii) Specific policies and practices aimed at preventing, controlling and combatting corruption within the healthcare system (= corruption-in-health policies).

Clear and effectively enforced general anti-corruption rules, independent and effective judicial follow-up on corruption cases, and sound general procurement systems, are a necessary precondition for successful targeted corruption in health policies and practices. The same applies to general healthcare policies and practices. General weaknesses in the healthcare system, including weak general supervision, can be an important, if not major, motivator, rationaliser and opportunity factor for healthcare corruption.

Good practices are exemplified the UK Bribery Act and the US Foreign Corrupt Practices Act, which can be considered to have set the international standard for anti-bribery legislation. Compliance with international anti-corruption standards (UN, OECD, GRECO) is also important for the healthcare sector. The development of a nation-wide anti-corruption strategy (e.g., 2012 Action-Plan Anti-Corruption Strategy in Croatia), the creation of an anti-corruption bureau (e.g. KNAB in Latvia), and collaboration between public agencies and private actors in the enforcement of the anti-corruption regulations (e.g. in Austria), can all have a positive effect on healthcare corruption.

In addition, convictions of (high-profile) corruption cases seem to have a deterrent and norm-setting effect. We, however, can conclude that what works in one country does not necessarily work in the other. As the effectiveness of a policy depends on multiple factors, simply developing stand-alone policies such as Sunshine Act-like initiatives or self-regulation measures will most likely prove insufficient. Carrying out systematic evaluations of policies and their effects (including the reasons behind this) is important in establishing the conditions for successful implementation.

There is no single policy in the successful fight against corruption. However, it is clear from our research that all successful policies in the fight against corruption are a combination of strong, independent institutions and a general rejection of corruption by the society. For example a corruption fraud reporting hotline in combination with effective judicial follow-up; or anti-fraud-and-corruption initiatives from within the health sector in combination with stricter government regulation.

Systematic corruption should be prevented and fought with good anti-corruption legislation, powerful anti-corruption enforcement, changes in healthcare and healthcare supervision systems and general changes in norms and attitude. Isolated healthcare corruption can be fought with more targeted measures (such as anti-fraud and corruption reporting hotlines). It is this bottom-up as well as top-down approach

that ensures a sustainable effort and, with time, a change in attitudes helping to prevent corruption from the outset.

## **Recommendations**

Following from the findings and conclusions, described above, we can formulate recommendations targeted at EU level, national level and research.

### ***EU level***

To address drivers of corruption that prevail in all EU MSs, EU-wide policies are needed. At the EU level it is recommended to a) set clear and effectively enforced general anti-corruption rules (e.g. UK Bribery Act and US Foreign Corrupt Practices Act), b) introduce independent and effective judicial follow up on corruption cases, and c) implement sound and transparent general procurement systems. General public procurement policies should also apply for the healthcare sector.

Another aspect that can be addressed at EU level concerns self-regulation, for example through a Code of Conduct or Code of Ethics. Industry organisations at the EU level, such as EUCOMED and EFPIA, have these already in place for their members. Self-regulation should also be organised at a national level. The good practices in the Netherlands and the United Kingdom illustrate that conditioned self-regulation can be an effective way of regulation a sector. It is recommended to find the right balance between formal regulation (legislation) and self-regulation and clearly define how the two function in parallel and complement each other.

### ***National level***

As the nature of the control procedures and frameworks is country specific it is recommended that MSs have structures in place that specifically deal with fraud and corruption in the healthcare sector. These structures should not only have a mandate to control, but also to sanction violations. This does not necessarily mean that separate organisations or bodies need to be set-up. Existing agencies within their existing mandate, but with dedicated resources for the health sector are probably best equipped.

In addition, transparency in healthcare systems should be improved, for example by publication of waiting lists. Also, transparency in the relations between the industry and healthcare providers can be initiated by either the sector and/or government policies (such as transparency enhancing initiatives resembling the Sunshine Act). The obligation for physicians to prescribe generic medicines instead of brand drugs is another good transparency enhancing policy that can be stimulated at MS level.

Finally, it is important to stimulate – independent – media involvement, ‘civil society’ watchdogs and patient groups to identify and report on corruption. Awareness raising campaigns and fraud and corruptions reporting hotlines are good examples of

mobilisation of countervailing powers. National governments should play a role in stimulating the mobilisation of such countervailing powers.

### **Research**

The analysis of cases collected identified two types of corruption that fall outside the scope of this study, but which are relevant in the corruption-and-fraud in healthcare debate. These are undue reimbursement claims and fraud, and embezzlement of medicines and medical devices. As undue reimbursement claims is currently high on the agenda of some MSs, it is recommended to study the actual scale of the issue and possible policies that may form a remedy.

Quantifying the size of the problem of corruption has shown to be a challenge for multiple reasons. Even for informal payments, the most visible form of corruption. Despite the fact that the impact of (in-) formal payments is well known internationally, little research has been carried out establishing the scope, scale and actual impact of informal payments in the healthcare sector in higher income countries. To get a full picture of the size of the problem, we recommend to initiate research in this field targeted at those countries.

We have found that policies and practices that work in one country do not necessarily work in another country. As the effectiveness of a policy depends on multiple factors, simply developing policies such as Sunshine Act-like initiatives will most likely prove insufficient. We therefore recommend to systematically evaluate the policies and their effects (including the reasons behind this) to enable successful implementation in specific contexts.

## Annex A      86 cases of corruption in health

### Introduction

Our 28 MS country rapporteurs have carefully selected the cases from interviews, research reports, media reports and court filings. All cases have actually occurred and are characterised by proven or suspected elements of fraud, corruption or other dubious activities. Sometimes corruption or fraud is proven in court. Other cases have appealed before court but are on-going or have been rejected. Cases that have not (yet) been proven often have provoked a debate in the media on suspected malpractice in healthcare.

### Table of contents

Table A.1	Bribery in medical service delivery
Table A.2	Medical devices
Table A.3	Pharmaceuticals
Table A.4	Revolving doors
Table A.5	Unclassified cases

### A.1 Bribery in medical service delivery

**1. Austria – Bribery for pre- and post-surgery treatment (2007)** - A known case that reached the media is about a medical doctor working at a regional hospital who asked for 60 euro per visitation on top of the official charges. Indications are that this is not an isolated case and that this problem is of a systemic nature. The doctor in question was not tried before court but the Chamber of Physicians undertook disciplinary procedures against him. In another case, a hospital doctor offered patients the possibility of moving up waiting lists for cash payments of between 300 and 500 euro. The doctor denied the charges and the State Attorney's office opened an investigation. Although it is illegal to offer bribes, the focus of the media and investigation is usually on the person who takes the bribe.

**2. Bulgaria – Under-the-table payments for a caesarean section (2012)** - A physician in Varna was arrested because he requested informal patient payments to perform a Caesarean section. When the pregnant woman came to the hospital for an emergency delivery, the physician on duty immediately asked for money. He said to the husband that he would not operate unless he received 400 BGL (about 200 euro). Since the husband did not have the money, the physician agreed that it could be handed over at the follow-up appointment in the physician's private practice when he was supposed to take out the stitches from the surgery. The husband brought the money (marked banknotes that could be identified by the police). The marked banknotes were found on the physician's desk.

## **A.1 Bribery in medical service delivery**

**3. Cyprus – Bribery for a swift knee replacement (2011)** - A television report revealed that specialists working in the public sector (mostly surgeons, obstetricians and gynaecologists) classified patients as emergency cases in exchange for money. According to the TV reportage these doctors systematically asked and received informal payments, which in some cases exceeded the amount of 500 euro. The television report revealed the case of a patient who needed a knee replacement. This person had to wait five months for the operation. In order to have an earlier appointment, he put 350 euro in an envelope and gave it to the doctor. Eventually, the doctor examined him and the operation was conducted within ten days. The patient said that he was aware of another three similar cases. These cases took place in 2011 and until now nobody has been convicted, since the cases never reached the court. Unofficial sources claim that this affair is covered up, as usually occurs in such cases.

**4. Croatia – Five thousand euro in cash (2008)** - From 1998 to 2006, a cardiac surgeon was accused of having accepted bribes from patients whom he had operated on at the Rijeka University Hospital Centre. This is a proven court case. He was sentenced to nine years of prison. Cardiac surgeon X was accused of having accepted bribes from patients who he had operated at the Rijeka University Hospital Centre, from 1998 to 2006. The Office for Prevention and Corruption and Organized Crime (USKOK) caught him when pursuing a controlled delivery of a total amount of five thousand euro in cash that he allegedly asked for an operation. He was sentenced to nine years in prison for taking bribes during 2001 - 2006. Because of dual citizenship, he evaded a penalty in Croatia. However, the Supreme Court of the Federation of Bosnia and Herzegovina pronounced the final verdict of the two and a half years in prison for bribery. After his release he was not allowed to work as a doctor anymore. Because of bad health (heart attack) he died after one year of being in custody.

**5. Germany – 'Organspende Skandal' (2012)** - Two senior doctors in Leipzig have been suspended after an investigation showed that they had manipulated records to push 38 liver patients up the waiting list for organs. It could not rule out that 'money had changed hands' in exchange. The head of the clinic as well as two senior doctors have been given a leave of absence while the institution conducts an internal probe. Public prosecutors have opened a preliminary investigation. The affair follows revelations in 2012 that other German hospitals engaged in dubious practices with organ transplants, such as the Göttingen and Regensburg university hospitals, which are alleged to have falsified medical records in nearly 50 cases, to push patients further up on the Eurotransplant waiting list. According to der Spiegel, the number of irregularities is much higher than initially assumed. The numbers vary between the hospitals: In the transplant centre in Göttingen irregularities were discovered in at least 60 cases. In Leipzig, a total of 38 patients were unjustified marked as dialysis cases. In Munich, almost 30 violations against the guidelines for liver transplantations were discovered between 2007 -2012.



## **A.1 Bribery in medical service delivery**

**6. Greece – *Fakelaki I (2007)*** - In 2007, a paediatric surgeon was sentenced to eight months in prison and suspended for three years, for accepting bribery ('fakelaki') before performing surgery on a child. The doctor accepted a 400 euro bribe from the child's mother in February 2007 at Papageorgiou Hospital in Thessaloniki, where the child would undergo treatment for genital phimosis. One day before the operation the boy's mother had asked the doctor what she could offer him, at which he 'very leniently' replied 400 euro. The case was revealed after the hospital conducted an internal investigation. At the time of the incident, the now-retired surgeon, was head of the hospital's Paediatric Surgery Clinic. A first instance court had given the doctor a 10-month suspended sentence.

**7. Greece – *Fakelaki II (2013)*** – Many cases of patients that have paid 'fakelaki' are described in the media. A characteristic example is the experience of Kristina Tremonti. Her grandfather, who was diagnosed with terminal prostate cancer, needed urgent treatment at the public hospital in Kalamata, southern Greece. One night he had incessant bleeding and she had to rush him to hospital. According to her words, they were faced with absolute negligence. Nobody gave them prompt attention and the medical personnel ignored her grandfather. She and her parents realized that the doctors were expecting a bribe, so as soon as her mother reached into her purse and gave them the amount - which was about 300 euro – her grandfather was submitted to the operating room within an hour. Note that Kristina Tremonti has set up Edosafakelaki (meaning 'I paid a bribe') that allows people to report anonymously on cases of bribe-giving or -taking and cases where bribes were refused.

**8. Hungary – *Bribery for delivery (2012)*** - In January 2012 eleven gynaecologists and two midwives were accused for repeatedly asking the patients to pay for delivery in MAV Hospital (State Health Centre) maternity ward. The Hospital itself brought a charge against their doctors (involving the former Head of Department as well). According to the accusation/indictment they asked for money at least in 20 cases for the procedure (for conducting the birth, anaesthesia and analgesia) between April 2007 and July 2008. These procedures are provided free of charge in the social health insurance package. The prosecutors asked for financial penalty in the case of the doctors and one midwife and prison penalty for the other midwife, who was accused of bribery committed in a commercial-scale. The accused denied that the money had been requested from the mothers. So far, the media has not reported any follow-up of the case.

**9. Latvia – *Caught by a hidden camera (2010)*** - In May 2010 a journalist filmed by hidden camera that an Elgava hospital physician (trauma-orthopaedic specialty) took illegal payments of 50 lats (about 30 euro) for a surgery. The physician asked a patient's husband to pay above the official price of surgery (250 lats is about 170 euro). The husband complained to the journalist, agreed for the hidden shooting and introduced the journalist as their son. Primarily, physician had got a reprimand from the hospital administration. Later on, he got fired from the hospital. The physician admitted guilty. In July 2011 the public prosecutor punished the physician with 140 hours of public works.

## **A.1 Bribery in medical service delivery**

**10. Malta – False sick leave statements (2003)** - In 2003 it was leaked to the press that doctors were involved heavily with issuing false sick leave certificates (in particular during the hunting season). One doctor issued 3500 certificates in 8-months' time.

**11. Netherlands – Informal payments to avoid taxes (2012)** - This case concerns a plastic surgeon, who worked in regional hospital. In February 2012 it became public that he had received informal payments for performing cosmetic surgeries (mainly breast augmentations) during his entire career in that hospital; he was employed there from 1972 - 2001. As the surgeon in question passed away before the news came out, it was difficult to assess what actually happened in detail. After this news became public, soon over 100 women came forward and admitted they paid this surgeon in cash. It was revealed that paying this way ensured that the operation would take place within more or less 2 weeks. As the procedures were kept off the books, these patients did not receive any follow-up care. After the allegations the hospital announced that it can be concluded that indeed cash payments were made. However, it cannot be ascertained with certainty whether or not the surgeon is also guilty of fraud (tax evasion). The research also showed that although initially over a 100 way came forward, the actual number of cases in which informal payments occurred was substantially lower: approximately 40. The other women that came forward did so because they were concerned about the received PIP implants (see PIP case from France).

**12. Poland – Bribery and malpractice (2007)** - The chief of the Cardio-Thoracic Surgery Clinic had accepted money before and after treatment of patients. He was also suspected of maltreating patients (which led to the death of 3 patients). The case went to court. He was only sentenced for accepting financial gain. The court has sentenced the doctor for an imprisonment of a year and suspended him for two years, for accepting 17.5 thousand PLN (4 000 euro) in bribes (19 cases of accepting money). The court has imposed a fine of 72 thousand PLN (17 000 euro). The proceedings against 20 persons who paid the bribes were discontinued. The case came to a conclusion in 2013.

**13. Romania – 180 euro per child (2013)** - Two doctors from a Romanian children's hospital in Bucharest were taken into custody after allegedly receiving a bribe to operate on three children. The Police found RON 6 000 (around 1 360 euro) in their pockets at the time of the search. The surgeon and anaesthesiologist were taken into custody for having taken a bribe. The prosecutors asked the court for a 29-day preventive arrest in their case. According to prosecutors, the surgeons allegedly received RON 1 800 to operate on three children, or RON 600 (180 euro) per child. Following the search, RON 3 000 (about 680 euro) was found in his pockets. The anaesthesiologist allegedly took RON 150 (35 euro) for one surgery and RON 200 for each of the other two. He also had around RON 3 000 (about 680 euro) in his pockets at the time of the search.

## **A.1 Bribery in medical service delivery**

**14. Romania – Orthopaedics bribery (2013)** - Orthopaedics is one of the most expensive medical specialties, while Romania also suffers from a shortage of specialized physicians. Therefore, patients could be in the position to buy officially their own prosthesis and additionally to pay informal payments to their surgeons and the rest of the hospital staff. This case can be considered typical: 'My sister in law has been operated at the Foisor Hospital of Orthopaedics in Bucharest. She needed a hip replacement. The doctors did not even notice her until they had negotiated the bribe. In fact, 6 000 lei (around 1 400 euro) for the surgeon and 1 500 lei (350 euro) for the anaesthesiologist, plus the daily bribes for nurses. The problem is that the intervention did not succeed from the beginning because it seemed that the doctor had forgotten a rest of a bandage and the wound started to suppurate. So, a new surgical intervention was needed. This time, the doctors' claims were at half of the price, but anyway they were much more than the efforts of the family who earned just a little above the minimum salary per economy (the minimum salary per month is set at 700 lei or 160 euro). They had to borrow a lot in order to be able to afford the bribes asked by the doctors. At the second surgical intervention, one of the hospital operation rooms (block) was in renovation and modernization and the surgeons were fighting with each other for scheduling their operations in the remaining operation rooms. In conclusion: some physicians get the equivalent of their monthly salary in every working day, just from the bribes paid by patients.'

**15. Romania – Intensive care bribery (2013)** - The case is typical and most frequent for the health system delivery in Romania, especially in big public hospitals. The person who took care of his relative to one hospital in Bucharest tells the story. The story also presented in the media: 'In September 2012, I went to visit his relative in the intensive care unit of a hospital in Bucharest. Talking with the people waiting on the hallways for their loved ones who were in the operation room or in the hospital, I found out how much we need to 'contribute' for our relatives. Nurses and caregivers cost, at this hospital, 60 lei (14 euro) per shift. Ms. A told me that her husband stayed in hospital for two months and she gave 60 lei per day only for nurses and caregivers so far. This means 1 800 lei (405 euro) per month, more than the monthly average salary per economy in Romania (which is 1 547 lei, around 348 euro). I also found out that the 'price' does not decrease after the patient is moved from the intensive care unit back to the hospital room. The amount remains the same: 10 lei (around 2 euro) per capita of nurse or caregiver on shift. (...) There are exceptions. I have been operated for emergency lymph nodes and the doctor did not accept any money, not even 50 lei (12 euro).'

**16. Slovakia – Bribery for surgery (2005)** - In 2005 the police has arrested the head physician of the Orthopaedic Department in a Slovak hospital. The doctor was tried by the Special Court for almost 40 cases of asking and receiving bribes for surgeries, with a total sum of almost 1 million Slovak crowns (about 33 000 euro). The patients were often retirees. The Court sentenced him to 3.5 years imprisonment, which was lowered to 2 years as the physician cooperated and pleaded guilty. After the physician served his sentence, he could not perform his job for 4 years. He was also fined 600 000 Slovak crowns (20 000 euro).

## **A.1 Bribery in medical service delivery**

**17. Slovakia – False sick leave statements (2008 - 2012)** - In November 2012 the Press Agency of the Slovak Republic (TASR) reported that a physician (general practitioner) from the city of Nitra was accused in a court by the investigator of the Office of the Fight against Corruption in Slovakia for taking bribes. The physician took 50 to 100 euro per patient for issuing a sick leave confirmation for healthy patients. The media uncovered similar cases in the period 2008 to 2012. In 2010 4 physicians were accused by the Office of the Fight against Corruption for issuing false sick leave certificates to healthy patients for a 'fee' (under-the-table) of 1 euro per sick leave day. The physicians can be sentenced up to 8 years of imprisonment. The patients who paid the bribes can be sentenced up to 3 years of imprisonment. Media coverage on the final court decision on these cases is yet available.

## **A.2 Medical devices**

### **Procurement corruption**

**18. Austria – Research subsidy (2006)** - In March 2006, a case at the Innsbruck University Clinic of Traumatology and Sports Medicine made headlines. A supplier of prosthetic parts made a payment of 57 000 euro into the account of the Association for Research into Trauma Surgery in Tirol. The article accused the management of the University Clinic of accepting the money in exchange for research into product improvements made for the company. The money was returned and the State Attorney dropped the case as a result. The management announced that in the future all externally sourced research funding will be paid into a central research fund and distributed following a transparent procedure and in accordance with all the rules.

**19. Bulgaria – Predetermined tender winner (2011)** - The Ministry of Health decided to choose one Bulgarian hospital as a place where new equipment for production of isotopes would be located. Requirements of the tender for isotopes implied that the winner in the competition was already predetermined. Based on official information published in the media, the prosecution stopped the investigation into this case.

**20. Cyprus – Procurement of medical devices (2009)** - A tender launched by the Ministry of Health for radiotherapy equipment supply at the General Hospital of Limassol was in favour of a specific company. More specifically, the allegations concerned the following aspects of the tender. (i) The whole procedure followed by the competent authority at the Ministry of Health in preparing the tender was in favour of a specific company, reflected in the terms of the tender. (ii) It recorded as evidence that members of the Ministry had unofficial meetings with the aforementioned company to conduct the terms of the tender. (iii) Further, the Ministry's competent authority preparing the terms provided an excessive estimate (about 4.5 million euro) of the cost of the medical equipment under tendering, giving ground to considerations for bribes etcetera. (iv) At the end it was suspected that the representatives of three medical equipment companies located in Cyprus formed a kind of cartel, forcing the Competition Committee to involve in the investigation process. Disciplinary procedures against three civil servants working in the Ministry of Health and numerous investigations from competent institutional authorities have been conducted, however without any final result nor judicial actions. The project was cancelled.

## **A.2 Medical devices**

### **21. Czech Republic – *Corruption in purchase of medical equipment II (2009)* -**

Throughout 2009 and 2010 newspaper articles and public voices pointed towards the fact that equipment in the hospital was being bought at above market prices. The method of corruption was described as use of a facilitator to extremely complicate the procedure. The facilitator helped in the formulation of the terms of reference (which contained many unclear points and contradictions) and conducted all the negotiations with suppliers to determine the price. The director (a political appointee with ties tied to the ruling political party) was the only one to authorize the procurement and purchase. He also insisted that all communication and negotiation was done directly through him, resulting in severely limited access to information for all other interested parties. The management of the hospital have close ties with the political ruling party in the region, which covers the endeavour. The facilitator arranged for overpriced goods and then 'tunneled' the money out by non-existent services and shared it with the political party by making a donation to the political party. This case is proven at the court.

### **22. Czech Republic – *Corruption in the purchase of medical equipment I (2008)* -**

In 2008 the management of a hospital decided on buying the next generation Gamma Knife, of which up to that point only 14 have been sold. The charity Charta 77 (owner of the machine) offered to sell the current machine and contribute the 800. 000 euro towards the purchase of the new one as co-owners. This offer was declined without giving a reason. And instead the government of the outgoing prime minister Mirek Topolánek committed to contribute CZK 121 million (4.84 million euro) to the project in the last week of the administration. Only under the condition that the entire ownership and oversight of the procedure remains exclusively in the hands of the hospital (of whose director belonged and was appointed to the post by the outgoing prime minister's party). In 2010 the hospital completed the transaction of the new Gamma Knife through the facilitator company Transkontakt-Medical s.r.o for a final price of CZK 152.4 million (6.1 million euro). This case is an example by a purchase of new equipment with debatable need and with strong political backing. It also shows the unnecessary use of a facilitating company in a purchase where it was not needed. The refusal of the charity's offer to co-finance and oversee the purchase and operation of the new machine would be highly suspicious on its own. But the active involvement and financial support in the very final days of an administration to push through the deal adds suspicion to the circumstances. This case was under suspicion, but has never been prosecuted or officially investigated.

## **A.2 Medical devices**

### **23. Czech Republic – Corruption in purchase of medical equipment III (2011)**

- IKEM is the Institute of Clinical and Experimental Medicine in Prague that falls directly under the supervision of (and is funded by) the Ministry of Health. In 2011 the anticorruption police begun to investigate the purchase of medical material and equipment supplied to it by the facilitating company Kardio Port. The suspicion is that the company was selling the institute material and equipment for a 50% - 100% higher price, than one for which it was acquired for. Kardio Port has an anonymous ownership structure, which means that the owners are not known and the law (until March 2013) did not require them to identify themselves, let alone to reveal their valuation. It was reported that the suppliers were encouraged and advised by Kardio Port to charge maximum prices for their products that the state insurer would cover. The difference was divided between the supplier (who sometimes made donations to the institute or political parties) and Kardio Port with unknown owners. This case perfectly explains the operational techniques and reaches the real movers in the background of corrupt cases and shows the close connection and influence of leading politicians. The case is under suspicion.

**24. Denmark – Conflict of interest through dual practice (2007)** - A senior physician, responsible for the purchase of medical equipment in a local hospital, made the equipment buying decision for the hospital dependent upon favourable pricing of new equipment to be purchased for his own private clinic. The doctor resigned from his position in the hospital after accusations of him receiving kickbacks.

**25. Finland – Nepotism in procurement (2000 – 2008)** - An Executive Director of the hospital district in northern Finland was accused in 2013 for favouring companies that were owned or controlled by his son. In 11 instances over 8 years the Executive Director bypassed procurement legislation and directed major IT programme contracts to these companies (health care IT programmes are classified as medical equipment). According to reliable sources, it seemed that the Executive Director of the hospital district actually did favour his son and the companies he was either owning or managing. The deals were constructed so that other players had no chance to participate. Agreements were made in private face-to-face meetings. Actually, purchases were sometimes also delayed so that the family companies had time to prepare for the calls for tender. – The executive received a 9-month suspended sentence for aggravated malfeasance in office.

**26. Greece – Smith & Nephew scandal (1998 - 2008)** - Smith & Nephew is a global medical device company with operations around the world and sells orthopaedic, endoscopic and wound-care products. The US Security and Exchange Commission (SEC) has charged the London-based medical device company Smith & Nephew with violating the Foreign Corrupt Practices Act (FCPA) for bribing public doctors in Greece for more than a decade to win business. The misconduct began in 1997, when Smith & Nephew subsidiaries developed a scheme to pay bribes to Greek doctors through a maze of offshore companies and subsidiaries of the firm, including US and German subsidiaries. Charges alleged that Smith & Nephew has channelled from 1998 to 2008 more than 9 million US dollars to persuade Greek surgeons to use



## **A.2 Medical devices**

its artificial hips and knees. The Greek distributor of Smith & Nephew justified the bribery system, saying that competitors were paying even higher rates at the time. In February 2012, the US subsidiary of Smith & Nephew agreed to pay more than 22 million US dollar (about 17 million euro) to the SEC and Ministry of Justice. Smith & Nephew's chief executive commented: 'These legacy issues do not reflect Smith & Nephew today. But they underscore that we must remain vigilant in every place we do business and let nothing compromise our commitment to integrity.'

### **27. Hungary – Tailored tender specifications for computer software (2009) -**

In 2009, the CEO on behalf of Healthcare Holding made a one-year contract with a limited liability for the use of a computer program. During one year the Hospital paid HUF 7.7 million (about 26 600 euro) for the use of the software. In April 2011 the holding company announced a tender procurement for the acquisition of the same software. The tender was won by the same company, whose software was used before, and the hospital paid 30 million HUF in addition to the HUF 7.7 million paid before.

According to the results of the investigation the value of the software was 5.1 million HUF (about 17 500 euro). In addition, the public procurement for a drug delivery/administration automat system was also the subject of investigation. In this case, only one company could satisfy the requirements mentioned in the tender. This contract was otherwise disadvantageous for the Holding since the Holding paid 700 million HUF (about 2.4 million euro) for the equipment without possessing it. Based on the contract the Holding would have paid 12.3 million HUF (about 42 000 euro) per month for 59 months without having ownership or pre-emption for the machine. The investigation found that the neighbouring health care institution purchased a similar machine for 460 million HUF (about 1.58 million euro), with ownership. The suspect was sentenced to pre-trial detention in February 2010. In March the pre-trial detention was prolonged until May 2012 as there were suspicions that the suspect can significantly impede the investigation. Since that time the media has not reported any follow-up of the case.

**28. Italy – Bribery to influence tender criteria (2013) –** A medical device company bribed public administrators to tailor tender criteria that would favour the company in winning the bid. The case is under investigation and on-going.

**29. Latvia – Kickbacks for purchasing medical equipment (2011) -** In 2011 a head of Elgava city hospital had been detained due to suspicion of getting a kickback of 3 700 lats (about 2 200 euro) for purchasing expensive medical equipment. A head of the hospital division was also detained suspected in intention to get a kickback of 300 lats (about 426 euro) from the equipment seller. Both administrators had been detained together with two representatives of the company. The money had been detected among papers, and none of the suspected did not admit to be guilty.



## **A.2 Medical devices**

**30. Lithuania – Violation of tender procedures (2008)** - In 2008, Sirvintu hospital conducted the procurement of laparoscopes through unannounced negotiations. The State Public Procurement Office (SPPO) decided that the hospital had to apply a method of open tendering instead of the closed procedure that followed, and concluded that favourable conditions for one single company had been created. In the first instance, no criminal signs were found, but the judges made a new trial in the local court.

**31. Poland, Greece and Romania –Johnson and Johnson case (2006)** - In this case, hospital employees who were part of the procurement decision process were bribed by the company Johnson & Johnson (J&J), to favour tender process and the purchase of medical equipment to the benefit of J&J. The investigation revealed that J&J paid everyone – from nurses and midwives, operating theatre chiefs, through doctors, up to chiefs, professors and hospital directors. The proceedings included cases that took place between 2001 - 2006 in approximately 100 hospitals, charges were made against 110 persons – employees of J&J and public healthcare. The bribes were covered up by providing fictitious services by the doctors for employees of J&J (for example, trainings, symposium, and overpaid consults) in exchange for money. So bribes were not paid in cash. In exchange for bribes the doctors were encouraging other doctors to become interested in purchasing J&J equipment and they tried to qualify the biggest amount of patients for procedures which influenced the sale of J&J medical equipment. Apart from these activities, J&J sponsored doctors' trips to symposiums and trainings. Many doctors claim that they could not get trainings if not for the financial support of such concerns like J&J, as the under-financed Polish healthcare does not invest in raising the doctors' qualifications. Moreover, inconsistencies in the tenders were also found. Furthermore, a former vice minister was also suspected for taking bribes of J&J while he was the deputy director in SKarżysko-Kamienna. He was accused for setting tenders for medical supplies in favour of the company. This case came before court and was proven. It was discovered that J&J was also guilty of corrupt practices in other countries.

**32. Poland – Uneven prices in medical equipment (2012)** - The Maria Skłodowska-Curie Institute of Oncology in Gliwice has purchased a True Beam radiation device by Varian, from Candela. It was a sole-source purchase for 17.1 million PLN (about 4 million euro), and 18.5 million (about 4.3 million euro) according to other sources. In November 2012 the Warmia and Mazury Institute of Oncology in Olsztyn has paid only 8.2 million PLN (about 2 million euro) for the same equipment purchased from the same company. The Institute in Olsztyn prepared open tender proceedings that were won by Candela company because they had the lowest offer. The Maria Skłodowska-Curie Institute of Oncology eventually annulled the contract with the company. Note that this not a clear case of corruption. It merely points at inefficiencies in the purchase process of medical equipment.

## A.2 Medical devices

**33. Portugal – *Leisure trips to the United States (before 2011)*** - Medical doctors from a regional hospital have been accused of passive corruption. The accusation was based upon the fact that they had accepted leisure trips for them and their families to places as Disneyworld or New York paid by the companies that provided Coimbra Hospital otorhinolaryngology unit with the necessary medical equipment. One of the doctors involved was they head of the unit The two companies that paid holidays and trips for the medical doctors and their families would have obtained a more favourable treatment in the procurement of their equipment by the Coimbra Hospital. The two companies were accused by the General Prosecution Office of having performed a crime of active corruption and also of harming international trade. The case came before court. However, the case was dismissed because there was no sufficient proof. The causality between the trips and the irregular procurement process could not be proven.

**34. Romania – *Procurement of useless medical equipment at overvalued prices (2001 - 2002)*** - A surgeon received bribes and ensured public procurement of useless medical equipment for hospitals at overvalued prices, as he favoured several firms in the procurement process. He was also a politician, as he has been senator of the Social-Democratic Party (in 2000 - 2004). Other suspects were: department head at the Military Hospital, head of the Independent Medical Service of the National Administration of Prisons, deputy secretary of the Ministry of Justice, advisor at the Ministry of Justice and director in the Ministry of Justice.

This case refers to the involvement of a reputed Romanian surgeon in public procurement for medical equipment in hospitals. During 2000 - 2004, a famous cardiovascular surgeon working at the biggest emergency hospital in Bucharest was senator of the Social-Democratic Party (which currently governs in coalition with the Liberal Party over a great majority). In 2006, the National Anticorruption Department announced the beginning of prosecutions of the surgeon and several high-ranking government officials. The prosecutors demonstrated that the value of the medical equipment unused by the 7 hospitals is of 3.3 million euro. In March 2007, he has been prosecuted for receiving bribes and working against the public interests in public procurement of useless medical equipment for hospitals at overvalued prices. The indictment of prosecutors mentioned: 'During 2001 - 2002, as President of the Committee for Evaluation of the Public Procurement organized by the Ministry of Justice, the defendant has decided the ad judgment of the procurement contracts from public money for medical equipment dedicated to the hospitals belonging to the prison system and Clinical Hospital Angelescu (all under the jurisdiction of the Ministry of Justice), by flagrant violation of the law. Vitiating the entire procurement procedure, the defendant has favoured the firms CC MED AG-Switzerland and BIOMEDICA GmbH-Austria by discretionary ad judgment of the contracts for product delivery, thus causing an actual loss of about 9 million euro in damage of the National Administration of Prisons. In exchange for fostering the aforementioned companies at the procurement through misuse of position they occupy, the defendant has received, in the bank accounts of his off-shore firm Arnell Development Ltd (from British Virgin Islands), open at the Union Bank of Switzerland from Zurich, the amounts of 500 000

## A.2 Medical devices

USD (about 385 000 euro) plus 3 594 333 euro representing the bribery for the activity done within the Committee for Procurement Evaluation.’ Only the surgeon was found guilty.

**35. Slovenia – Genetic tests (2009)** - An adviser in a public institute of medical genetics started the negotiation between a private company and a Chinese institute (BGI) on the sale of non-invasive genetics tests for prenatal diagnosis of Down syndrome. He has facilitated the negotiations and he was advising pregnant women to do prenatal diagnostic of the company, although same tests could be provided in the public sector. In this way, he shifted potential revenues from the public institute of medical genetics to the private companies. He had acted as a correspondent between Medgen and BGI, trying to establish a new price per test. Judicial follow-up: ‘The advisor is temporarily suspended from his previous position’. The Commission for the Prevention of Corruption of the Republic of Slovenia currently examines his case.

**36. Spain – Public and private positions (2013)** - The head of a company in medical equipment occupied high positions in the Catalanian Healthcare and Social Committee. He was also mayor of a municipality in Northern Spain. He is suspected of using his public position to obtain private profits through public accreditations to his enterprise. The company should have been awarded 50 million euro of contracts since 2002, without fulfilling several requirements along with other irregularities that have been committed. The Spanish anti-corruption agency concluded that an evident conflict of interest existed and following this report Barcelona’s public prosecutor’s office started investigations. The case is still under investigation.

**37. Slovakia – Uneven prices in medical equipment (2012 - 2013)** - Individual hospitals purchase medicaments from pharmaceutical companies paying different prices for the same goods, with up to 300% difference. Example: The hospital in city X purchased 1 pack of certain antibiotics for 21 euro and the hospital in city Y purchased the same pack for 7 euro. The latter hospital bought 1 pack of antithrombotic medicine for 48 euro and hospital in city Z bought the same medicine for 108 euro. In a media interview, the director of the Association for Purchase and Sale of Medicaments stated that: ‘the manufacturer decides on the price’. The hospitals argue they prefer the lowest price. However, an analyst from a local NGO promoting economic and social reforms, stated that the prices differences cannot be explained by quantity discounts (as some hospitals argue): ‘If one hospital buys one type of medicine 100 to 300% more expensive than another, there is a big chance that somewhere an inefficient purchase is happening.’ The Ministry of Health recently started a dialogue with hospitals on how to save money in acquisition of pharmaceuticals. Note that this is not a clear case of corruption. It merely points at inefficiencies in the purchase process of medical equipment.

## A.2 Medical devices

### Sale of non-certified products

**38. Spain – ‘Magnet therapy case’ (2011)** - The Spanish agency of drugs and health products detected fraudulent commercial procedures concerning magnet therapy equipment. This case was detected after several persons reported to the regional authorities (police) that suspicious commercial procedures were being undertaken. Independent or grouped individuals contact potential customers via internet or phone calls in order to fix an appointment and close the sale. Besides the fact that those individuals present no qualified medical formation, it is strictly forbidden to sell medical products without an official supervision and certification. In some particular cases, those practices included falsified healthcare ministry certifications. Commercializing uncertified magnet therapy equipment can engender health problems, as these products can produce adverse reactions to its users and that pregnant women, children and persons suffering from haemophilia or tumours are specifically discouraged from using it. The targeted customers were most of the time elderly people, complaining about muscle pains. While faking official healthcare ministry propagandas, the malefactors attracted their victims ensuring them that the magnet therapy equipment would mitigate their pain. The group used its legal coverage from an enterprise established in Guipuzcoa. The equipment was sold between 1 500 and 2 600 euro. This case was proven before court.

**39. France – PIP case (2011)** - In late 2011, health officials in at least a half-dozen countries scrambled to cope with the anxieties raised by the disclosure that tens of thousands of women received breast implants that were made in France with substandard silicone - and that were rupturing at unusually high rates. French prosecutors have said that the maker of the implants, Poly Implant Protheses (PIP), substituted a cheap, industrial-grade silicone for medical-grade silicone that is the industry standard. The French authorities have said that the substandard product causes inflammation to body tissues when implants are compromised. The owner of the implants production enterprise, has acknowledged using the unapproved product, telling investigators that it was cheaper, but of higher quality than the surgical-grade material. Implants made by PIP were banned in 2010, after it was discovered that they contained industrial-grade, which has more contaminants than the medical-grade gel they should have used. In December 2011, authorities in France sparked a worldwide alert when they advised 30 000 French women who had been fitted with the potentially defective implants to have them removed. The producer openly admitted the fraud in the certification of the breast implants.

**40. Germany – Overpriced sale of cheap imported dentures (2004)** - One of the most prominent scandals in the history of the German health sector was the Globudent Skandal. A trading company ‘Globudent’ that imported cheap dentures from Turkey and Hong Kong and sold them overpriced to dentists and other dental firms caused this scandal. Dentists would subsequently invoice the cheap dentures to the health insurance companies as if these were high-end dentures ‘made in Germany’. The profits enabled Globudent to pay these dentists and other dental firms

## **A.2 Medical devices**

reimbursements in cash (kick-backs). In some cases these reimbursements added up to over 200 000 euro for individual dentists. Under normal proceedings, these reimbursements would be provided to patients and health insurance companies. The public prosecutor charged Globudent managers for 68 cases of fraud undertaken between 1999 and 2002 in which they realized an estimated profit of 17.9 million euro. About 450 dentists from across Germany were involved in the scheme. All managers confessed and even though the total damage for insurance companies and patients amounted about 50 million euro, they were held responsible for three million only. The Court in Duisburg sentenced two of the three managers to prison for three years without probation and the third one for two years under probation. Also dentists were punished. Over 40 of them lost their license.

### **41. Netherlands – *Conflict of interests through consultancy contracts (2012)***

- This case concerns the allegation that orthopaedic surgeons have a conflict of interest (COI) resulting from consultancy contracts with manufacturers of metal-on-metal (MoM) hip implants. It is claimed that surgeons continued to use these implants, even after learning they were not safe, because of the COI. The Dutch TV-show 'KRO Reporter' and the independent weekly journal for physicians 'Medisch Contact' jointly carried out a survey on the use of MoM implants in 95 hospitals in the Netherlands. The results of their investigation were presented in the journal and during an episode of the TV-show on 25 May, 2012. It was found that several hospitals continued to implant the devices even though there were concerns about the safety. The first concerns were already voiced in 2007, but many hospitals kept implanting these medical devices; at the beginning of 2012 the last hospital still using the implants also stopped. Over the years, around 10 000 of these MoM implants have been placed in the Netherlands.

After the episode of 'KRO Reporter', a Dutch lawyer filed claims on behalf of hundreds of patients (currently, the number is 500). Moreover, the lawyer contacted the Inspectorate for Healthcare to ensure that the experiences of the patients were included in the report that the Inspectorate is preparing for the Minister of Health, Welfare and Sports. Considering the scope of the study on corruption in health care, the important aspect of this case is not the liability of the suppliers for the faulty devices, but rather the allegation that orthopaedic surgeons have a COI because of the consultancy contracts. The chairman of the Netherlands Orthopaedic Association stated that around 55 orthopaedic surgeons in the Netherlands had such a contract at that time. He explains that orthopaedic surgeons with a consultancy contract can be asked to do lectures and participate in innovation & development and scientific research paid for by the industry. It is argued that because of the consultancy contracts, the surgeons have a commercial interest in the sales of these implants and hence, they choose to implant them for personal gain. Patients are unaware of these ties between their surgeon and the industry. The orthopaedic surgeons claim that these contracts do not influence their treatment decisions. This case has again lit up the discussion for the need for more transparency about the ties between physicians and the industry.

## A.3 Pharmaceuticals

### Procurement and purchase

#### **42. Bulgaria – *Direct purchase of antiviral drugs for pandemic influenza (2009)***

The head of the department Budget and Accounting in the Ministry of Health was accused for cooperating with the former Minister of Health in signing unprofitable transactions with a pharmaceutical company related to the delivery of 200 000 packs of antiviral patent medicine Tamiflu by the pharmaceutical Company Roche Bulgaria. Although the proposal of Roche Bulgaria was less beneficial than a competing offer from the United Kingdom, the Ministry signed a contract with Roche Bulgaria. According to the prosecutor's office these contracts damaged the state budget and the estimated losses amounted to over 2 million BGL (about 1 million euro). The former minister of Health and the head of the department Budget and Accounting were accused of deliberately signing unprofitable transactions. The prosecutor's office asked for five years in prison for the former minister and two years conditionally for the head of the department Budget and Accounting. In January 2010, the investigation started. It became clear that under the influence of the media hysteria during the flu pandemic, tender procedures were circumvented. The negotiations were conducted directly with the representative of the manufacturer. The Bulgarian law permits this practice when it comes to 'force majeure'. However, the prosecutor's office mentioned that the pharmaceutical product Tamiflu was ordered after the peak of the flu pandemic passed. Eventually, the case against ended in acquittal on the court.

**43. Belgium – *Purchase of pandemic influenza vaccine (2010)*** - In 2010, journalist David Leloup became interested in the Belgian experts who recommended the federal government to buy an adjuvant vaccine from GlaxoSmithKline (GSK) to fight against the pandemic influenza A/H1N1. The journalist began its investigation because of two elements. Belgium did not organize any tender to acquire the vaccine. And unlike other countries, Belgium placed its vaccine order only to one single provider, the GSK laboratory. Inquiries led to the following conclusion: Of the fifteen experts recruited from the academic ranks, at least five of them had a conflict of interest with GSK. These five experts have confirmed that they have signed the recommendations of the Scientific Committee of Influenza in 2008 and 2009. Their conflict has 'influenced their attitude in providing advice or recommendations.'

**44. Finland – *Direct purchase of pandemic influenza vaccine (2009 - 2011)*** - The Office of the Chancellor of Justice received 50 complaints criticizing the Ministry of Social Affairs and Health (STM), the National Institute for Health and Welfare (THL) and the Finnish Medicines Agency (Fimea) and some of their officials. The complaints focused on the procurement procedure of Pandemrix, a pandemic influenza vaccine, particularly criticizing that the vaccine was not subjected to a normal call for tender. In addition, the impartiality of THL was questioned and conflict of interest was suspected. A direct purchase was possible because this was considered an exceptional case. The procurement legislation has allowances for direct purchase instead of call for tender if the purchase is absolutely necessary and the normal procurement schedule cannot be followed due to extreme hurry caused by



### **A.3 Pharmaceuticals**

unpredictable reasons beyond the control of the purchasing unit. An influenza pandemic could be considered as such reason, and direct purchase of the vaccine was therefore considered legal.

**45. Netherlands – Purchase of pandemic influenza vaccine (2009)** – The Ministry of Health bought a relatively large number of vaccines using also advice of prominent researcher in this area, which had a conflict of interest as (part-) owner of consultancy companies advising producers of vaccines. One expert was also head of the European Scientific Working Group on Influenza (ESWI) that is being sponsored by vaccines producers. It is not proven that a conflict of interest actually influenced his advice or the decision to buy this number of vaccines.

This case concerns the alleged conflict of interest (COI) of virologist when advising the government on the purchase of vaccines for the so-called Mexican flu; the N1H1 virus. Compared to other countries the Dutch government purchased a large amount of vaccines; 34 million euro to ensure that everyone could be vaccinated twice. In 2009 it came to light in the media, that the influenza expert has shares in the company Viroclinics, which is involved in the development of vaccines for the Mexican flu. This news made people question whether his advice on buying the large amount of vaccines was compromised as a result of a COI. As an influenza expert and in his role as an advisor to the government he was in the media almost every day warning about the dangers of the Mexican flu and the need for vaccination. The virologist was also criticized for being the chairman of ESWI. The big pharmaceutical players such as GSK and Novartis provide financing for this group. The virologist claims that he does not make a lot of money from his shares, but that when the company would be sold he would receive his cut. He has no influence on the financial policy of the company and claims that all money Viroclinics receives from pharmaceutical companies is invested in scientific research. He denied that there exists a COI and that these shares influenced his advice on vaccination for the Mexican flu. The House of Representatives requested an emergency debate with the Minister to discuss the role and alleged conflicts of interest in the decision to purchase the 34 million vaccines. Politicians noted that it is the task of the Minister to ensure that there is not even the appearance of COI for his advisors. The Minister noted that he would like to make it mandatory for physicians and advisors to reveal their ties with the pharmaceutical industry.

**46. Slovenia – Influencing tender process for vaccines (2011)** - The case concerns a medical doctor who was also member of the independent body of a tender procedure for vaccines against Human Papilloma Virus (HPV). The vaccinations should be provided for free by primary health care centres (owned by local municipalities). The national insurance company made a public tender for purchasing the vaccines. The Institute of Public Health has formed a group of independent experts that should make the decision which provider has the best offer. One of the members of this independent body was especially in favour of the Four Valence vaccine of the company GSK. The Slovenian media published that this medical doctor also works for GSK as a special consultant. GSK did not deny this. They claimed that

### **A.3 Pharmaceuticals**

they use his intellectual service, but that there is no conflict of interests. The media published the document showing how the decision was made. The document confirms that other pharmaceutical companies had better and cheaper vaccines on offer. The Slovenian Commission for the Prevention of Corruption is checking this case since 2011.

**47. Lithuania – Predetermined tender by insurance fund (2011)** - In 2011, the State Health Insurance Fund (SHIF) conducted a centralized procurement of medicines to treat prostate cancer. Primarily, three participating suppliers were recorded as eligible for considering their proposals. However, ten days later, with participation of more specialists, only the company Interlux was selected according to technical specifications, and won the tender with the more expensive (by 15%) price. Regarding the winner Interlux, it had been stated that a son of the Deputy Director of the SHIF who was in charge for the tender used to work in that company.

**48. Czech Republic – Hospital losing money due to a facilitating company** - Since 1996, the hospital is almost exclusively supplied with medicine and pharmaceuticals by a facilitating company. The press secretary of the hospital has revealed that each month they buy pharmaceuticals worth roughly CZK 10 million (0.4million euro). The minister of health at the time (currently in prison and under investigation for corruption of which he has been caught red handed) confirmed that Stylmed was charging additional 3% transaction fee. This means that the hospital was losing CZK 3 million (about 150 000 euro) each year in useless transaction fees. On top of that the distributor charges on average additional 4% transaction fee, which constitutes a loss of around CZK 5 million (about 190 000 euro). This was largely due to the fact that it refused to procure these medicines through a public procurement procedure, but rather fragmented the orders and employed select facilitators.

### **Improper marketing relations**

**49. Austria – Pharmaceutical lobbying (2003 - 2009)** - The Head of the Technical Evaluation Commission responsible for drug and equipment lists and the corresponding price lists. At the same time the head of the Pharmaceutical Economics Department that led the procedure for the preparation of the supporting documentation and research upon which decisions were made. She met privately with a very high-profile private pharmaceutical lobbyist during her tenure. Contextual indications are that pharmaceutical companies have withdrawn efforts from the supply side (lobbying doctors directly) and focused efforts on the demand side (with national insurers, making efforts to influence drug and price lists). The great difficulty lies in how to address these issues. Lobbying as such is not against the law and preserving the value of a free media will seemingly always come at the cost of a certain amount of abuse or misuse.



### A.3 Pharmaceuticals

**50. Croatia – Pfizer affair (2009)** - Accusations of bribery relating to the period 1997 - 2001: The company Pfizer wanted to increase the prescription of their pharmaceutical products. It is believed that the company has bribed high-ranking Croatian officials to favour the inclusion of certain drugs on the list of the Croatian Institute for Health Insurance. 'Awards' were distributed in the form of a percentage of the price of the ordered medication (paid in cash) and organized trips. The Pfizer scandal in Croatia erupted eight years ago and since then investigations are on-going. In the same period Bloomberg reported about the bribery of high-ranking doctors in Croatia. As a consequence of the publication of these scandals, the general manager of the Croatian representation of Pfizer got an extraordinary dismissal. Some of the names of suspects were leaked to the public. The indictment of the U.S. court, paragraph 30, stated that at least since 1997 till the end of 2004 Croatia Pfizer (actually in Croatia called Pharmacia Croatia, which was bought by Pfizer) paid physicians who worked for the Croatian government. The payments, they say, were intended to increase the prescription of Pfizer and Pharmacia drugs and to ensure that regulatory authorities gave their approval for the inclusion of their medicines on the list of the Croatian Institute for Health Insurance. In addition, from February 1997 until May 2003, Pharmacia Croatia monthly transferred an amount of 1 200 USD (about 900 euro) to a doctor's bank account in Austria. The doctor was a member of several Croatian national committees and oversaw the registration of pharmaceutical products. The case is under suspicion.

**51. Croatia – Rewards for promotion of medical products (2010)** - This case concerns an advertising campaign of the company Bauerfeind (orthopaedic equipment and medical products) in 2010. In this campaign, doctors or pharmacists were promised a 7-day educational seminar for 2 persons in Las Vegas or Los Angeles when they would prescribe their product for an amount exceeding 150 000 Croatian kuna (200 000 euro). The trip would be for only 1 person if the total price of the prescribed products was 100 000 Croatian kuna (130 000 euro). If the total amount was 75 000 Croatian kuna (10 000 euro), the reward would be a 4-day seminar in Barcelona. Bauerfeind also offered additional presents, such as gift coupons for a local supermarket chain named Konzum.

**52. Croatia – Pharmaceutical company on suspicion of paying 350 family doctors (2012)** - Croatian authorities arrested more than 26 employees and the entire management of the pharmaceutical company Farmal on suspicion of paying doctors to prescribe the company's drugs, according to local media reports. 350 doctors were alleged to have received bribes as part of this arrangement. Authorities learned of the bribery operation through investigative reporting by Free Dalmatia reporter Natasha Skaricic. According to an official release by the Prosecutor's office: 'This is proof that this is a widespread phenomenon.' Croatian Health Minister Rajko Ostojic said at the press conference: 'It causes great harm to the profession and destroys confidence in the health system.' Ostojic would not comment further on the details of the case, as it is on-going. Farmal is majority-owned by German conglomerate Dermapharm, which bought the Croatian firm in early 2011, according to media reports.

### A.3 Pharmaceuticals

**53. Cyprus – Excluding cheap medicines (2004 - 2005)** - A high ranking employee in the Ministry of Health, who was member of the committee for the preparation of the positive list of medicines in 2005, managed to exclude a number of very cheap drugs from the list and generally from the market, which he substituted by much more expensive medicines. The medicines could be added to the list as simplified procurement procedures were applied. A senior in the Ministry of Health was prosecuted, however prosecution failed to provide efficient testimony and the accused was acquitted from all charges.

**54. Finland – Sponsoring and lobbying (2013)** - For decades pharmaceutical companies have been sponsoring doctors to attend meetings and conferences in Finland and abroad. This has been considered as necessary and unavoidable, because the hospital districts and hospitals and health centres have limited funding for Continued Medical Education. However, this is considered as a potential risk for conflict of interest in drug procurement decisions. The most important target group of the pharmaceutical companies seem to be national or regional key opinion leaders, who can influence drug selection and procurement decisions. Today the doctors are technically invited through their employers, but it is still usually the key opinion leaders who get to travel. For example, recently 15 Finnish professionals attended a scientific meeting on immunisation of adults. Twelve were either sponsored or employed by Pfizer. The company was lobbying heavily to get the four attending members of the National Advisory Committee on Vaccination to recommend their new pneumococcal vaccine to adults. One member of the committee had actually been sponsored by the company, three had not. The rest of the attending physicians were key infectious disease opinion leaders of their districts. Subsequently they may be involved in procurement of vaccines.

**55. France – Mediator case (2013)** - Mediator and its French manufacturer, Laboratoires Servier, a privately held company, find themselves at the centre of France's largest public-health scandal in at least a decade. Health officials estimate that as many as 2 000 people died, with thousands more hospitalized, victims of cardiac valve damage and pulmonary hypertension apparently linked to the drug. Politicians and the press have pilloried Servier, charging that it concealed the dangers of Mediator for decades. Many have noted that two Servier weight-loss products, both closely related to Mediator, were at the centre of the fen-phen scandal of the late 1990s in the United States. In France, government investigators have accused Servier of licensing Mediator as a diabetes drug to avoid scrutiny, but urging doctors to prescribe the pills as a diet aid to bolster sales. Magistrates are investigating the company on charges of consumer fraud and manslaughter, and a public prosecutor has charged Servier with defrauding the French health system. Servier says it did nothing wrong and has insisted that the discovery of the dangers of the drug, also known as Benfluorex, depended in part upon recent advances in echocardiography.

The withdrawal of Mediator from the market came in 2009, after the French Drug Authorising Authority assessed - through the clinical observation of several patients who were prescribed the Mediator - that the drug might lead to severe cardiac

### A.3 Pharmaceuticals

problems (pulmonary arterial hypertension and, in one case, cardiac valvulopathy). In January 2011, the inter-ministerial commission leading the inquiry charged that Servier had deceived health authorities and patients in order to keep Mediator on the market. But in their report, investigators also wrote that health officials had ignored a series of warning signs beginning a decade before. They additionally found that regulatory decisions taken by the Afssaps (today called ANSM), the drug-licensing agency, were in fact a 'co-production,' reached in 'cooperation' with drug makers.

At the Afssaps, voting members of the approval committee have long served simultaneously as consultants or employees of the pharmaceutical firms they are meant to regulate, officials acknowledge. And while members are expected to declare conflicts of interest, there are no penalties for not doing so. Consultants or employees from various companies, including Servier, remain active participants. Trials against Servier have recently started.

**56. Germany – Ratiopharm case (2005 - 2008)** - A representative of an Israeli pharmaceutical company, Ratiopharm was found guilty of corruptive behaviour in business transactions when paying checks amounting up to 18 000 euro to panel doctors. The pharmaceutical companies bonus scheme foresaw payments of 5% of the manufacturer's price to panel doctors when they prescribed the company's medicaments. The representative was convicted to pay a fine. This conviction was the first time in the history of the German health system that a representative of a pharmaceutical company was convicted for corruption. It triggered a legal discussion that lasts until today. Doctors were allegedly paid to prescribe the company's drugs. However, the Federal Court of Justice cannot penalize independent doctors who run their own practices. Panel doctors operate on a freelance basis and therefore cannot be regarded as officeholders (Amtsträger) or as official representatives of health insurance companies when providing healthcare services. The Medical Association punished 163 Ratiopharm doctors after state prosecutors have made the files available to the Association.

**57. Hungary – Sponsored trip (2010)** - The National Institute of Pharmacy (NIP) initiated an investigation against the pharmaceutical company Medico Uno, accusing it for illegal influencing physicians occurring during a 'study' trip to Thailand. The physicians were invited by the company to take part in a marketing research in Thailand. However, the investigation found out that the conditions were not provided to carry out this research. It has been proven that this pharmaceutical company organized holidays for health care professionals abroad, while violating the legislation that prohibits pharmaceutical companies to influence doctors. The NIP imposed a fine of HUF 52 million (around 18 000 euro) to the company and made a proposal to the National Health Insurance Fund to delete the company's products from the list of subsidized pharmaceuticals.

### A.3 Pharmaceuticals

**58. Poland / the Netherlands – Philips Poland case (1999 - 2007)** - Royal Philips Electronics was fined 4.5 million US dollar by the US Securities and Exchange Commission (SEC) because of alleged bribery in Poland. The company accepted to pay the fine imposed by the SEC to settle the matter. From 1999 to 2007, in at least 30 bids, employees of Philips' subsidiary in Poland made improper payments to public officials of Polish healthcare facilities to increase the likelihood that public tenders for medical equipment would be awarded to Philips. Philips would submit the technical specifications of its medical equipment to officials drafting the tenders, who would incorporate these specifications into the contracts. This greatly increased the likelihood that Philips would win the bids. Certain officials were involved in these arrangements and they also made the actual decision of whom to award the tenders.

When Philips won, these officials were allegedly paid the improper payments by employees of Philips Poland. The bribes and kickbacks were 3% to 8% of the contract amounts. Philips Poland employees also kept some of the money for themselves. The employees also often utilized a third party agent to assist with the improper arrangements and payments to the officials. The improper payments were falsely characterized and accounted for in Philips's books and records as legitimate expenses and were at times supported by false documentation created by Philips Poland employees and/or third parties. A court case against the former Philips workers and 16 hospital directors accused of paying or receiving a total of about 3 million zloty (700 000 euro) began in 2011 and has not finished.

**59. Poland – Refinanced medicine list (2007 - 2008)** - Suspicion existed about the payment by the company Servier for 'positive opinions' to get the medicine on the refinanced medicine list of the Ministry of Health. Firstly, it was suspected that the company paid cardiologists in exchange for positive advice on the medicine to the Ministry of Health. Secondly, informal contacts between high officials of the Ministry of Health and the company existed. The vice Minister of the Ministry of Health had close contacts with the company and met informal and formal situations with representatives of the company. It shows that high officials did not follow standards of behaviour. Other opinions from within the Ministry that were against the inclusion of the medicine were ignored, which increased the suspicion about possible corruption taking place. In 2008, Iwabradyna was crossed out of the refunded medicine list; the Agency for Health Technology Assessment (AHTAPol) stated that the medicine is very expensive and not very effective. It was the only case of removing medicine off the list. The corruption was never proven.

**60. Latvia – Rewards for promotion of medical products (2013)** - At the beginning of 2013, TV3 journalists had information that Latvian branch of pharmaceutical company KRKA (Slovenia) bribed psychiatrists for prescription of expensive medicines produced by the company. Prescriptions of the drugs were 'awarded' by food from the supermarkets Maxima and Rimi, Douglas gift certificates, and paid travels to foreign resorts.

### **A.3 Pharmaceuticals**

**61. Lithuania – Sponsored trip (2012)** - A journalist from the major Lithuanian newspaper met about 50 physicians and heads of healthcare facilities at the airport when they returned from their trip to Israel. The physicians tried to keep it silent. Pharmaceutical company 'KRKA Lithuania' paid the trip. Pharmaceutical companies are, according to Pharmacy Law, allowed to arrange exclusively research – related events for physicians. However, it was suspected that this was a leisure trip. All physicians officially were on holiday. The case is under investigation.

**62. Netherlands – Research or marketing (2010)** - In June 2011, the Health Care Inspectorate (Inspectorate) fined the pharmaceutical company Allergan with 45 000 euro for providing 'illegal benefits'. These benefits are considered 'gunstbetoon', which roughly translates into inducement. Physicians play an important role in the needs assessment for procurement of medicines and as inducement may affect this needs assessment, this case is related to the procurement of pharmaceuticals. Allergan, located in Eindhoven in the Netherlands, provided the benefits to neurologists for a meeting that took place in March 2010. The case was discussed in the media after the newspaper Trouw managed to get a hold of the report made by the Inspectorate by invoking the 'Wet Openbaarheid van Bestuur'. The meeting for neurologists, that took several hours, was held in a hotel in Utrecht. It included a lunch, drink and a luxurious diner. The subject of the meeting was the use of Botox as a preventative treatment for chronic migraines. This is a controversial use of Botox and is not allowed on the Dutch market. Allergan invited the neurologists to this meeting as they hope that it will be allowed in the future. During the meeting, one of the main topics of interest was the results of Allergan-financed clinical trials. Moreover, it was discussed how these results should be communicated to physicians. Six physicians accepted the invitation and next to the lunch, drink and dinner, they received 1 200 euro for participating. The chairman of the meeting, also a neurologist, was paid 2 000 euro for his contribution to the meeting.

After receiving a tip from a physician who noticed that the focus was more on marketing than on research, the Inspectorate visited the meeting. It was concluded that the fees paid to the neurologists were disproportionate to the efforts of participating in the advisory meeting. The Inspectorate received criticism from the chairman of the meeting on not having the authority to barge in on a private meeting. The response of the Inspectorate was that this was justified under the Pharmaceutical Act (in Dutch: Geneesmiddelenwet). Although Allergan claims that the fees they paid to the neurologists were not unreasonable, they paid the fine (a so-called 'bestuurlijke boete'). The neurologists that accepted the invitation were not fined or prosecuted.

**63. Slovenia – Rewards for promotion of medical products (2007 - 2008)** - Doctors (oncologists and haematologist) were bribed by a pharmaceutical company (Novartis) to prescribe the drug Aredia. If physicians prescribed certain amount of Aredia, Novartis would provide them with a trip to a symposium in Dubrovnik. The representatives of Novartis were also negotiating with physicians of possibilities to include Aredia in clinical protocols. In order to hide their involvement in payments,

### A.3 Pharmaceuticals

Novartis paid a donation to physicians' association Znanje and then Znanje paid the fees, accommodation and traveling costs for the symposium. Fees were paid not only for doctors but also for their families. Annually the Health Insurance Institute of Slovenia, with assistance of Ministry of Health and pharmacy-economic council negotiate with pharmaceutical companies which drugs will be purchased and therefore fully reimbursed. Private insurance companies that are providing voluntary health insurance usually agree with the outcome of the negotiations. The representatives of physicians' society are also involved in the decision making process. The representatives of physicians' societies are asked to give their professional opinion on which drug from the similar group of drugs should be reimbursed. The company also seemed to have bribed the Minister of Health in Albania to influence the inclusion of the medicine in the 'positive list'. The fact that the company made an attempt to influence physicians' society raises serious concerns that corruption is present even in a higher level. Through physicians' societies, the company can indirectly influence the insurance companies. Six persons (medical doctors and pharmacists) were accused for corruption in national court. The case is still under investigation and there are no details for which type of corruption they are accused. According to the country profile, problems of public procurement of pharmaceuticals and medical equipment represent the systemic corruption in Slovenia.

**64. Sweden – Sponsored trip (2003)** - In August 2003, 42 employees from an orthopaedic clinic went on a sponsored four day study trip to Prague. The group consisted of doctors, nurses, physiotherapists, an occupational therapist and a chef. The trip was initiated by the clinic. The manager of the clinic contacted various medical device and pharmaceutical companies for sponsoring. The cost was 3400 SEK (about 390 euro) per person, of which the employees themselves paid 250 SEK (about 28 euro). In this case three doctors were charged with bribery (requesting and accepting bribes). The prosecution also charged representatives from four different pharmaceutical companies. The indictment towards the doctors and representatives of companies were initially dismissed. The Court of Appeal later took up the case. Finally the operational manager of the clinic was found guilty of bribery and was sentenced to a 60-day custodial sentence. One of the doctors was sentenced to 30 days custody for bribery. The indictment against the pharmaceutical companies was dismissed. Regulations of the relationship between healthcare providers and the industry have only been in place since June 2004 in Sweden. These regulations do include guidelines for sponsoring of activities. However, the regulations were not in place at the time of trip and all of the defendants stated that such sponsored trips were commonplace at the time.



### **A.3 Pharmaceuticals**

#### **Sale of public medicines for private gain**

**65. Portugal – ‘Esquizofarma’ (2011)** – Eight persons from the pharmaceutical sector (pharmacy owners, distribution companies employees etc.) were accused of having circumvented the law and collecting funds from highly co-financed medicines by the Portuguese Government. They sold co-financed medicines in foreign countries. This case was proven.

**66. Portugal – Remedio Santo (2010)** - Medical doctors prescribed medicines of NHS list to patients that could not read/write or were dead. These medicines were co-financed by the state (mostly 90-95%) and they were acquired in accomplice chemistries (for 10-5% of their value). Subsequently, the medicines were sold in foreign countries against a high profit (benefits estimated at 30%-35%). The acts have been punished by the General Health Inspection (IGAS) by dismissing the two arrested doctors from the public service.

**67. Portugal – Fraud in chemistries invoicing and stock management system (2013)** - Manipulation of stock management system of chemistries: Pharmacists invoice prescribed medicines to the National Health Administration without actually being purchased by the patient. The case is still under investigation.

**68. Romania – Parallel export (2013)** - Embezzlement of medicines paid from public funds in hospitals and resold (under the table) to patients or directed to parallel export. False prescription – no or much less medicines are released.

**69. Spain – SERGAS Case (2011)** - The Galician ‘Consellería de Sanidade’ (SERGAS) detected fraudulent techniques in the purchase and sale of pharmaceuticals. Some local pharmacies purchased more drugs than needed in order to make benefits selling them to the local customers or foreign countries from which they could get a high profit sale. Spanish pharmacies are by law restricted from purchasing medicines on wholesale; they must only order to specific wholesale entities, thus as minor purchasers. This came before court and is still under investigation.

**70. Spain – Health card fraud (2012)** - The Guardia Civil arrested four geriatrics directors in several municipalities across the Andalucía region that were accused of having purchased medicines with the healthcare card of deceased people. The individuals waited for elders to decease, in order to use their electronic healthcare cards and purchase medicines highly covered by the social security. This case was proven before court.

## **A.3 Pharmaceuticals**

### **Sale of unauthorized or counterfeit medicines**

**71. Ireland – Sale of counterfeit and illegal medicines (2012)** - Authorisation and procurement process were bypassed by companies/individuals to sell illegal medicines (often these medicines were imported from a foreign country). A fine was given to a man from Cork for the unauthorised supply of medicinal products. In addition, four websites in Ireland were also brought into compliance, with the removal of certain advertisements. Separately, the Irish Domain Name Registrar was requested to withdraw the registrations of two websites in Ireland.

**72. Malta – Falsified medicines (2006)** - In 2006 it was detected that two brothers, one working as head of the pharmaceutical department in government may have breached the medicines act by importing items without a licence. The imported medicines were forwarded to patients outside the EU.

**73. Malta – Illegal sale of Viagra over Internet** - Individual was caught selling Viagra over Internet without licence and were confirmed to be counterfeit. Individual was sentenced to a fine.

**74. United Kingdom – Operation Singapore (2007)** - The Medicines and Healthcare products Regulatory Authority (MHRA) regulates the supply of medicines into the United Kingdom (UK), the MHRA Enforcement and Intelligence Group has responsibility for enforcing the law on medicines legislation, and can prosecute where the law has been broken. Operation Singapore is an example of a successful prosecution relating to unauthorised drugs entering the UK supply chain. Operation Singapore was described by the Medicines and Healthcare products Regulatory Authority (MHRA) as 'the most serious known breach of counterfeit medicine in the regulated supply chain.' The case saw illegal drugs infiltrating the UK's legal supply chain for a five month period in 2007. The counterfeit drugs were produced in China and shipped into the UK via Hong Kong, Singapore and Belgium; they were packaged as French Medicines using barcode technology to simulate authenticity. Concerns about the legitimacy of the medicines were raised by a pharmacy worker who identified a reversed embossed blister pack number. The drugs brought into the country were the medicines Zyprexa, Casodex and Plavix used in the treatment of Schizophrenia, advanced prostate cancer and heart disease. A key part of the fraud was a pretence that the medicines had originated in France rather than China. Special French style bar-code labels were produced and imported separately from the drugs, and then added on an industrial estate in Basingstoke. The case was brought to court following a £750 000 (about 870 000 euro) three and a half year investigation by the MHRA. Charges brought against the four defendants included: conspiracy to defraud, Medicines Act offences and Trade Mark offences. The trial lasted four months and resulted in a conviction of the company director (eight year prison sentence). Four other men were acquitted.



## **A.4 Revolving door corruption**

**75. United Kingdom – *Perceived revolving doors (2011)*** - Concerns have been raised regarding a perceived, 'revolving door' between the Department of Health, and private sector companies involved in the delivery of healthcare in the UK. Instances of this occurring have been raised in a radio programme as well as a report by Transparency International UK (Transparency International UK, Cabs for Hire, Fixing the Revolving Door Between Government and Business, 2011). The BBC 'File on 4' programme found that a former Director General of Commissioning at the Department of Health moved on to become head of Global Healthcare at KPMG. Concerns were raised that: 'having been responsible for designing new ways of commissioning healthcare whilst in government, he was now on the other side, working for a company that was bidding for many of the contracts that resulted from his reforms.' KPMG has since won three such contracts. (The report that this example comes from does not include details on the types of contracts won, but it appears to relate to procurement rules more generally). The Transparency International report also highlights other examples of movement between Government officials at the Department for Health, and private sector healthcare suppliers.

**76. Czech Republic – *'Richelieu of the Czech health sector' (2006 - 2010)*** - Between 2006 and 2010 Mr. Snajdr was the first deputy (second highest position after the minister) of three different Ministers of Health, before becoming an MP in 2010. During his spell at the ministry, Snajdr was referred to as the 'Richelieu of the Czech health sector', meaning that he was the Eminence Gris, the mastermind and moving force behind Czech health system. During his spell under the ODS government of Mirek Topolánek (2006 - 2009), Snajdr was not only political appointed as a deputy in the ministry of health, but then also as the chairman of the board of directors of the state insurance company (VZP). By gaining control of both the ministry and, as a consequence, the main insurer, Marek Snajdr positioned himself in the controlling seat of running the Czech healthcare system. In 2007, the governor of the Hospital Central Bohemia was Petr Bendl. Under him several hospitals in the region were privatised (many with anonymous owners), one in particular was the hospital in Horovice. This hospital was small, poorly run, close to a large town, but never the less with a large catchment area. The hospital's management, as well as the governor, was keen to prevent the hospital from closing down. This example is a case in point how intertwined politics is with corruption and private vested interest. Despite endless accusations and several court cases, Snajdr has never been convicted of corruption or wrong doing by a court in the Czech Republic.

**77. Latvia – *Career switch: from governance to the pharmaceutical industry (2009 - 2011)*** - Mr. Y was employed by pharmaceutical company Grindeks as a deputy director for marketing and trade, and deputy director for research and development. Since 1999 he worked at the Ministry of Welfare and Ministry of Health on various positions. At the end of 2011, it had been announced that he is leaving his position at the Ministry of Health as Deputy of the State Secretary for the position of director of Grindeks. There was a discussion in the media about (un)ethical aspects of such a career move.

## **A.5 Unclassified cases**

**78. Ireland – Tender for healthcare centres (2012)** – A tender procedure for healthcare centres was different from procedures for other tenders. The Minister and the wider Cabinet disregarded carefully-worked-out criteria for deciding which towns should get these centres. These criteria were developed by HSE (Health Service Executive) officials for the then minister of state and leaned heavily towards disadvantaged areas in greatest need of health facilities. However, they were set aside by Ministers in an exercise in pork-barrel politics. A particular primary care centre was being developed on land owned by a Fine Gael supporter and by a developer who has in the past contributed to the party.

**79. Ireland – Sponsorship of health programmes by pharmaceutical companies** – Concerns relate to potential if unproven links between a growing corporatisation of medicine in Ireland and a parallel increase in the prescription of drugs, especially in the field of mental health. In such a situation it is felt that the use of particular pharmaceuticals is driven by pressure emanating from the private sector (due to funding of programmes and training) rather than an impartial medical opinion. An illustrative example is the case of a mental health patient being given literature on a particular condition covering advice on lifestyle, but which included a large logo of a pharmaceutical company 'sponsoring' the advice. The patient was also given a leaflet stating, 'your doctor has recently prescribed you Zyprexa...congratulations on taking this important step on the road to recovery.' Note: This is not a clear case of corruption. Patient marketing is not against the law.

**80. Finland – Embezzlement of research funding/clinical drug trial funding (1999, 2001, 2009)** – There are several examples of embezzlement of clinical drug trial funding from two Finnish universities: University of Kuopio (Paavo Riekkinen Sr, in 1999 a 2-year prison sentence for aggravated embezzlement of research funding) and University of Turku (Urpo Rinne, in 2001 a 4-year prison sentence for embezzlement of research funding). The research contracts were institutional, but the professors diverted the funding to personal bank accounts. Another similar case at the University of Kuopio was dismissed as embezzlement, but nevertheless the researcher who had received the funding as a personal grant had avoided taxes and received a 5-month prison sentence.

**81. France – Networking between private and public** – The 'generous donors' wanted to fund a former hospital director to provide a networking base in the political establishment.

**82. Italy – Illegal financial transactions of hospitals (2010)** – The Milan prosecutor's office discovered many illegal financial transactions that involved two hospitals specialised in rehabilitation. The relations could be summarized as follows. Hospital employees received money from the two hospitals in order to obtain a financial transfer from the region that is not related to activities actually performed. There are strong suspicions, actually not yet proven, that this money supported the political campaign of the regional governor and other politicians. The hospitals got the money both from the region, from medical equipment and other services providers.

## **A.5 Unclassified cases**

One person was convicted in December 2012 to a prison sentence of 10 years.

**83. Italy – *Clinical trials without approval of authorities (2012)*** - Surgeons were involved in unauthorised clinical trials on behalf of 10 providers of cardiac devices. Cardiac devices were sometimes defective and caused injuries and human death. Investigation is on-going and is covered by secrecy. The suspicion was that surgeons did the clinical trial because some 10 providers of cardiac devices corrupted them.

**84. Netherlands – *Charging for a fictional dentist practice (2011)*** - This is a case that has already been appealed. It concerns a dentist in Amsterdam who set up a fictional dentist practice. He had the actual practice, however, no patients. He had access to the system used for filing claims with insurance companies. This system contains information on all people with health insurance in the Netherlands. In this system, the dentist filed claims for treatments for under aged children. The reason for this is that these bills are directly send to the health insurance company and not to the patients themselves. The fictional claims he filed cost different health insurance companies hundreds of thousands of euros. The case came to light when he filed a claim for a filling of a molar for a 2-year old, a so-called 'drievlaksvulling'. This caught the attention of the health insurance company as 2-year olds do not have molars that require such fillings. They called the parents to verify the treatment and of course they never heard of the dentist in question. This got the ball rolling.

**85. Sweden – *Health workers receive inheritance from patients*** - A patient, who had no relatives, mentioned three health workers in his will. When the patient died, the health workers were told that if they wanted to accept the will, they had to resign from the institute. Two health workers refused to do this. The one that accepted was charged in court and sentenced to pay a fine.

**86. Sweden – *Borrowing from patient*** - A patient lend money to a nurse that provided home care to help her with her private finances. This loan was to be repaid, but the patient died before full repayment was made. The employee resigned and paid a fine as she had not followed the code of conduct and the district court ruled that it was abuse of a power relationship.

## Annex B Eurobarometer perceptions

**Table B.1 Perceptions of corruption and healthcare corruption in Europe (Eurobarometer 2012)**

	Healthcare Corruption (1)	Healthcare Bribery (2)	General Corruption (3)	GDP/Capita (PPS) (4)	Freedom of press (5)
Greece	78	8	75	75	28,46
Slovenia	78	1	59	62	20,49
Hungary	71	13	50	60	26,09
Romania	71	17	61	49	23,05
Cyprus	70	2	60	91	13,83
Bulgaria	63	12	63	47	28,58
Spain	63	0	23	97	20,5
Portugal	58	1	28	75	16,75
Lithuania	56	15	64	70	18,24
Czech Republic	53	3	33	79	10,17
Ireland	53	0	15	129	10,06
Italy	46	1	40	98	26,11
Malta	46	1	29	86	23,3
Latvia	42	6	57	62	22,89
Slovakia	40	13	53	75	13,25
France	38	1	20	108	21,6
Austria	37	2	24	131	9,4
United Kingdom	37	0	18	110	16,89
Estonia	32	1	30	68	9,26
Sweden	32	0	14	128	9,23
Belgium	31	0	14	119	12,94
Germany	26	0	19	121	7,08
Poland	26	5	48	66	13,11
Luxembourg	12	0	13	271	6,68
Netherlands	11	0	17	128	6,48
Finland	7	0	6	115	6,38
Denmark	6	0	14	125	7,08
EU-27	41	2	30	100	

1. Giving and taking of bribes, and the abuse of positions of power for personal gain, are widespread among people working in the public healthcare sector (% of respondents agree) Eurobarometer 374, QC1.1;

2. Over the last 12 months, has anyone asked you, or expected you, to pay a bribe for his or her services? Yes, a person working in the public healthcare sector (%) Eurobarometer 374, QC5;

3. Corruption is a major problem in our country (% of respondents totally agree) Eurobarometer 374, QC1.1.

Source: Special Eurobarometer 374, 2012.

4. GDP per capita in PPS; Index (EU27=100); Source: Eurostat, 2012.

5. Freedom of Press Index 2013; Source: <http://en.rsf.org/press-freedom-index-2013,1054.html>.

## Annex C EU 28 MS research

As part of our research we conducted in-depth interviews with major stakeholders in all EU Member States, including Croatia, during the months of February and March 2013. We have conducted 107 interviews in all EU28 countries including Croatia. Instructions to our 28 EU MS rapporteurs are presented in Annex E. Research in the 28 EU MSs has been conducted by:

**Table C.1 Rapporteurs in 28 EU MSs**

Derek Alan Barker	Austria
Diletta Zonta & Jakub Gloser	Belgium, France, Luxembourg & Czech Republic
Elka Atanasova	Bulgaria
Mamas Theodorou	Cyprus
Hindrik Vondeling	Denmark
Liuba Marauskieneis	Estonia, Latvia, Lithuania
Kari S. Lankinen	Finland
Thijs Viertelhausen	Germany
Savvas Avgoustatos	Greece
Charalampos Economou	Greece
Petra Baji	Hungary
Nicky Smith	Ireland, United Kingdom
Eli Borgovoni	Italy
Julian Mamo	Malta
Kim Weistra	Netherlands
Ewa Dzielnicka	Poland
Myriam Perez Andrada	Portugal, Spain
Constanta Mihaescu-Pintia	Romania
Martin Rusnak	Slovakia
Jelena Arsenijevic	Slovenia
Sandra Frost	Sweden
Maja Hranilovic	Croatia

The number of interviews per country differs (between 2 in Denmark, Ireland and the United Kingdom to 7 in Croatia, Finland and Italy). Some interviewees hold several positions. As a result the number of interviews per stakeholder categories (114) exceeds the number of interviews per MS. Table C.2 presents an overview of the number of interviews per EU MS. Table C.3 indicates to which stakeholder category these interviewees belong.

**Table C.2 Number of interviews per MS**

Member State	Number of interviews
Austria	4
Belgium	5
Bulgaria	4
Croatia	7
Cyprus	3
Czech Republic	3
Denmark	2
Estonia	3
Finland	7
France	3
Germany	3
Greece	4
Hungary	3
Ireland	2
Italy	7
Latvia	3
Lithuania	4
Luxembourg	3
Malta	4
The Netherlands	4
Poland	4
Portugal	4
Romania	6
Slovakia	3
Slovenia	3
Spain	3
Sweden	4
UK	2
<b>Total</b>	<b>107</b>

**Table C.3 Number of interviews per stakeholder category**

Stakeholder category	Number of interviews
Government regulator	36
Healthcare provider	20
Anti-corruption agency	16
Payers of healthcare	10
Academic (corruption) expert	6
Medical devices industry	8
Pharmaceutical supplier	8
Investigative journalist	3
Demanders of healthcare	2
Procurement agency	2
Notified body	1
Advocacy	1
Civil society organisation	1
<b>Total</b>	<b>114</b>

## Annex D Country reports

Each interview in the 28 EU MSs covered the following topics: The perception of corruption in the healthcare sector, both in general and for the three focus areas of this study in specific; The prevailing types of healthcare corruption; The risks for and causes of corruption in general and in the healthcare sector in specific; Specific policies and practices to prevent and control corruption.

A summary of the main observations of the interviews is presented in this annex, each chapter containing the results for one particular country. Note that these reports reflect personal and professional perceptions of several but not many interviewees. Each country report contains a brief introduction of the characteristics of the healthcare system.

Table D.1 presents an overview of the cases (as described in Annex A) per MS. Table D.2 presents an overview of the policies and practices (as described in chapter 4) per MS.

**Table D.1 Overview cases (from Annex A) per MS**

MS	Title	Type of corruption*	No
Austria	<i>Bribery for pre- and post-surgery treatment</i>	Bribery in msd	1.
Austria	<i>Research subsidy</i>	Medical devices	18.
Austria	<i>Pharmaceutical lobbying</i>	Pharmaceuticals	49.
Belgium	<i>Avian Flu GSK Pandemrix medicines</i>	Pharmaceuticals	43.
Bulgaria	<i>Under-the-table payments caesarean section</i>	Bribery in msd	2.
Bulgaria	<i>Predetermined tender winner</i>	Medical devices	19.
Bulgaria	<i>Direct purchase of influenza medicines</i>	Pharmaceuticals	42.
Croatia	<i>Five thousand euro in cash</i>	Bribery in msd	4.
Croatia	<i>Las Vegas and local supermarket coupons</i>	Medical devices	20.
Croatia	<i>Pfizer affair</i>	Pharmaceuticals	50.
Croatia	<i>Rewards for promotion of medical products</i>	Pharmaceuticals	51.
Croatia	<i>Pharmaceutical paying 350 family doctors</i>	Pharmaceuticals	52.
Cyprus	<i>Bribery for a swift knee replacement</i>	Bribery in msd	3.
Cyprus	<i>Procurement of medical devices</i>	Medical devices	20.
Cyprus	<i>Excluding cheap medicines</i>	Pharmaceuticals	53.
Czech R.	<i>Purchase of medical equipment II</i>	Medical devices	21.
Czech R.	<i>Purchase of medical equipment I</i>	Medical devices	22.
Czech R.	<i>Purchase of medical equipment III</i>	Medical devices	23.
Czech R.	<i>Transaction costs of a facilitating company</i>	Pharmaceuticals	48.
Czech R.	<i>'Richelieu of the Czech health sector'</i>	Revolving doors	76.
Denmark	<i>Conflict of interest through dual practice</i>	Medical devices	24.
Finland	<i>Nepotism in procurement</i>	Medical devices	25.
Finland	<i>Direct purchase of influenza medicines</i>	Pharmaceuticals	44.
Finland	<i>Sponsoring and lobbying</i>	Pharmaceuticals	54.



MS	Title	Type of corruption*	No
Finland	<i>Embezzlement of research funding</i>	Unclassified	80
France	<i>PIP case</i>	Medical devices	39
France	<i>Mediator case</i>	Pharmaceuticals	55
France	<i>Networking between private and public</i>	Unclassified	81
Germany	<i>'Organspende Skandal'</i>	Bribery in msd	5
Germany	<i>Overpriced sale of cheap imported dentures</i>	Medical devices	40
Germany	<i>Ratiopharm case</i>	Pharmaceuticals	56
Greece	<i>Fakelaki I</i>	Bribery in msd	6
Greece	<i>Fakelaki II</i>	Bribery in msd	7
Greece	<i>Smith &amp; Nephew scandal</i>	Medical devices	26
Greece	<i>Johnson and Johnson case</i>	Medical devices	32
Hungary	<i>Bribery for delivery</i>	Bribery in msd	8.
Hungary	<i>Tailored tender specifications</i>	Medical devices	27.
Hungary	<i>Sponsored trip</i>	Pharmaceuticals	57.
Ireland	<i>Sale of counterfeit and illegal medicines</i>	Pharmaceuticals	71.
Ireland	<i>Tender for healthcare centres</i>	Unclassified	78.
Ireland	<i>Sponsorship of health programmes</i>	Unclassified	79.
Italy	<i>Bribery to influence tender criteria</i>	Medical devices	28.
Italy	<i>Illegal financial transactions of hospitals</i>	Unclassified	82.
Italy	<i>Clinical trials without approval of authorities</i>	Unclassified	83.
Latvia	<i>Caught by a hidden camera</i>	Bribery in msd	9.
Latvia	<i>Kickbacks for purchasing medical equipment</i>	Medical devices	39.
Latvia	<i>Rewards for promotion of medical products</i>	Pharmaceuticals	60.
Latvia	<i>From government to the pharmaceutical industry</i>	Revolving doors	77.
Lithuania	<i>Violation of tender procedures</i>	Medical devices	30.
Lithuania	<i>Predetermined tender by insurance fund</i>	Pharmaceuticals	47.
Lithuania	<i>Sponsored trip</i>	Pharmaceuticals	61.
Malta	<i>False sick leave statements</i>	Bribery in msd	10.
Malta	<i>Falsified medicines</i>	Pharmaceuticals	72.
Malta	<i>Illegal selling of Viagra over Internet</i>	Pharmaceuticals	73.
Netherlands	<i>Informal payments to avoid taxes</i>	Bribery in msd	11.
Netherlands	<i>CoI through consultancy contracts</i>	Medical devices	41.
Netherlands	<i>Medicines for Mexican Flu</i>	Pharmaceuticals	45.
Netherlands	<i>Research or marketing</i>	Pharmaceuticals	62.
Netherlands	<i>Charging for a fictional dentist practice</i>	Unclassified	84.
Netherlands	<i>Philips Poland case</i>	Pharmaceuticals	58.
Poland	<i>Bribery and malpractice</i>	Bribery in msd	12.
Poland	<i>Uneven prices in medical equipment</i>	Medical devices	32.
Poland	<i>Refinanced medicine list</i>	Pharmaceuticals	59.
Poland	<i>Philips Poland case</i>	Pharmaceuticals	58.
Poland	<i>Johnson and Johnson case</i>	Medical devices	31.
Portugal	<i>Leisure trips to the United States</i>	Medical devices	33.
Portugal	<i>'Esquizofarma'</i>	Pharmaceuticals	65.

MS	Title	Type of corruption*	No
Portugal	<i>'Remedio Santo'</i>	Pharmaceuticals	66.
Portugal	<i>Fraud in chemistries</i>	Pharmaceuticals	67.
Romania	<i>180 euro per child</i>	Bribery in msd	13.
Romania	<i>Orthopaedics bribery</i>	Bribery in msd	14.
Romania	<i>Intensive care bribery</i>	Bribery in msd	15.
Romania	<i>Procurement of useless medical equipment</i>	Medical devices	34.
Romania	<i>'Parallel export'</i>	Pharmaceuticals	68.
Romania	<i>Johnson and Johnson case</i>	Medical devices	32.
Slovakia	<i>Bribery for surgery</i>	Bribery in msd	16.
Slovakia	<i>False sick leave statements</i>	Bribery in msd	17.
Slovakia	<i>Uneven prices in medical equipment</i>	Medical devices	37.
Slovenia	<i>Genetic tests</i>	Medical devices	35.
Slovenia	<i>Influencing tender process for vaccines</i>	Pharmaceuticals	46.
Slovenia	<i>Rewards for promotion of medical products</i>	Pharmaceuticals	63.
Spain	<i>Public and private positions</i>	Medical devices	36.
Spain	<i>'Magnet therapy case'</i>	Medical devices	38.
Spain	<i>SERGAS Case</i>	Pharmaceuticals	69.
Spain	<i>Health card fraud</i>	Pharmaceuticals	70.
Sweden	<i>Sponsored trip</i>	Pharmaceuticals	64.
Sweden	<i>Health workers receive inheritance</i>	Unclassified	85.
Sweden	<i>Borrowing from patient</i>	Unclassified	86.
UK	<i>Operation Singapore</i>	Pharmaceuticals	74.
UK	<i>Perceived revolving doors</i>	Revolving doors	75.

\*msd=medical service delivery

**Table D.2 Overview of policies and practices (chapter 4) per MS**

Policies and Practices		
MS	No	Type
Austria	4.2.2	Anti-corruption institutions
Austria	4.4.5	Introduce transparent waiting lists
Austria	4.4.6	Increase penalties for bribery
Austria	4.6.3	Self-regulation of the pharmaceutical industry
Belgium	4.3.1	Fraud in healthcare control I - DGEC
Belgium	4.5.2	Include the healthcare sector in general procurement regulations
Croatia	4.2.3	Anti-corruption-in-health-strategy
Croatia	4.7.4	Transparent waiting lists
Czech Republic	4.4.4	Formalise informal payments
Czech Republic	4.5.1	Break the cycle of systemised corruption
Czech Republic	4.5.3	Centralise the maximum price of pharmaceuticals
Estonia	4.6.1	Prescribe main active substances
Finland	4.6.3	Self-regulation of the pharmaceutical industry
France	4.3.2	Fraud in healthcare control II – CNAMTS
France	4.6.4	Sunshine Act à la Européenne
Greece	4.7.3	Civil society reporting website
Hungary	4.4.1	Increase in salaries of healthcare providers I
Lithuania	4.6.1	Prescribe main active substances
Lithuania	4.6.3	Self-regulation of the pharmaceutical industry
Malta	4.6.3	Self-regulation of the pharmaceutical industry
Netherlands	4.6.2	Code of Conduct for medical devices
Netherlands	4.6.4	Sunshine Act à la Européenne
Netherlands	4.6.5	Conditioned self-regulation in the pharmaceutical sector
Portugal	4.3.4	Collaboration between competent authorities and the public - IGAS
Romania	4.4.2	Increase in salaries of healthcare providers II
Slovakia	4.4.7	Doctor's initiative against bribery
Slovakia	4.6.1	Prescribe main active substances
Spain	4.6.1	Prescribe main active substances
Sweden	4.6.3	Self-regulation of the pharmaceutical industry
United Kingdom	4.2.1	Anti-corruption legislation
United Kingdom	4.3.3	Fraud in healthcare control III - NHS
United Kingdom	4.6.5	Conditioned self-regulation in the pharmaceutical sector
United Kingdom	4.7.1	Awareness campaign and reporting line
United States	4.7.2	Investigative Journalism database

## Austria

### General description of the healthcare system<sup>171</sup>

The organisation of the Austrian healthcare system is based on the country's federalist structure. Apart from hospital care, the federal government is the regulating actor in all types of health care provided within the Länder. The main responsibility of the nine Länder in the hospital sector consists of the ratification of basic law and the regulation of policy implementation and enforcement. Since 2002, the Austrian hospitals in all Länder - except for Vienna - have been privatised, which encloses the hospitals' responsibility for their own management.

The healthcare system is mainly funded by health insurance contributions and taxes (70%). The remaining 30% stems from private household payments. The mandatory social health insurance (SHI) is the main financier of healthcare costs. The financing system is highly decentralized by assigning responsibility to the twenty-one health insurance funds for the collection of contributions and provision of the healthcare services in accordance with the social insurance act. Only the financing system of the hospital sector is characterized by a pluralistic system, in which 40% of hospital care is financed by SHI. Each employee belongs to the social insurance fund of its occupational group and shares the contribution costs with its employer for fifty percent. The contribution levels are pre-defined and determined by national health policy makers.

### Health care delivery

Outpatient care is primarily delivered by general practitioners who mainly work on an individual basis. Insured are free to choose a provider for outpatient care. Inpatient care is provided in public as well as private hospitals and outpatient clinics. Although waiting times are not considered to be of major problem in Austria, there are inequalities in the delivery of health care between the different Länder.

The financing system of inpatient care in public hospitals is performance based and twofold. On the one hand, hospital care is financed by a case fee payment system, which is based on the national DRG system. On the other hand hospital care is financed by the Länder-specific DRG fund control area. Alternatively, outpatient care is financed by public as well as private insurance' contributions and household out-of-pocket payments.

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<sup>171</sup> Main sources for this section: Hofmarcher M M, Rack H-M. Austria: Health system review. *Health Systems in Transition*, 2006; 8(3):1–247.[http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0009/96435/E89021.pdf](http://www.euro.who.int/__data/assets/pdf_file/0009/96435/E89021.pdf) and Fink M. (2012). asisp Annual National Report 2012 Austria. Pensions, Health Care and Long-term Care. Downloaded from: [http://www.socialprotection.eu/files\\_db/1200/asisp\\_ANR12\\_AUSTRIA.pdf](http://www.socialprotection.eu/files_db/1200/asisp_ANR12_AUSTRIA.pdf).

Indicators of the healthcare system, 2010 (or nearest year)		
Financing of the healthcare system (1)		
	<i>Austria</i>	<i>EU average</i>
Total health expenditure as % of GDP	11%	9%
Public expenditure as % of total health spending	77%	73%
Private insurance as % of total health spending	5%	4%
Private-out-of-pocket as % of total health spending	17%	21%
Organisation of the healthcare system (2)		
Social insurance or tax-based system?	Social insurance	
Gatekeeping by a general practitioner (GP)?	Not necessary	
How are physicians paid? (e.g. salary, fee-for-service (FFS), capitation)	FFS/Capitation	
Patient organisation involvement (3=good, 2=intermediary, 1=not-so-good)	3	
Accessibility (3=good, 2=intermediary, 1=not-so-good) (3)		
Family doctor same day access	2	
Major surgery < 90 days	2	
Cancer therapy < 21 days	3	
CT scan < 7 days	3	

Sources: (1) OECD Health at a Glance Europe 2012<sup>172</sup>, (2) Joint Report on Health systems (2010)<sup>173</sup>, HEIDI WIKI<sup>174</sup> and EuroHealth Consumer Index 2012<sup>175</sup>, (3) EuroHealth Consumer Index 2012.

Corruption in healthcare perceptions		
<b>Do you think that the giving and taking of bribes, and the abuse of positions of power for personal gain, are widespread among people working in the public health sector?</b>		
	<i>Austria</i>	<i>EU average</i>
(% of respondents agree - Eurobarometer)	24%	30%
<b>Please indicate on a scale of 1 (= no problem) to 5 (= very serious problem) to what extent corruption is a serious issue in your country (average score of 3 interviewees)</b>		
	<i>Austria</i>	
Informal payments in medical service delivery	3.25	
Certification and procurement of medical equipment	2.75	
Authorisation and procurement of pharmaceuticals	2	

Sources: Special Eurobarometer 374, table QC4 (fieldwork September 2011); own research (fieldwork February/March 2013).

## Types of healthcare corruption

The interviewees have mentioned various types of prevailing corruption types:

<sup>172</sup> <http://www.oecd.org/els/health-systems/HealthAtAGlanceEurope2012.pdf>.

<sup>173</sup> [http://europa.eu/epc/pdf/joint\\_healthcare\\_report\\_en.pdf](http://europa.eu/epc/pdf/joint_healthcare_report_en.pdf).

<sup>174</sup> [https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing\\_healthcare/Healthcare\\_financing\\_systems](https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing_healthcare/Healthcare_financing_systems).

<sup>175</sup> Health Consumer Powerhouse – EuroHealth Consumer Index 2012: <http://www.healthpowerhouse.com/index.php?Itemid=55>.

***Informal payments in service delivery:***

- According to one interviewee these exist, but the actual extent is unknown. Incentives to make informal payments are to obtain better treatment or to move up waiting lists of publicly funded health care providers (about 30% of people have additional private insurance and hope to get earlier treatment also in public hospitals and at private providers); the rest cannot;
- Another interviewee said that bribes are generally not a problem, but also mentioned the problem of queue jumping (estimated to happen twice a week). This involves clientalism: 'One type of corruption (...) that is still regarded in Austria as acceptable is clientalism or favouritism – swopping a favour for a favour. This is regarded as not only acceptable but as polite and expected behaviour'.

***Certification and procurement of medical equipment:***

- Sometimes a conflict of interest exists when doctors have a vested interest (they are involved in some way or receive benefits from medical suppliers);
- According to one interviewee: 'I consider that providers of medical equipment represent the worst of all three areas under discussion. They try to influence in multiple ways the outcomes of bids' and 'I believe it is very usual that companies give something for buying their equipment; personal experience with offers of conference participation, presents, etc.'

***Authorisation and procurement of pharmaceuticals:***

- Interviewees did not identify any prevailing types of corruption in this area. Rather they identified a decreasing or low risk of corruption in this area, because this area is highly regulated and the new anti-corruption legislation is mentioned as reducing risks.

***Other phenomena interviewees noticed:***

- Payments in advance / higher cost treatments: Patients are sometimes required to pay in advance in cash and claim back the money later from the national health insurance agency; in cases of doctors with a contract with the national agency, this is illegal (in cases of listed interventions); in cases of doctors in private practice, this is legal, and prices are sometimes set at higher levels than that which is reimbursed by the national agency, so the patient ends up partially subsidising his/her own treatment. The patient is generally informed of this in advance;
- Steering patients from public to private health care providers: Listed doctors in private practice usually also work in public hospitals or hospitals funded with public money; patients at public hospitals are sometimes steered towards private health care services.

***Causes and risks***

Many causes and risks were mentioned by the interviewees:

***Informal (under-the-table) payments in medical service delivery:***

- Most interviewees mentioned pure greed as the main risk for corruption.
- Many one-person practices and very few group practices – no control over one-on-one sessions and possible misuse of the information gap;
- Under the table payments to get higher up on waiting lists; patients feel more privileged when they make payment and this is often a matter of social status;
- One-person practices, very few group practices – no control over one-on-one sessions; possible misuse of the information gap;
- Doctors working in public hospitals and at a private practice at the same time: (patients at public hospitals are sometimes steered towards private health care services).
- Information gaps can steer patients to unlisted treatments, which very often have to be self-financed and are not necessary;
- Some doctors demand payment in advance in cash and advise the patient to claim back the money later from the insurance agency;
- Oversupply of services that are not necessary.

***Certification and procurement of medical equipment:***

- Influencing the reimbursement system to get treatments involving certain equipment to be included in the list of health services so they are covered by the insurance bodies. Control measurements / indicators are missing for deciding on what equipment and what devices should be bought;
- Pressure placed by medical equipment suppliers on parties that do not want to cooperate with them, for example: Suppliers are criticising reports saying that they are not scientific enough. Suppliers may also go over the heads of insurance fund employees to try to influence decisions on what gets on the reimbursement lists;
- There is an inverse relationship between the inherent value of products and sales push (that is, the higher the margin, particularly for products that have low or questionable curative properties, the greater the intensity of advertising and distribution);
- Dangerous, risky products of less quality and of questionable medical value are pushed for commercial reasons;
- Offering perks by the industry not directly to the person but to the institute; this happens much more often than perks offered to individuals and is regarded much more positively.
- Some doctors develop medical equipment, which is preferred by them for medical treatment to increase their income or they receive benefits from medical suppliers or companies.

**Authorisation and procurement of pharmaceuticals:**

- High pressure from companies on reimbursement lists of national health insurance agency. Companies are very creative in exercising influence, for example there was a case in which the media was to pressure the health insurance fund to list the drug, without research being done proving the supposed effects of the drug. This is an indirect way of lobbying;
- Pharmaceutical treatments are very well regulated in Austria. All patients have the same opportunity to receive the adequate pharmaceutical medication;
- It could be possible that medical companies give something for buying their medical equipment, e.g. bribes, presents, holiday trips;
- Over-prescription; line-extension; over-medicalization;
- High pressure from medical industry on reimbursement lists of the national health insurance agency. However, since the Anti-corruption legislation of 2008 and the centralisation of procurement, there are no visits to heads of departments from salesmen of pharmaceutical companies and consequently less offers of conference participations.

**Pharmaceuticals and medical devices:**

- Producers have a financial incentive; they also want to tap advantages of unfair competition (higher margins / market share, etc.);
- Inverse relationship between inherent value of products and sales push (the higher the margin, particularly for products that have low or questionable curative properties, the greater the intensity of advertising and distribution);
- Dangerous risky products of less quality and of questionable medical value are pushed for commercial reasons.

**Actual and suggested policies and practices****Establishing an environment unfavourable to corruption**

Both the Criminal Law Reform of 2008, the amendment in 2009, as well as the establishment of the Office for Prosecution for Corruption and the Federal Anti-Corruption Bureau (both new offices and the first of their kind in Austria), are viewed by participants to be important developments in the fight against corruption. On the legal side, high penalties have a strong dissuading effect on overt or highly visible types of corruption (cash payments, conference participation). To support this famous politicians (former minister Strasser) have been confronted and been in court; that is, very striking public examples of convictions for corruption serve as warning to lower levels.

As a result the interviewees have noted a sea-change in attitudes towards corruption from a high level of tolerance 20 years ago to a high level of social non-acceptance (interviewees cite growing awareness of consumers and the work of NGOs as having caused this change).



***Change in procurement of pharmaceuticals***

Centralised procurement has been identified, to have also led to very high downward pressure on prices of pharmaceuticals and this has decreased the incentive of companies to mobilise large armies of sales personnel to promote products, and has reportedly led to disappearance (according to interviewees) of gifts of conference participations, etc. Pharmaceutical companies appear to have re-directed their efforts towards research to support claims that their drugs are better than others, etc. in an effort to convince health insurance bodies to list their drugs for reimbursement. Self-regulation by pharmaceutical companies takes the form, primarily, of official ethics policies. However, the public generally regards these policies as cynical and made for the purposes of public relations only.

***Increasing transparency***

There is a draft amendment under discussion regarding the formalisation of waiting lists and procedures for ensuring that waiting lists for medical treatments are transparently managed. Apart from this, however, there have been independent efforts to improve transparency in this area. In 2008/9, the Vienna Hospital Association (with the exception of one hospital) introduced a computerized registration system ('OPERA') towards greater transparency in waiting lists. This system is reportedly functioning well.

## Belgium

### General description of the healthcare system<sup>176</sup>

The Belgium healthcare system is characterized by mandatory health insurance, freedom of choice for patients and remuneration based on fee-for-service. The social security programme is organised and managed at the governmental level. The broad package of services and medications that are covered by the mandatory insurance are described in the nationally established fee schedule, together with the reimbursement rates. These rates are negotiated on a yearly basis between the social security system and the providers of medical care, according to fixed fee schedules for sets of procedures.

The health insurance system is funded by employer and employee contributions. These compulsory, pre-defined contributions are paid to the government in addition to income taxes. This is administered by five sickness funds, which all have political or ideological roots.

Roughly 20% of the healthcare expenditures are out-of-pocket payments which consist of, amongst other thing, official co-payments on for example drugs and supplements. With regard to co-payments; these are the same for everyone with the exception of people with a preferential reimbursement status<sup>177</sup>. Another source of private expenditure in the Belgium system is private voluntary health insurance.

### Healthcare delivery

The majority of hospitals in Belgium are not-for-profit privately owned and physicians are in general self-employed. Freedom of choice for patients and competition between healthcare providers is promoted. Waiting lists are an uncommon phenomenon in Belgium.

Pharmaceuticals are exclusively available through community and hospital pharmacies and the establishment of new pharmacies is strictly regulated. Only physicians, dentists and midwives can prescribe pharmaceuticals.

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<sup>176</sup> Main sources for this section: Gerkens S, Merkur S. Belgium: Health system review. *Health Systems in Transition*, 2010, 12(5):1–266.[http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0014/120425/E94245.PDF](http://www.euro.who.int/__data/assets/pdf_file/0014/120425/E94245.PDF) and Segaert S. (2012). asisp Annual National Report 2012 Belgium. Pensions, Health Care and Long-term Care. Downloaded from: [http://www.socialprotection.eu/files\\_db/1203/asisp\\_ANR12\\_BELGIUM.pdf](http://www.socialprotection.eu/files_db/1203/asisp_ANR12_BELGIUM.pdf).

<sup>177</sup> Based on the gross annual taxable income of a household.

Indicators of the healthcare system, 2010 (or nearest year)		
Financing of the healthcare system (1)		
	Belgium	EU average
Total health expenditure as % of GDP	10.5%	9%
Public expenditure as % of total health spending	76%	73%
Private insurance as % of total health spending	5%	4%
Private-out-of-pocket as % of total health spending	19%	21%
Organisation of the healthcare system (2)		
Social insurance or tax-based system?	Social insurance	
Gatekeeping by a general practitioner (GP)?	Financially encouraged	
How are physicians paid? (e.g. salary, fee-for-service, capitation)	FFS	
Patient organisation involvement (3=good, 2=intermediary, 1=not-so-good)	2	
Accessibility (3=good, 2=intermediary, 1=not-so-good) (3)		
Family doctor same day access	3	
Major surgery < 90 days	3	
Cancer therapy < 21 days	3	
CT scan < 7 days	2	

Sources: (1) OECD Health at a Glance Europe 2012<sup>178</sup>, (2) Joint Report on Health systems (2010)<sup>179</sup>, HEIDI WIKI<sup>180</sup> and EuroHealth Consumer Index 2012<sup>181</sup>, (3) EuroHealth Consumer Index 2012.

<b>Corruption in healthcare perceptions</b>		
<b>Do you think that the giving and taking of bribes, and the abuse of positions of power for personal gain, are widespread among people working in the public health sector?</b>		
	<i>Belgium</i>	<i>EU average</i>
(% of respondents agree - Eurobarometer)	14%	30%
<b>Please indicate on a scale of 1 (= no problem) to 5 (= very serious problem) to what extent corruption is a serious issue in your country (average score of 3 interviewees)</b>		
	<i>Belgium</i>	
Informal payments in medical service delivery	1.5	
Certification and procurement of medical equipment	2	
Authorisation and procurement of pharmaceuticals	1.5	

Sources: Special Eurobarometer 374, table QC4 (fieldwork September 2011); own research (fieldwork February/March 2013).

### Types of healthcare corruption

Some interviewees stated that there is little evidence of widespread corruption and over the past decades there have not been large corruption scandals in the healthcare sector in Belgium. There are examples of fraud/corruption but they are on a rather isolated and limited scale.

<sup>178</sup> <http://www.oecd.org/els/health-systems/HealthAtAGlanceEurope2012.pdf>.

<sup>179</sup> [http://europa.eu/epc/pdf/joint\\_healthcare\\_report\\_en.pdf](http://europa.eu/epc/pdf/joint_healthcare_report_en.pdf).

<sup>180</sup> [https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing\\_healthcare/Healthcare\\_financing\\_systems](https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing_healthcare/Healthcare_financing_systems).

<sup>181</sup> Health Consumer Powerhouse – EuroHealth Consumer Index 2012: <http://www.healthpowerhouse.com/index.php?Itemid=55>.

In one of the interviews it was mentioned, that the most common way of fraud is that of making non-existent claims by healthcare providers (for example hospitals, doctors, nurses).

***Other types that were mentioned:***

- Very few cases (3 in 10 years) of collusion between insured person and doctor occurred. The aim was to get higher shares of reimbursement through, for instance, the falsification (or false multiplication) of the certification of treatments provided;
- Petty fraud in reimbursement procedures;
- Conflicts of interest (general);
- Conflicts of interest for members of consultancy bodies.

***Relating to procurement, the following types of corruption were observed:***

- Conflict of interest;
- Hidden arrangements between a public official and the bidder, i.e. to ensure that the technical specifications of the product /service to be procured meets the technical characteristics of the product /service a specific company can provide (and possibly is the only one that can provide such product/service);
- Hidden arrangements between bidders;
- Modification of tendering criteria to prefer one specific product/service. In relation to this, an interviewee also mentioned that hospital doctors or members of the administrative council of hospitals could make use of the 'exclusivity' clause (art.17 of the regional law of 24.12.93) indicating that a certain type of service or a certain product, in order to be compatible with those already in use, has to present specific characteristics that can often only be met by one or very few product categories;
- Change in the subject matter of the contract. (The subject of the contract is the basis for the measurable technical specifications that can be applied directly in a public procurement procedure. The subject matter of the contract cannot differ from the subject matter of the procurement procedure).

**Causes and risks**

Various causes and risks were mentioned:

***Control mechanisms:***

- Lack of a risk analysis system and a fraud detection system for the overall health sector (it only exists in the dental care sector). When fraud is detected by one insurance company, the National Institute for Health and Disability Insurance is generally warned after 3 months. This period of time is considered too long by the interviewees;
- A single procurement case is controlled by more than one public service: the administrative regulator has control over the administrative part of the procurement

case, while another public service is responsible for the technical part. As two different controls exist, a risk of a lack of internal coordination might arise. The risk is that the technical service allows for subsidies in a procurement case that has been rejected in its administrative part by the other service.

### ***Legal framework:***

- It is difficult to express in judicial forms what actual fraud is. Illegal behaviours in reimbursement procedures are generally referred to as non-conformity or over-consumption of reimbursement tools. Concerning fraud, it is very difficult to prove in the judiciary the intention of such illegal behaviour. For these reasons, a dossier rarely reaches the judicial level;
- In addition to this, there is no official definition of 'conflict of interest'<sup>182</sup> in Belgium, not in the common language, not in the judicial language nor in medical language;
- In Wallonia, there is no unique legal form for public hospitals. A potential lack of transparency might arise from the fact that the public regulator does not have a clear overall view of the whole hospital sector.

### ***Human resources***

Risk elements that might facilitate the development of corrupt behaviour are the lack of personnel, the consequent mobility of health personnel across regions and countries, and the phenomenon of subcontracting.

### ***Procurement***

The recent legislative developments concerning the use of procurement procedures for the acquisition of goods, services and works in the health sector might also constitute a risk, in a sense that such procedures require skills, training and competences that a regular hospital might not have developed yet. In turn, the obligation to run procurement procedures for all purchases might attract individuals whose aim is to obtain personal financial advantages.

### ***Certification of pharmaceuticals***

Two interviewees indicated that the main risk of corruption originates from the limited choice among the independent health experts, who are responsible – within a health regulatory or advisory body, an international organization, a government laboratory – for the decision whether a pharmaceutical product can enter the market or not. Such experts are chosen according to their specific skills and experience which are considered necessary to carry out analysis, assessments and certifications prior to the entry into the market of certain pharmaceutical products. As there is a limited choice among health experts, this could raise the opportunities for conflicts of interest.

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<sup>182</sup> [http://www.acteo.be/wp-content/uploads/2011/06/LES\\_CONFLITS\\_DINTERETS\\_diaporama.pdf](http://www.acteo.be/wp-content/uploads/2011/06/LES_CONFLITS_DINTERETS_diaporama.pdf).

**Actual and suggested policies and practices:**

The following policies and practices were mentioned:

***Procurement:***

- According to the country expert, the procurement of equipment and pharmaceuticals is centrally and heavily controlled, leaving little room for corruption;
- The harmonization of public controls over public procurements (new law of 15/6/2006 in July 2013): This law will oblige public hospitals to apply the same procurement requirements as all other contracting authorities. This will also facilitate the adoption of coherent decisions among the different public services competent for the controls over different parts of one procurement dossier. Moreover, the 'single window' approach (E-guichet) will enter into force, ensuring a single online management of procurement dossiers within the Wallonian administration. On the one hand, this will allow hospitals to submit only one procurement dossier. On the other hand, the Wallonia region will be able to reply 'with one single voice'.

***Code of conduct on Conflict of Interest***

The code of conduct of the Belgian regulatory body for pharmaceutical products (AFMPS – Agence Federale des medicaments et des Produits de Sante) on conflict of interest for their employees, members of boards and committees and external experts. A contact point exists as well, to whom a person can anonymously disclose information on possible drug law violations.

***Reimbursement system:***

- According to several interviews, due to the reimbursement system that allows for informal payments, corruption risk is minimized. Such a system has been in place for most of the previous century and therefore the population is accustomed to it and it has been improved over time. It also shows that society has developed a low tolerance towards corruption;
- The reimbursement system has undergone reinforced controls, which includes centralized billing procedures, peer reviews and mediation procedures. The insurer keeps close contact with the patient and encourages whistleblowing as a source of information gathering. In order to prevent corruption, the insurer aims to achieve constructive investigations focusing on the dialogue with the suspect;
- In 2010, a reform on the remuneration of pharmacists and wholesalers has taken place. This applies to drugs included on the list of reimbursable pharmaceutical products. The new system aims to foster good pharmaceutical practice by introducing more equal and fair compensations for the given services. Previously, the remuneration was directly linked to the selling price of drugs. Nowadays, the remuneration is decomposed in two parts: i) A margin which is linked to the economic production price of the drug and which must cover the expenses resulting

from the economic activity or the pharmacist; and ii) a margin of the remuneration corresponding to the fees linked to the remuneration of pharmaceutical products, all based on fixed amounts.

***International network:***

- The creation of the European Healthcare Fraud and Corruption Network (EHFCN) and the membership of Belgium. This Network aims to fight cross-border fraud and corruption within healthcare. Belgium is also a member of the UN Global Compact Corruption Network which is a platform for dialogue and for learning and offering guidance to companies on how to implement anti-corruption measures;
- The creation of the Global Compact Corruption Network<sup>183</sup>: By partnering with the UN Office on Drugs and Crime (UNODC), Transparency International (TI), the International Chamber of Commerce (ICC), the World Economic Forum Partnership Against Corruption Initiative (PACI) and the World Bank Institute (WBI), the UN Global Compact contributes to the fight against corruption by providing a platform for learning and dialogue and by offering guidance to companies on how to implement the anti-corruption principles. Currently, 60 Belgian enterprises are registered as members.

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<sup>183</sup> [http://www.unglobalcompact.org/Issues/transparency\\_anticorruption/](http://www.unglobalcompact.org/Issues/transparency_anticorruption/).

## Bulgaria

### General description of the healthcare system<sup>184</sup>

In Bulgaria there is a system of mandatory social health insurance (SHI), which allows for the possibility to take out (additional) voluntary health insurance. The SHI contributions, that finance the National Health Insurance Fund (NHIF), are shared between employer and employee. Unemployed or self-employed citizens have to pay the contributions entirely by themselves. Two other important sources of financing, next to the SHI contributions, are out-of-pocket payments and general taxation. The National Revenue Agency is in charge of pooling the funds for both the central budget and the NHIF.

The NHIF is an autonomous public institution that is independent from the government. It has one national office, Regional Health Insurance Funds (RHIF) in all 28 districts and 105 municipal offices. The NHIF is the sole responsible organisation for the SHI and is the main purchaser of healthcare services in Bulgaria. It is governed by a Supervisory Board (that includes representatives of the government, employers and insured individuals) and the Governor of the Fund (who is elected by the National Assembly). The National Assembly annually has to approve and pass the budget that is submitted by the NHIF.

Every year, the benefit package and prices of services are negotiated between the NHIF and the professional associations of physicians and dentists in Bulgaria<sup>185</sup>. At the end of these negotiations the National Framework Contract (NFC) is signed. The RHIF then contracts providers that meet the criteria in the NFC. Selective contracting is not possible – the RHIF have to sign contracts with all public and private healthcare providers in their territory that satisfy the criteria.

### Delivery of healthcare

Many health service centres are owned by the state, such as the university hospitals, the specialised hospitals at the national level and the centres for emergency medical care and psychiatric hospitals. The RHIF carry out healthcare at the regional level and the municipalities own a significant part of the providers. Moreover, a share of the hospitals and many of the dental care centres, pharmacies and specialised outpatient care centres are in the private sector.

<sup>184</sup> Main sources for this section: Dimova A, Rohova M, Moutafova E, Atanasova E, Koeva S, Panteli D, van Ginneken E. Bulgaria: Health system review. *Health Systems in Transition*, 2012, 14(3):1–186. [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0006/169314/E96624.pdf](http://www.euro.who.int/__data/assets/pdf_file/0006/169314/E96624.pdf) and Neykov I and Salchev P (2012). *asisp Annual National Report 2012 Bulgaria. Pensions, Health Care and Long-term Care*. Downloaded from: [http://www.socialprotection.eu/files\\_db/1206/asisp\\_ANR12\\_BULGARIA.pdf](http://www.socialprotection.eu/files_db/1206/asisp_ANR12_BULGARIA.pdf).

<sup>185</sup> By law four professional medical organisations are established and membership of these associations is mandatory (source: HiT report – Bulgaria, 2012).



<b>Indicators of the healthcare system, 2010 (or nearest year)</b>		
Financing of the healthcare system (1)		
	<i>Bulgaria</i>	<i>EU average</i>
Total health expenditure as % of GDP	7.2%	9%
Public expenditure as % of total health spending	55%	73%
Private insurance as % of total health spending	0%	4%
Private-out-of-pocket as % of total health spending	43%	21%
Organisation of the healthcare system (2)		
Social insurance or tax-based system?	Mixed	
Gatekeeping by a general practitioner (GP)?	Compulsory (with exceptions)	
How are physicians paid? (e.g. salary, fee-for-service, capitation)	Capitation + fee-for-service	
Patient organisation involvement (3=good, 2=intermediary, 1=not-so-good)	3	
Accessibility (3=good, 2=intermediary, 1=not-so-good) (3)		
Family doctor same day access	2	
Major surgery < 90 days	2	
Cancer therapy < 21 days	1	
CT scan < 7 days	2	

Sources: (1) OECD Health at a Glance Europe 2012<sup>186</sup>, (2) Joint Report on Health systems (2010)<sup>187</sup>, HEIDI WIKI<sup>188</sup> and EuroHealth Consumer Index 2012<sup>189</sup>, (3) EuroHealth Consumer Index 2012.

<b>Corruption in healthcare perceptions</b>		
Do you think that the giving and taking of bribes, and the abuse of positions of power for personal gain, are widespread among people working in the public health sector?		
	<i>Bulgaria</i>	<i>EU average</i>
(% of respondents agree - Eurobarometer)	63%	30%
Please indicate on a scale of 1 (= no problem) to 5 (= very serious problem) to what extent corruption is a serious issue in your country (average score of 3 interviewees)		
	<i>Bulgaria</i>	
Informal payments in medical service delivery	3	
Certification and procurement of medical equipment	3.5	
Authorisation and procurement of pharmaceuticals	4	

Sources: Special Eurobarometer 374, table QC4 (fieldwork September 2011); own research (fieldwork February/March 2013).

## Types of healthcare corruption

### Informal payments

Most common practices in corruption in healthcare appear to be related to informal patient payments (giving gifts in-kind and cash payments). Informal payments include

<sup>186</sup> <http://www.oecd.org/els/health-systems/HealthAtAGlanceEurope2012.pdf>.

<sup>187</sup> [http://europa.eu/epc/pdf/joint\\_healthcare\\_report\\_en.pdf](http://europa.eu/epc/pdf/joint_healthcare_report_en.pdf).

<sup>188</sup> [https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing\\_healthcare/Healthcare\\_financing\\_systems](https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing_healthcare/Healthcare_financing_systems).

<sup>189</sup> Health Consumer Powerhouse – EuroHealth Consumer Index 2012: <http://www.healthpowerhouse.com/index.php?Itemid=55>.

all unofficial payments for goods and services that are supposed to be free-of-charge and funded from pooled revenue as well as all official payments for which providers do not receive a receipt. The size of the informal payments was estimated<sup>190</sup> to be equal to 3.6% of public expenditure on health (47.1% of all out-of-pocket payments). Patients usually pay informally to have shorter waiting times for services, to access a specialist without referral, or to secure better conditions and service quality in hospitals.

In July 2010 a nationally representative survey took place with 1003 respondents. In total, 74% of respondents visited a physician during the previous year. About 76% of the users reported out-of-pocket payments for visits and 13% reported informal payments. The average amount paid informally per year for outpatient visits was 92 BGL (about 46 euro). The average probability of hospitalizations was 16%. Two-thirds (66.5%) of the users paid for hospitalization and one-third (32.9%) paid informally as well. The average amount paid informally for inpatient services was nearly twice higher (198 BGL, about 100 euro, per year) than for outpatient services.

According to the interviewees, asymmetry of information in communication between physician and patient is a key feature of health care. Bulgarian patients do not know what is covered by health insurance, what part of a treatment they can receive free of charge and what charges they should pay. Health care providers often speculate with patient's dependent position, which results in a large number of informal payments in the sector.

In 2006, a Ministry of Health ordinance was passed, which allowed patients to choose a physician or treatment team at prices set by the hospitals. This has become another way for health care providers to raise funds by formalising these payments. Patients are often not aware that they can avoid these payments, if they decide to forego the free choice of physicians. Sometimes, according to an interviewee, patients are even forced by health care providers to make such a choice, without being informed that they will have to pay for this.

### ***Procurement of medical equipment***

A general consensus from the interviews have suggested that the scale of corruption in procurement is endemic with prearranged tender or no public procurement taking place at all. The opportunities and loopholes of the Public Procurement Act are used to achieve this as well as participation in secret collusions and the paying and receiving of bribes. The corruption in procurement is so institutionalised, that it has almost become the norm.

### ***Authorisation and procurement of pharmaceuticals***

The interviewees stated that situation in the procurement of pharmaceuticals is also very grave. Special committees in the hospitals usually include people, usually lawyers who are well equipped to make the best use of the loopholes of the Public

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<sup>190</sup> The estimate has been identified in one of the national cases.

Procurement Act for their own interest and with the aim to carefully tailor ToR to only one company.

Pharmaceutical companies also send the physicians to seminars abroad. They make a variety of gifts including the so called credit points, which physicians 'collect' in order to prove the improvement in their qualification.

### ***Extent of corruption in society***

According to the interviewees, the Bulgarian society is convinced that the intrusion of corruption in every step in the health system is so bad that it would simply not work without it. The political involvement is staggering and the judicial system is unreliable and itself susceptible to corruption. Such environment simply encourages corruption as an alternative means to the system. Together with a culture of such system the Bulgarian health system is perceived by as chronically corrupt.

### **Causes and risks**

Several reasons came out from the interviews that besides greed, the limited number of successful and timely prosecutions of corruption indicate a relative risk-free environment to conduct corruption.

Other reasons identified by the interviewees:

### ***A weak control and audit systems***

Various structures have been created in the country (including in the health system). Behaviour algorithms have been developed, but they do not work adequately because they have not been fully accepted by the professional community and are not treated as obligatory. Bad cases are not detected and even if reported they are not punished. Under the Law for Financial Management and Control in the Public Sector adopted in 2006, all institutions from public sector can create commissions and regulations to combat corruption (i.e. it is not compulsory, but rather recommendable). This process is controlled by the Ministry of Finance and in practice these structures exist only formally. They take action only when cases of corruption become publicly visible.

### ***Limited or no engagement civil society in the oversight of policy and services***

Citizens do not appear to trust the justice system, nor do they often have the financial means to initiate proceedings against doctors or medical facilities. Civil society engages in the discussion on corruption practices only after media reports of bad practices, but usually citizens' reactions are limited to private debates or over internet forums.

***Cultural attitudes***

Patients believe that if they want to get the best quality services from the most qualified doctors they will have to use informal ways - to pay out of pocket money (cash and gifts in kind) for the sake of their life and health or the life and health of their relatives. It is an open question in society whether both giving money or gifts to doctors before or after treatment is really corruption.

***Inconsistent legislation (loopholes)***

Frequent changes in regulations (Health Insurance Act has changed over 20 times) and the existing contradictions between laws reinforce the confusion and create good ground for corruption. This includes frequent minister change (four ministers of health changed within the mandate of the last government), each bringing new changes in the regulations and management style of the department adding to the inconsistency an allowing space for corrupt practices to omit discovery.

***The salaries of healthcare providers are low and/or irregular***

Health professionals are undervalued and not well paid. Although the specialized outpatient care is paid on a fee-for service basis, these remunerations are not very high. The general practitioner (GP) is a gatekeeper to the access to specialist and patients always needs their referrals. Unlike the specialists who receive additional fees for their services, GPs are paid on a mainly 'per capita' system. The low remunerations of Bulgarian health care providers (especially the GPs) motivate corrupt behaviour as informal payments are one way to increase income.

Another consequence of this is the on-going exodus of Bulgarian doctors and nurses to other EU countries, putting further pressure on the already struggling system.

**Actual and suggested policies and practices*****Transparency***

Information on the fees and how to pay them is posted in front of all offices and labs. A box for signals as well as a complaint book is being placed on a visible place. A special complaint committee, whose role is not only to respond to complainants, but also to examine the cases and inform the managers, is being set in 2008. Another positive step to curbing corruption is the introduction of a central registration system, which requires that all payments take place at the cashier. This has been said during the interviews decreases the informal payments during the visits to the medical specialists.

***Focused governmental institution***

The Executive Agency 'Medical Audit' is a subordinate to the Minister of Health and signals of corruption can be handed in to the agency. These cases are subject to

verification. Over 70% of them are fully justified. This newly created agency (in March 2010) received 553 complaints from patients in 2010, 73% of which were related to the quality of care (failure to comply with medical standards and untimely or inadequate care) and 14% were related to corruption<sup>191</sup>.

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<sup>191</sup> As revealed by our national cases, research and interviews.

## Croatia

### General description of the healthcare system<sup>192</sup>

After the health care reform in 2005, the Croatian healthcare sector has become increasingly decentralized. At the central level, the Ministry of Health is responsible for policy-making, planning and evaluation and public health programmes. The responsibility for the management of health services at the local level have been delegated to municipalities and local authorities.

The Croatian Health Insurance Institute (HZZO) is a main actor in the health sector as it is responsible for the financing and budgeting of the Health Insurance Fund.

The health insurance system is mainly funded by a combination of health insurance contributions of employers and employees. Complementary financial resources are out-of-pocket payments and private health insurance. In line with the decentralization of health care services, local governments increasingly contribute to the public expenditures in health care.

### Health care delivery

An important role in the Croatian health care delivery is assigned to primary care physicians, which serve as gate keepers of the health system. Patients are obliged to sign up with a specific general practitioner. Access to secondary care can only be obtained after a referral by the patients' GP. Secondary care is mainly provided by public, county-owned hospitals.

The financing of hospitals is characterized by a two-tiered system. Where investments in capital and technology are state funded, direct services are reimbursed by an input based, fee-for-service system. Additionally, hospitals are confronted with an annual budget cap. In 2002, Croatia has introduced a performance based payment system to stimulate an efficient use of resources for some high volume and costly interventions. Aim of this new strategy is cost containment and reduction of waiting list for these cases. This payment system has slightly decreased the length of stay in hospitals.

The health care reform in 2006 partly aimed to stimulate free choice of provider.

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<sup>192</sup> Main sources for this section: Voncina L, Jemai N, Merkur S, Golna C, Maeda A, Chao S, Dzakula A. Croatia: Health system review. *Health Systems in Transition*, 2006; 8(7): 1–108.  
[http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0010/96445/E90328.pdf](http://www.euro.who.int/__data/assets/pdf_file/0010/96445/E90328.pdf) and Vončina, L. et al. 2012. 'Croatian 2008–2010 health insurance reform: hard choices toward financial sustainability and efficiency'. *Croatian Medical Journal* 53(1): 66–76.

<b>Indicators of the healthcare system, 2010 (or nearest year)</b>		
<b>Financing of the healthcare system (1)</b>		
	<i>Croatia</i>	<i>EU average</i>
Total health expenditure as % of GDP	7.8%	9%
Public expenditure as % of total health spending	85%	73%
Private insurance as % of total health spending	1%	4%
Private-out-of-pocket as % of total health spending	15%	21%
<b>Organisation of the healthcare system (2)</b>		
Social insurance or tax-based system?	Social insurance	
Gatekeeping by a general practitioner (GP)?	Public: compulsory	
How are physicians paid? (e.g. salary, fee-for-service, capitation)	Capitation	
Patient organisation involvement (3=good, 2=intermediary, 1=not-so-good)	3	
<b>Accessibility (3=good, 2=intermediary, 1=not-so-good) (3)</b>		
Family doctor same day access	3	
Major surgery < 90 days	1	
Cancer therapy < 21 days	2	
CT scan < 7 days	1	

Sources: (1) OECD Health at a Glance Europe 2012<sup>193</sup>, (2) Joint Report on Health systems (2010)<sup>194</sup>, HEIDI WIKI<sup>195</sup> and EuroHealth Consumer Index 2012<sup>196</sup>, (3) EuroHealth Consumer Index 2012.

<b>Corruption in healthcare perceptions</b>		
<b>Do you think that the giving and taking of bribes, and the abuse of positions of power for personal gain, are widespread among people working in the public health sector?</b>		
	<i>Croatia</i>	<i>EU average</i>
(% of respondents agree - Eurobarometer)	NA	30%
<b>Please indicate on a scale of 1 (= no problem) to 5 (= very serious problem) to what extent corruption is a serious issue in your country (average score of 3 interviewees)</b>		
	<i>Croatia</i>	
Informal payments in medical service delivery	NA	
Certification and procurement of medical equipment	NA	
Authorisation and procurement of pharmaceuticals	NA	

Sources: Special Eurobarometer 374, table QC4 (fieldwork September 2011); own research (fieldwork February/March 2013).

According to the interviewees, the level of corruption in the health care in Croatia is in general decreasing, which is due to: strong anticorruption campaigns, high sensitivity of the general public, the media towards corruption and several cases that ended up in court.

<sup>193</sup> <http://www.oecd.org/els/health-systems/HealthAtAGlanceEurope2012.pdf>.

<sup>194</sup> [http://europa.eu/epc/pdf/joint\\_healthcare\\_report\\_en.pdf](http://europa.eu/epc/pdf/joint_healthcare_report_en.pdf).

<sup>195</sup> [https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing\\_healthcare/Healthcare\\_financing\\_systems](https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing_healthcare/Healthcare_financing_systems).

<sup>196</sup> Health Consumer Powerhouse – EuroHealth Consumer Index 2012: <http://www.healthpowerhouse.com/index.php?Itemid=55>.

### **Types of healthcare corruption**

In the interviews the following types were identified:

- Paying and receiving bribes:
  - Bribing doctors to obtain timely treatment, including to avoid waiting lines;
  - Bribing nurses to get better healthcare services.
- Clientelism / favouritism / nepotism;
- Corruption in procurement: Technical specifications are modified to favour one manufacturer;
- One of the interviewees indicated that it is common practice in Croatia for pharmaceutical companies to offer certain benefits to doctors who prescribe their drugs.

### **Causes and risks**

Various causes and risks were mentioned by interviewees:

- Large administrative burden can be seen as a cause for corruption in the field of medical products and medical devices;
- The lack of transparency and information (these areas are currently being improved);
- Control and audit mechanisms (currently there are only three Inspectors in Croatia, which is not sufficient, which leads to a lack of capacity for inspections and controls. Monitoring and inspection staff are not well enough trained for their job);
- Regulatory framework is too strict and not flexible;
- Waiting lists in hospitals are too long;
- Economic factors: Low salaries; Lack of appreciation for hard working or extraordinary efforts (Many doctors feel they 'deserve' extra gifts from patients);
- Beliefs, attitudes, social value system: 'General acceptance' of gifts from patients to medical doctors; offers of pharmaceutical companies to sponsor participation of medical doctors attending conferences/seminars abroad, etc.; but on the other side the low level of moral responsibility and integrity of doctors and medical staff, i.e. low resistance towards corruption.

### **Actual and suggested policies and practices**

The following policies and practices were mentioned in the interview reports as good practices:

#### ***Action Plan Anti-Corruption Strategy (2012):***

Successful measures are:

- Introduction of a national waiting list which is publicly available;
- Introducing eBooking;
- Insight into the overall ordering process;



- Integration of hospital procurement for hospitals;
- Supervision of the execution of contractual obligations and spending of funds from the statutory medical insurance;
- Unified procurement of medical equipment and supplies;
- Decision on the registration of the drug; Import and export permissions.

### ***Policies related to registration and authorisation of medical products***

A strong ethical code exists within the Agency for medical products and medical devices (HALMED):

- Every document is double-checked and has 2 different signatures;
- A minimum of 20 people from the Agency is involved in the process (there are 17 experts in the Committee for registration and an additional 12 external experts – which makes it almost impossible to influence a decision of the Agency);
- There is thorough checking on possible conflicts of interest;
- Employment in the Agency is only possible for those with proven absence of links to clients;
- Inspection of traders of medical devices are always performed by a minimum of 2 persons, and they are not allowed to stay alone with the client;
- Good salaries in the Agency reduce the risk of corruption;
- Flexibility with the speed of the procedure;
- All the permits given are publicly known: they are published on the website of the Agency.

### ***Agreement on Ethical Advertising of Medicines (example of a good and bad practice):***

- According to this Agreement, health care workers should not be involved in the procurement or prescription of drugs;
- The Agreement does *not prevent* corruption because the medical chamber has limited equal say in their decision-making and/or procedures;
- At the same time this Agreement is very difficult to control;
- Penalties for unethical promotion of medicines include: deleting drugs from the list, informing the public about unethical promotion and annul refunds.

Despite discussions about the usefulness of this Agreement, it was signed by almost all pharmaceutical firms present in the Republic of Croatia.

## Cyprus

### General description of the healthcare system<sup>197</sup>

Cyprus is the only European country in which the public and private health system are of approximately the same size. The public system provides peoples with free healthcare services and does not include any significant cost-sharing measures. It is financed through the state budget; the Ministry of Finance collects the public revenues and allocates annual budgets to all Ministries, including the Ministry of Health. The private system is largely financed through out-of-pocket (OOP) payments. Voluntary health insurance plays a minor role in Cyprus.

The public system is a centralised system which is closely controlled by the Ministry of Health, whereas the private system is largely unregulated. The fragmentation of the system leads to many inefficiencies and creates the risk for duplications resulting from poor communication. An example of these inefficiencies are the long waiting lists in the public sector while the expensive medical technology in the private sector is underutilised. Moreover, the high level of OOP payments raises concerns with regard to affordability and access to the health system.

To address the inefficiencies associated with the current system a new health insurance scheme has been designed. Because of the associated costs, it has not yet been implemented. In 2012 the Cabinet recommitted to the reform and it is now expected to come into effect in 2016<sup>198</sup>. The new General Health Insurance Scheme has been designed to introduce competition between sectors through new payments systems and to provide universal coverage. It will be funded through a combination of taxes, social insurance contributions by both employees and employers and co-payments. All sources of financing will be pooled into a central fund that will be administered by the Health Insurance Organisation, which will also be the sole purchaser within the new system.

### Healthcare delivery

The public and private healthcare delivery systems exist in parallel. Public facilities are under direct control of the Ministry of Health and the physicians and other medical staff are civil servants that are paid a salary. In the private sector, most providers and facilities are independent and physician-owned or private companies in which physicians own shares.

There are also several minor healthcare delivery subsystems in Cyprus such as the Union Schemes that provide mostly primary care services through their own network

<sup>197</sup> Main sources for this section: Theodorou M, Charalambous C, Petrou C, Cylus J. Cyprus: Health system review. *Health Systems in Transition*. 2012; 14(6):1–128. [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0017/174041/Health-Systems-in-Transition\\_Cyprus\\_Health-system-review.pdf](http://www.euro.who.int/__data/assets/pdf_file/0017/174041/Health-Systems-in-Transition_Cyprus_Health-system-review.pdf) and Petmesidou M (2012). asisp Annual National Report 2012 Cyprus. Pensions, Health Care and Long-term Care. Downloaded from: [http://www.socialprotection.eu/files\\_db/1209/asisp\\_ANR12\\_CYPRUS.pdf](http://www.socialprotection.eu/files_db/1209/asisp_ANR12_CYPRUS.pdf).

<sup>198</sup> Cylusa, J., Papanicolasb, I., Constantinouc, E. and Theodoroud, M. (2013). 'Moving forward: Lessons for Cyprus as it implements its health insurance scheme». *Health Policy*. Volume 110, Issue 1, pp. 1–5.

and there are schemes by the semi-state (e.g. the Electricity Authority of Cyprus) that use private providers.

Indicators of the healthcare system, 2010 (or nearest year)		
Financing of the healthcare system (1)		
	Cyprus	EU average
Total health expenditure as % of GDP	7.4%	9%
Public expenditure as % of total health spending	43%	73%
Private insurance as % of total health spending	6%	4%
Private-out-of-pocket as % of total health spending	49%	21%
Organisation of the healthcare system (2)		
Social insurance or tax-based system?	State budget + Out-of-pocket payments	
Gatekeeping by a general practitioner (GP)?	Not yet; Reform plan	
How are physicians paid? (e.g. salary, fee-for-service, capitation)	Public: Salary / Private: FFS	
Patient organisation involvement (3=good, 2=intermediary, 1=not-so-good)	3	
Accessibility (3=good, 2=intermediary, 1=not-so-good) (3)		
Family doctor same day access	3	
Major surgery < 90 days	1	
Cancer therapy < 21 days	3	
CT scan < 7 days	1	

Sources: (1) OECD Health at a Glance Europe 2012<sup>199</sup>, (2) Joint Report on Health systems (2010)<sup>200</sup>, HEIDI WIKI<sup>201</sup> and EuroHealth Consumer Index 2012<sup>202</sup>, (3) EuroHealth Consumer Index 2012.

<b>Corruption in healthcare perceptions</b>		
<b>Do you think that the giving and taking of bribes, and the abuse of positions of power for personal gain, are widespread among people working in the public health sector?</b>		
	<i>Cyprus</i>	<i>EU average</i>
(% of respondents agree - Eurobarometer)	60%	30%
<b>Please indicate on a scale of 1 (= no problem) to 5 (= very serious problem) to what extent corruption is a serious issue in your country (average score of 3 interviewees)</b>		
	<i>Cyprus</i>	
Informal payments in medical service delivery	2	
Certification and procurement of medical equipment	3	
Authorisation and procurement of pharmaceuticals	2	

Sources: Special Eurobarometer 374, table QC4 (fieldwork September 2011); own research (fieldwork February/March 2013).

<sup>199</sup> <http://www.oecd.org/els/health-systems/HealthAtAGlanceEurope2012.pdf>.

<sup>200</sup> [http://europa.eu/epc/pdf/joint\\_healthcare\\_report\\_en.pdf](http://europa.eu/epc/pdf/joint_healthcare_report_en.pdf).

<sup>201</sup> [https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing\\_healthcare/Healthcare\\_financing\\_systems](https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing_healthcare/Healthcare_financing_systems).

<sup>202</sup> Health Consumer Powerhouse – EuroHealth Consumer Index 2012: <http://www.healthpowerhouse.com/index.php?Itemid=55>.

## **Types of healthcare corruption**

Interviewees noticed the following corruption types:

- Informal payments are mainly observed in medical service delivery, notably obstetricians-gynaecologists;
- Long waiting times force patients to offer money or gifts to the doctors;
- Another practice mainly used by surgeons in the public sector, is when doctors direct their patients to their private clinics for operation, which involves an extra payment (patients may 'choose' for this alternative in order to avoid the long waiting time of the public sector for elective surgeries);
- Many hospital doctors tend to order implants and consumables (i.e. pacemakers, stents) from specific import companies which creates suspicion that they receive gifts or money from these companies. In some cases there is conflict of interest when procurement decision makers have a direct link with import companies;
- Corruption in decision making processes for patient authorizations and for coverage of the medical expenses for treatment abroad;
- On a smaller scale, corruption is observed in the supply of medical equipment, where decisions are taken mostly by civil servants of the Ministry of Health, without the necessary knowledge and expertise.

## **Causes and risks**

The following causes and risks were mentioned:

- The health system itself does not possess mechanisms to secure transparency of procedures in the Procurement System and to provide effective tools of control and management;
- The fact that the supply of consumables is centralised at the Ministry of Health might create favourable conditions for corruption;
- Within the public health service, there is no internal audit to impose penalties and punishments when irregularities are reported;
- The health system lacks accountability towards citizens who do not participate at any decision making level and are not being informed on health issues, which makes them passive receivers of inadequate pharmaceutical and medical coverage/services;
- The lack of punishment in cases of corruption.

## **Actual and suggested policies and practices**

***With regard to complaints and opinions the following policies are considered to be a good practice:***

- The law for the Safeguarding and Protection of Patients' Rights. This law required the establishment of a Complaints Examination Committee in each district resulting in a better and more effective system for management of patients' complaints;

- The established practice of the Ministry of Health to request the opinion of interest groups (patients, citizens, providers, trade unions, local authorities) before major policy changes, and the participation of employers and employees in the governing board of Health Insurance Organization.

***More rules and laws:***

- The Tender Review Authority, the guardian of law, legal procedures and regulations regarding public procurement. Interviewees saw the establishment of this authority as an important step forward towards more transparency and less corruption in the health sector;
- The adoption of the European Council Directive 89/105/EEC, for more transparency of national provisions regulating the pricing and reimbursement of medicinal products;
- The involvement of the police in the investigation and prosecution of public hospitals' surgeons working illegally in the private sector;
- The composition of committees, responsible to make the decisions for validating the tenders, are considered to be a bad practice. They consist of civil servants working for the Ministry of Health, who sometimes not have the necessary knowledge of the material and equipment they order.

***Suggestions:***

- The centralized administration system of procurement is stated not to be very effective in combating corruption. Decentralization of the system and the delegation of procurement responsibilities to public hospitals could be a positive step forwards;
- Better management of the appointment system for outpatient departments, diagnostic tests, and waiting lists in hospitals to reduce external interventions and to limit the opportunities for a physician to ask for informal payments from patients (this means the appointments are not under the doctors' influence and interventions);
- Expansion and completion of integrated IT systems in all public hospitals;
- A committee for internal auditing should be set up in the Ministry of Health with the authority to control and impose penalties where and when irregularities are detected during process of procurement tendering;
- Responsibilities, such as the preparation of the tenders and the evaluation of offers for all consumables of each public hospital separately, can increase transparency. The hospital manager will have the incentive for cost containment policies and, in this way, the corruption will be minimized. However, this firstly requires the autonomy of hospitals on their own budget and management team;
- According to the interviewees, the current institutional framework is relatively effective in promoting transparency and combating corruption, though it is not fully or properly implemented and this is considered as a serious weakness and negative practice which leads to corruption in health care.

## Czech Republic

### General description of the healthcare system<sup>203</sup>

Main features of the Czech Republic healthcare system are mandatory social health insurance, privately owned health facilities and free choice of provider. The healthcare system is authorised by three main actors which are the Ministry of Health, regional authorities and health insurance funds. The main responsibility of the Ministry of Health is health policy-making together with the preparation and enforcement of the health legislation. Both the regional authorities and the health insurance funds are charged with providing equal access to health care. The regional authorities' task is to register health care providers. Being the main purchasers of health care, the health insurance funds are required to contract the providers.

Health care in Czech Republic is primarily funded by Social Health Insurance (SHI), which consists of mandatory employer and employee SHI contributions. The self-employed are obliged to pay a share of their profit as SHI contribution. Since 2009, ten health insurance funds are responsible for the collection of the SHI contributions. The remaining funding stems from state SHI contributions which compensate for the unemployed citizens.

### Healthcare delivery

The healthcare delivery system is not based on a gatekeeping system. Patients can freely choose their provider, whether it concerns a general practitioner or a specialist. Patients need to sign up with a primary care physician, however they are allowed to switch between primary care physicians every three months. Primary care as well as secondary care is mainly provided by privately owned healthcare providers/facilities.

Payments of general practitioners are based on capitation and a fee-for-service scheme. As of 2007, hospitals are financed by a combination of performance based payments (diagnosis-related groups), global budgets and fee-for-service. Noteworthy is the ex post risk adjustment of funds by redistributing SHI contributions based on the age and gender of their insured.

<sup>203</sup> Main sources for this section: Bryndová L, Pavloková K, Roubal T, Rokosová M, Gaskins M and van Ginneken E. Czech Republic: Health system review. *Health Systems in Transition*. 2009; 11(1): 1-122. [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0010/97633/E92968.pdf](http://www.euro.who.int/__data/assets/pdf_file/0010/97633/E92968.pdf) and Holub M and Havá P (2012). asisp Annual National Report 2012 Czech Republic. Pensions, Health Care and Long-term Care. Downloaded from: [http://www.socialprotection.eu/files\\_db/1212/asisp\\_ANR12\\_CZECH\\_REPUBLIC.pdf](http://www.socialprotection.eu/files_db/1212/asisp_ANR12_CZECH_REPUBLIC.pdf).

<b>Indicators of the healthcare system, 2010 (or nearest year)</b>		
<b>Financing of the healthcare system (1)</b>		
	<i>Czech Republic</i>	<i>EU average</i>
Total health expenditure as % of GDP	7.5%	9%
Public expenditure as % of total health spending	84%	73%
Private insurance as % of total health spending	0%	4%
Private-out-of-pocket as % of total health spending	15%	21%
<b>Organisation of the healthcare system (2)</b>		
Social insurance or tax-based system?	Social insurance	
Gatekeeping by a general practitioner (GP)?	Not necessary	
How are physicians paid? (e.g. salary, fee-for-service, capitation)	FFS/Capitation	
Patient organisation involvement (3=good, 2=intermediary, 1=not-so-good)	2	
<b>Accessibility (3=good, 2=intermediary, 1=not-so-good) (3)</b>		
Family doctor same day access	3	
Major surgery < 90 days	2	
Cancer therapy < 21 days	2	
CT scan < 7 days	2	

Sources: (1) OECD Health at a Glance Europe 2012<sup>204</sup>, (2) Joint Report on Health systems (2010)<sup>205</sup>, HEIDI WIKI<sup>206</sup> and EuroHealth Consumer Index 2012<sup>207</sup>, (3) EuroHealth Consumer Index 2012.

<b>Corruption in healthcare perceptions</b>		
<b>Do you think that the giving and taking of bribes, and the abuse of positions of power for personal gain, are widespread among people working in the public health sector?</b>		
	<i>Czech Republic</i>	<i>EU average</i>
(% of respondents agree - Eurobarometer)	33%	30%
<b>Please indicate on a scale of 1 (= no problem) to 5 (= very serious problem) to what extent corruption is a serious issue in your country (average score of 4 interviewees)</b>		
	<i>Czech Republic</i>	
Informal payments in medical service delivery	2	
Certification and procurement of medical equipment	4.25	
Authorisation and procurement of pharmaceuticals	2.5	

Sources: Special Eurobarometer 374, table QC4 (fieldwork September 2011); own research (fieldwork February/March 2013).

## Types of health care corruption

The following prevailing types of corruption were mentioned by the interviewees:

<sup>204</sup> <http://www.oecd.org/els/health-systems/HealthAtAGlanceEurope2012.pdf>.

<sup>205</sup> [http://europa.eu/epc/pdf/joint\\_healthcare\\_report\\_en.pdf](http://europa.eu/epc/pdf/joint_healthcare_report_en.pdf).

<sup>206</sup> [https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing\\_healthcare/Healthcare\\_financing\\_systems](https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing_healthcare/Healthcare_financing_systems).

<sup>207</sup> Health Consumer Powerhouse – EuroHealth Consumer Index 2012: <http://www.healthpowerhouse.com/index.php?Itemid=55>.

***Informal payments***

From the interviews it arose that there are several non-life threatening procedures, which are still susceptible to informal payments. These are cases when the patient feels great discomfort (such as hip issues) but is not detrimental to one's health. The other example is gynaecology and child birth, which are highly personal procedures, where women are very keen to ensure a trusted doctor at their side. The current going rate is CZK20 000 (800 euro) in order to guarantee the doctor's availability for child birth. There have been attempts legalised and formalised such process with the fees being split between the hospital and the doctor, but this has not caught on.

***Procurement***

In procurement offering kickbacks (money and non-monetary kickbacks) is by far the most common way. The corruption in the procurement of medical equipment is a very serious issue and has become deep seated and institutionalised. Such worrying development has meant that politicians, companies, hospital management and local authorities have all become involved and have a stake in continuing the corrupt mechanism. The methods are complex and well thought through making their eradication difficult. The procurement and authorisation of pharmaceuticals is much less of an issue due to tighter regulation and initiative by the Czech state to tackle the problem.

***Procurement and authorisation of pharmaceuticals***

The creation of SUKL (national certificatory body and price setter) the problem of overpriced pharmaceuticals has been greatly diminished. This was combined with a substantial internal clean up of the practices of big pharmaceutical companies, which were prosecuted for active involvement in corruption. As a result the sector has been cleaned up in terms of the company-regulator relationship and is improving in terms of the company-doctor one.

***Procurement of medical equipment***

According to the interviewees, the main problem is the interconnectivity of politics and corruption, which is inseparable and institutionalised. The structure of political integration and implication with corruption is by large managed by powerful individuals in the back ground of a political party, but in fact are the key decision makers/instigators. These 'eminence grise' or specific facilitators ('kompletator') influence the front public figures (such as ministers) as well as appoint and then control the executive public officials such as the directors of hospitals (the 'white horses'), who are told to tailor the TOR to a selected winner. They do this most frequently by trading in influence (such as political support in key voting or promising a seat at a prominent and well paid board of directors of a state/municipal company) or alternatively by kickbacks and political party funding. At the same time they are also the connection with business that channel and realise their ambitions through them (for a reward). In fact these figures are the masterminds of corruption.



During the late 2000's with a vast inflow of EU money, the number of facilitators exploded with no value added, but, according to one interviewee on average increasing the price of equipment by 15%-30%.

### ***Extortion***

According to the interviewees, is also conducted on this level, when a company that has lost the tender goes to, say, the director of a hospital and explains that it will keep attacking the tender in court, therefore delaying it and preventing the hospital from operationalizing the machinery in its deadline. They demand a sum in order not to proceed with such legal action and hide it by arranging fake training or consultations somewhere else. Such extortion is very difficult to prevent as it is almost impossible to spot and is based on legal procedure.

### **Causes and risks**

Interviewees mentioned the following causes and risks:

- Most interviewees mentioned greed as the main motivation for corruption;
- The lack of reliable and independent control mechanism allow corruption to take place;
- Together with the political backing and active involvement of politicians this creates an environment that makes corruption a relatively risk free and profitable endeavour.

### **Actual and suggested policies and practices**

#### ***Increasing independence and efficiency of police and public prosecution:***

- Over the past couple of years there has been a significant shift from within the police and the public prosecution office (with extensive literature written about this topic as well as all interviewees confirming this). The police have become braver and willing to investigate even prominent members of the establishment. Importantly they have improved their techniques and prevented previous information leaks about on-going investigations and especially the undercover ones. On top of that the newly appointed chief public prosecutors continued to support such endeavours of the police and pushed several high profile cases in front of the courts. This development has meant that corruption is beginning to be prosecuted resulting in increasing the risk of committing corruption;
- The arrest of a top Czech politician and doctor by special police and secret police operations during the act of accepting a bribe, and his subsequent prosecution, has sent a wave across the nation. The capture of such a 'big fish' has signalled that the authorities have grown independent and brave enough to increasingly effectively fight corruption. As a result the risks of corruption have gone up significantly and especially in the central Bohemia region all public procurement officers are scared of being spied on by the secret services and as a consequence corruption has gone down dramatically. In recent month this tendency has continued with the biggest police undercover operation that has led to several very high profile arrests and has

led to the fall of the government due to the Prime Ministers chief of staff's involvement.

### ***Abolition of anonymous shares***

One method of delivering kickbacks to the correct people was with the use of secret (anonymous) shares in a company that he can sell at a later stage without the need to declare his acquisition. These shares thus allowed a corrupt official to secretly own a part of any company (or most often a specially created one) and when he left office he could sell his share and thus collect his reward for participating in the corrupt project. The Czech Republic was, until May 2013, one of the last places (in EU the only) countries that allow the holding and transaction of such shares. The government has passed legislation forcing companies to register the owner of shares with the company house from the start of 2014, thus eradicating an easy means of corruption.

### ***Medical co-funding and its positive externality***

After the formation of the last centre right government in 2010, the governmental initiated a widespread healthcare reform. Besides other initiatives it introduced mandatory payment to doctors and hospitals as co-participation in healthcare by the patients.

The scheme constitutes of a tiny payment of CZK30 (1.20 euro) every time one consults a doctor and CZK100czk 4 euro per day spent in the hospital. The aim of this has been to increase citizen participation (besides taxes this is the only co-participation) in the increasingly expensive healthcare system and also to decrease non-essential visits to a doctor or prolonged stays in hospitals (evaluated to have been a major issue in the land). This move has been deeply unpopular with the general public and senior citizens.

According to industry experts as a positive externality it has largely wiped out informal payments since the people feel that already they are voting with their feet and paying the right doctor.

### ***SUKL & standard pricing of pharmaceuticals***

SUKL (State Institute for Drug Control) is responsible for authorisation of pharmaceuticals, oversight of the use and sale of pharmaceuticals by pharmacies and medical facilities and the setting of maximum price of pharmaceuticals. Overall SUKL is well respected and the authorisation of pharmaceuticals thorough with tight controls. The price setting is conducted by an innovative mechanism, which first evaluates the benefits of the new pharmaceuticals (or reevaluates generics), before placing them into categories that have a standard price attached to it. Innovative products that are not easily categorised are assessed on a more individual and closer basis. Lastly all finding are publicly available and open to public consultation and debate, with the aim of the system to be flexible to adapt to new market situations and innovations. Such a mechanism has already demonstrated its value, where,

according to the interviewees, it has almost halted corrupt methods in overpricing medicine.

### ***DRG payments***

The introduction in 2008 of a DRG payment system has meant that medical institutions are reimbursed per category of ailment. This means that ailment types have been categorised and each treatment of the category has been given a standard price. If it turns out that the procedure can be done more effectively the medical institution can retain a larger margin of the fee (providing that the patients troubles are solved well). It is a stark contrast to the previous system, which saw insurance companies reimbursing per item of procedure. This incentivised medical institutions to prolong the process including unnecessary steps (sometimes even completely unnecessary operations). The DRG system should incentivise hospital management to focus on improving the efficiency of their facility in order to provide healthier financial results. Furthermore it means that the cost of corruption (in say an overpriced machine) is absorbed by the institution rather than the insurer or the state. Refocusing the responsibility structure and increasing the disincentives for corruption is key, as any cost is felt by the organisation itself in its ability to function effectively.

### ***Control mechanisms***

Several interviewees have stated that the control mechanism (auditors & financial inspection) does not work in the Czech Republic. It has been evaluated by the EC as the most unreliable in the EU<sup>208</sup>. When a case is taken forwards to the courts, the Czech judicial system has such long (inefficient) process and delays that there is scope for interference, key people moving on or simply fizzling out. In the event that it is followed it is the 'white horse' that takes the blame, rather than the real mastermind behind the operation.

The government has been very meek in its reform of the control mechanism; however the European Commission and European Court of Auditors have not. In March 2012 the Commission froze all transfer of structural funds as a response to poor control mechanism and high error rate in public procurements. As a consequence a region affected has reorganised the board of directors of its hospitals and introduced tougher internal controls (audit on anything over 50million CZK). It has shaken up the old structures and reformed the way in which hospitals are run.

In fact several interviewees would like to see greater involvement and power of the European institutions to ensure an objective control mechanism.

A secondary reason of slowly improving control mechanisms and declining levels of corruption is the current deep and on-going economic crisis. There is simply less money to provide the same standard of care and as a result any inefficient use of resources is closely scrutinised and noticed. The crisis and continued healthcare reform has made corruption more visible and therefore more risky.

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<sup>208</sup> DG Regio Annual Activity Report 2012 [http://ec.europa.eu/atwork/synthesis/aar/doc/regio\\_aar\\_2012.pdf](http://ec.europa.eu/atwork/synthesis/aar/doc/regio_aar_2012.pdf).

***Failure of formalised payments system***

The ministry of health has made an attempt in the summer of 2011<sup>209</sup> at formalising payments to allow for a transfer of a select doctor. The aim was to mimic what already happens in informal payments, but in a transparent and legal way. It also includes the opportunity to pay for better equipment and treatment, for instance a higher quality hip replacement that is considered by the legislator as adequate and is covered by the insurer. Unfortunately in practice it has not taken off and is not used. The main reason behind this is the limited incentives for the doctors to participate. Since the payments were to be shared with the hospital as well as taxed, they amounted to roughly a fifth of the going rate informally.

***Negative impacts of governmental redistribution policy***

According to several sources, last year a number of insurers finished their financial year with a positive balance, while others ended with a loss. Despite the fact that all of these insurers are private not-for-profit organisations and that they all are required to have a contingency reserve fund, it was viewed important by the ministry of health to intervene. The legal basis was that health insurance is mandatory and therefore all payments constitute public money. The profits of the successful insurers were taken and redistributed to the struggling ones (6bn CZK, around 240 million euro). Insurers naturally react to the change of incentives and as a result the following financial reports showed all insurers making a loss. Besides the apparent disincentive for efficiency and profit making, this was an opportunity missed. If instead the authorities allowed for the profit to be used in allowing for lower insurance payments to be requested (the minimum payments are set for all citizens by the state), it could have allowed for price competition between insurers. Instead of the gains and more effective market, the market incentives have been decimated, the repercussion of which will last for a long time.

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<sup>209</sup> <http://www.leosheger.cz/news/standard-nadstandard-vase-nejcastejsi-otazky/>.

## Denmark

### General description of the healthcare system<sup>210</sup>

Denmark has a statutory health system that is compulsory, universal and provides free access to a wide range of healthcare services. It allows for the purchase of voluntary health insurance. The health system is fairly decentralised; the five regions and 98 municipalities in Denmark are responsible for primary and secondary care. The Ministry of Health is responsible for the overall regulation and supervision and for the governance of the municipal and regional organisation and management of healthcare. Moreover, the Ministry has responsibility for the pharmacy sector and the market authorisation of pharmaceuticals.

The government derives income from a variety of taxes and duties which are all collected at the central level. The health system is additionally funded by out-of-pocket payments which are particularly widespread for outpatient dental care and glasses and drugs obtained outside the hospital.

Every year the Ministry of Health, the Ministry of Finance, the association of regional councils, (Danish Regions) and the association of Danish municipal councils (Local Government Denmark) negotiate on the targets for healthcare expenditure and service levels and on the financial resources to be allocated. The municipalities derive their income from proportional income taxes (which are set locally but collected centrally) and block grants they receive from the state. Regions derive their income from block grants and activity-based financing from the state and from contributions and activity-based financing by each municipality in the region.

### Healthcare delivery

The public hospitals are owned and managed by the state and work with a budget and a variety of targets (e.g. on production and service levels). Healthcare professional working independently, such as GPs, also have to work according to official targets.

All healthcare professionals who work in public hospitals are employed by the hospital and are paid a salary, which is negotiated between different professional organisations and Danish Regions. Reimbursement levels for private practitioners and providers are negotiated between the relevant professional organisations and Danish Regions.

The municipalities are responsible for, amongst other things, health promotion, disease prevention, outpatient rehabilitation, nursing homes and home care.

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<sup>210</sup> Main sources for this section: Olejaz M, Juul Nielsen A, Rudkjøbing A, Okkels Birk H, Krasnik A, Hernández-Quevedo C. Denmark: Health system review. *Health Systems in Transition*, 2012, 14(2):1 – 192. [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0004/160519/e96442.pdf](http://www.euro.who.int/__data/assets/pdf_file/0004/160519/e96442.pdf) and Kvist J (2012). asisp Annual National Report 2012 Denmark. Pensions, Health Care and Long-term Care. Downloaded from: [http://www.socialprotection.eu/files\\_db/1218/asisp\\_ANR12\\_DENMARK.pdf](http://www.socialprotection.eu/files_db/1218/asisp_ANR12_DENMARK.pdf).

Indicators of the healthcare system, 2010 (or nearest year)		
Financing of the healthcare system (1)		
	Denmark	EU average
Total health expenditure as % of GDP	11.1%	9%
Public expenditure as % of total health spending	85%	73%
Private insurance as % of total health spending	2%	4%
Private-out-of-pocket as % of total health spending	13%	21%
Organisation of the healthcare system (2)		
Social insurance or tax-based system?	Tax-based system	
Gatekeeping by a general practitioner (GP)?	Compulsory	
How are physicians paid? (e.g. salary, fee-for-service, capitation)	FFS/Capitation	
Patient organisation involvement (3=good, 2=intermediary, 1=not-so-good)	3	
Accessibility (3=good, 2=intermediary, 1=not-so-good) (3)		
Family doctor same day access	2	
Major surgery < 90 days	2	
Cancer therapy < 21 days	3	
CT scan < 7 days	1	

Sources: (1) OECD Health at a Glance Europe 2012<sup>211</sup>, (2) Joint Report on Health systems (2010)<sup>212</sup>, HEIDI WIKI<sup>213</sup> and EuroHealth Consumer Index 2012<sup>214</sup>, (3) EuroHealth Consumer Index 2012.

<b>Corruption in healthcare perceptions</b>		
<b>Do you think that the giving and taking of bribes, and the abuse of positions of power for personal gain, are widespread among people working in the public health sector?</b>		
	<i>Denmark</i>	<i>EU average</i>
(% of respondents agree - Eurobarometer)	14%	30%
<b>Please indicate on a scale of 1 (= no problem) to 5 (= very serious problem) to what extent corruption is a serious issue in your country (average score of 2 interviewees)</b>		
	<i>Denmark</i>	
Informal payments in medical service delivery	1	
Certification and procurement of medical equipment	1.5	
Authorisation and procurement of pharmaceuticals	1.5	

Sources: Special Eurobarometer 374, table QC4 (fieldwork September 2011); own research (fieldwork February/March 2013).

## Types of healthcare corruption

The perception of the interviewees is that wide-spread corruption does not exist in Denmark:

<sup>211</sup> <http://www.oecd.org/els/health-systems/HealthAtAGlanceEurope2012.pdf>.

<sup>212</sup> [http://europa.eu/epc/pdf/joint\\_healthcare\\_report\\_en.pdf](http://europa.eu/epc/pdf/joint_healthcare_report_en.pdf).

<sup>213</sup> [https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing\\_healthcare/Healthcare\\_financing\\_systems](https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing_healthcare/Healthcare_financing_systems).

<sup>214</sup> Health Consumer Powerhouse – EuroHealth Consumer Index 2012: <http://www.healthpowerhouse.com/index.php?Itemid=55>.

- During the interviews it was mentioned that because Denmark has an important pharmaceutical industry every now and then corruption takes place, e.g. in the form of wages, gifts, the possibility to attend conferences etc.;
- Informal payments, bribery, kickbacks and embezzlement are stated not to be a problem in Denmark;
- Conflict of interest: this happens every now and then. If a doctor wears two hats, a public one and a private one, a conflict of interest may arise. The economic incentives are present in all specialties but especially when pharmaceuticals are concerned. This is related to the fact that there are many pharmaceutical companies in Denmark, e.g. Novo Nordisk and Lundbeck;
- Trading in influence: according to the interviewees this is undocumented in Denmark, but it must be out there to some extent. The interpretation was that especially doctors are in a favourite position, becoming saints when curing complex cases. This issue is also linked to widespread lobbying, especially with regard to the National Board of Health.

### **Causes and risks**

Generally the risk for corruption is considered to be low:

- Procurement and authorization of medical supplies: There is a high level of decentralisation, with few stakeholders around the table and this can be considered a risk factor. More specifically, there are only five to six major players, e.g. Philips, Siemens, General Electric, Toshiba etc. This does not always benefit the procurement process and there is a lot of money at stake here;
- Economic factors: Out-of-pocket payments are relatively high for e.g. dentistry and pharmaceuticals which, just as the health system being tax-based, is considered a risk factor for corruption;
- Currently the risks of corruption are related to increasing contacts with mafia like organisations from e.g. Romania.

### **Actual and suggested policies and practices**

According to Transparency International, Denmark is, together with Finland, the least corrupt country in the world. This may explain the relative lack of attention of the Danish government to the subject. The country expert suggests that Denmark/Scandinavia could serve as an example to other countries. According to the country rapporteur, sections 122 (active bribery) and 144 of the criminal code (passive bribery) can be considered examples of good policies. This is illustrated with an example for section 122 in a brief report of the Ministry of Justice entitled How to avoid corruption (2007): 'A patient has undergone major surgery at a public hospital. After the end of the patient's treatment at the hospital, the patient offers the surgeon who performed the surgery a sum of money as 'an expression of gratitude for a successful surgery'. The patient and the surgeon have not discussed this matter prior to or in connection with the surgery.' In this example the patient would not be liable to punishment for violation of section 122 of the Criminal Code as the gift was not offered for the purpose of affecting the surgeon's work'.

## Estonia

### General description of the healthcare system<sup>215</sup>

Estonian health care is organised by a centralized system which is controlled by the Ministry of Social Affairs. Other main bodies which act under the Ministry of Social Affairs are the State Agency of Medicines (SAM), the Estonian Health Insurance Fund (EHIF), Health Care Board (HCB), National Institute for Health Development (NIHD) and the Health Protection Inspectorate (HPI). The main responsibility of the Ministry of Social Affairs is to collect the contributions for healthcare. Additionally, the Ministry funds ambulance services, public health programmes and emergency care (only for the uninsured). The EHIF is responsible for the purchase of healthcare services and for contracting healthcare providers.

Aside from the Ministry funding a few health care services, the main funding stems from employees' contributions who finance two third of the healthcare expenditures by social payroll contributions. Another important source of financing are out-of-pocket (OOP) payments. Currently, the Estonian health care is funded for one quarter by OOP payments. The share of OOP payments is even expected to increase in the future, consequently threatening healthcare access for low income groups.

### Healthcare delivery

Primary care is privatised and regulated by self-employed providers. Hospitals are publicly owned, but also acting under private regulation. Primary care forms the centre of the Estonian healthcare delivery and specialised care is stimulated to be provided in outpatient settings. Only the provision of high technology care occurs at the central level in a small number of specialised institutions. Patients may freely choose their provider as well as their physician. Only the frequently asked doctors are confronted with large waiting lists. Access forms an important barrier in health care delivery. Recently more emphasis is put on the volume of healthcare services, to decrease patient' waiting times.

Primary care is financed by a mixed payment system. Basically, primary care providers are compensated by an age-adjusted capitation. Only services provided in selected areas are paid by a fee. Since 2006, a quality bonus system has been introduced in primary care, which is aimed at encouraging disease prevention and chronic disease management. Hospital payments are originally based on a fee-for-service system. As from 2004, the fees are complemented by payments based on the system of diagnoses related group (DRG).

<sup>215</sup> Main sources for this section: Koppel A, Kahur K, Habicht T, Saar P, Habicht J and van Ginneken E. Estonia: Health system review. *Health Systems in Transition*. 2008; 10(1): 1-230.  
[http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0011/80687/E91372.pdf](http://www.euro.who.int/__data/assets/pdf_file/0011/80687/E91372.pdf) and Vörk A and Segært S (2012). asisp Annual National Report 2012 Estonia. Pensions, Health Care and Long-term Care. Downloaded from: [http://www.socialprotection.eu/files\\_db/1221/asisp\\_ANR12\\_ESTONIA.pdf](http://www.socialprotection.eu/files_db/1221/asisp_ANR12_ESTONIA.pdf).



Indicators of the healthcare system, 2010 (or nearest year)		
Financing of the healthcare system (1)		
	Estonia	EU average
Total health expenditure as % of GDP	6.3%	9%
Public expenditure as % of total health spending	79%	73%
Private insurance as % of total health spending	0%	4%
Private-out-of-pocket as % of total health spending	19%	21%
Organisation of the healthcare system (2)		
Social insurance or tax-based system?	Social insurance	
Gatekeeping by a general practitioner (GP)?	Financially encouraged	
How are physicians paid? (e.g. salary, fee-for-service, capitation)	Capitation/FFS/combination of some more	
Patient organisation involvement (3=good, 2=intermediary, 1=not-so-good)	2	
Accessibility (3=good, 2=intermediary, 1=not-so-good) (3)		
Family doctor same day access	2	
Major surgery < 90 days	2	
Cancer therapy < 21 days	1	
CT scan < 7 days	3	

Sources: (1) OECD Health at a Glance Europe 2012<sup>216</sup>, (2) Joint Report on Health systems (2010)<sup>217</sup>, HEIDI WIKI<sup>218</sup> and EuroHealth Consumer Index 2012<sup>219</sup>, (3) EuroHealth Consumer Index 2012.

<b>Corruption in healthcare perceptions</b>		
<b>Do you think that the giving and taking of bribes, and the abuse of positions of power for personal gain, are widespread among people working in the public health sector?</b>		
	<i>Estonia</i>	<i>EU average</i>
(% of respondents agree - Eurobarometer)	30%	30%
<b>Please indicate on a scale of 1 (= no problem) to 5 (= very serious problem) to what extent corruption is a serious issue in your country (average score of 3 interviewees)</b>		
	<i>Estonia</i>	
Informal payments in medical service delivery	2	
Certification and procurement of medical equipment	2	
Authorisation and procurement of pharmaceuticals	2	

Sources: Special Eurobarometer 374, table QC4 (fieldwork September 2011); own research (fieldwork February/March 2013).

### Types of healthcare corruption:

Interviewees explained various prevailing corruption types:

- For doctors, the following is a serious situation of conflicting interests: due to the specificity of healthcare and the smallness of Estonia, it is impossible to avoid a

<sup>216</sup> <http://www.oecd.org/els/health-systems/HealthAtAGlanceEurope2012.pdf>.

<sup>217</sup> [http://europa.eu/epc/pdf/joint\\_healthcare\\_report\\_en.pdf](http://europa.eu/epc/pdf/joint_healthcare_report_en.pdf).

<sup>218</sup> [https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing\\_healthcare/Healthcare\\_financing\\_systems](https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing_healthcare/Healthcare_financing_systems).

<sup>219</sup> Health Consumer Powerhouse – EuroHealth Consumer Index 2012: <http://www.healthpowerhouse.com/index.php?Itemid=55>.

situation where the one who wrote the description of a produce to be purchased (i.e. the doctor) may be associated with the provider(s) of the product through entrepreneurship or more indirectly;

- It was estimated that almost one quarter of Estonian physicians had got financial support from pharmaceutical companies for participation in scientific and training events abroad;
- Patients are paying bribes to doctors mainly to get quicker appointment time or to obtain health care of better quality. The healthcare related corruption survey of 2010 of the Ministry of Justice and University of Tartu (RAKE) showed that 2% of the patients had paid money unofficially to doctors;
- For many people, patient charges/co-payments (even officially paid and documented) are 'corrupted practices', partially due to the Soviet-time experience of declared 'free' healthcare. It means that often the patients consider all payments in healthcare facilities as corruption;
- Nepotism/favouritism could be also mentioned when speaking about the types of corruption in the public sector. Actually, all physicians graduated from the same university and as a result, everybody knows each other.

### **Causes and risks:**

The interviewees mentioned the following causes and risks:

- Politicians and physicians state that there is no public money to assure professional training which is dramatically needed. Therefore, the support of pharmaceutical companies is of great value, and it increases the risk of conflict of interest;
- Transparency and information is an important risk factor with regard to informal payments: patients do not exactly know for what they should pay, which creates confusion. This situation is getting worse due to the long waiting lists;
- Co-payments and 'under-financing' makes corruption easier as well.

### **Actual and suggested policies and practices**

#### ***Suggested mapping and transparency of corruption:***

- Conducting comprehensive studies to learn more about the phenomenon of corruption;
- A comprehensive patient survey in the field is an important step in the prevention and control of corruption, to gain a better insight in the phenomenon of corruption;
- Another remedy is transparency of decision making, and use of different methods to improve transparency, such as IT-technologies.

#### ***Illegal payments:***

- There is an intention to establish a single system of the patient registration seeking better management of the patients' queues;

- According to the authors: 'Patients are confused what is legal and what is not and third of patients regard also paid health services as corruption and another third as unethical'. The experts state that the system has increasingly become more transparent and more and more electronic. Therefore it's increasingly difficult to bribe;
- They also underline that physicians have their private work and can easily move to other Scandinavian countries. If physicians want to get more money, such options abroad are much more attractive than be involved in illegal deals.

***Prescribing the active substance:***

- Physicians have the legal obligation to prescribe only the active substance, and not the brand name of medication. Though it could shift a risk of corruption from physicians towards pharmacists;
- This rule was improved significantly when it started to be managed under physician contract with Patient Fund (penalties are also listed).

***Pharmaceuticals***

Some suggestions to increase transparency in the field of pharmaceuticals are: giving priority for sponsorship for acknowledged scientific events instead of expensive marketing presentations; assure information for the patients which pharmaceutical company sponsors a particular physician, etc.

***Hospitals:***

- Unfortunately, success was not achieved in doing strategic recommendations together with hospitals. Hospitals still keep their particular position in denying certain approaches proposed. At the same time, some hospitals started (and it is suggested to become a common procedure) conducting an interest disclosure in public procurement;
- Hospitals could treat themselves as commercial companies, and not apply public procurement rules;
- Lack of consensus between the state authorities and hospitals on applying certain approaches to prevention of corruption (e.g. public procurement rules).

***Other factors:***

- Due to economic crisis a failure in implementation of previously planned activities to raise awareness about corruption occurred;
- Lack of clarity in defining the role of private clinics and privately rendered services in public facilities;
- Education and training, information dissemination (particularly regarding paid services officially permitted to be rendered in public healthcare facilities), and establishing codes of ethics.

## Finland

### General description of the healthcare system<sup>220</sup>

In Finland there are three different healthcare systems with public funding: municipal healthcare, private healthcare and occupational healthcare. The largest share of healthcare is provided by municipal healthcare. Occupational healthcare takes the form of provision of preventative healthcare services for employees. This is compulsory by law and many large- or medium sized employers also provide curative outpatient services as part of occupational health.

Finland has a system of dual financing. While municipal healthcare is financed through municipal taxes, state subsidies and user-fees, the other two systems are financed through the National Health Insurance (NHI). The NHI is run by the Social Insurance Institution, which falls under the authority of parliament, and has approximately 260 local offices across Finland. It covers all Finnish residents and is funded by the state and fed by compulsory insurance fees for employees and employers.

All municipal healthcare services, except for outpatients drugs and transport costs, are funded by the municipalities. The NHI funds, amongst other things, sickness allowances, about one third of the costs of private healthcare and 40% of employers' expenses on occupational healthcare. For municipal healthcare there are user charges for different services as well as out-of-pocket payments for outpatient drugs. There is legislation in place that establishes annual ceilings for both types of user charges. With regard to occupational healthcare services; these are free of charge for employees.

The public responsibility is highly decentralised. At the national level, the Ministry of Social Affairs and Health is responsible for the regulation and guidance of the healthcare system.

In May 2011 the new Comprehensive Health Care Act was implemented. The key features of this act are: lowering barriers between primary and specialised care, increasing patient choice, improving the mobility of patient records, centralising organisational responsibility of ambulance and emergency services, and strengthening the role of tertiary care regions.

### Delivery of healthcare

Healthcare providers can be public or private services.<sup>221</sup> By law all municipalities are required to have a health centre providing primary care services. Moreover, the country is divided into 20 hospital districts and each municipality has to be a member of one of these districts. All members are involved in the financing and management of the hospitals in their district. Tertiary care is provided by university central hospitals

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<sup>220</sup> Main sources for this section: Vuorenkoski L, Mladovsky P and Mossialos E. Finland: Health system review. *Health Systems in Transition*. 2008; 10(4): 1–168. [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0007/80692/E91937.pdf](http://www.euro.who.int/__data/assets/pdf_file/0007/80692/E91937.pdf) and Vidlund M Kivelä S L (2012). asisp Annual National Report 2012 Finland. Pensions, Health Care and Long-term Care. Downloaded from: [http://www.socialprotection.eu/files\\_db/1230/asisp\\_ANR12\\_FINLAND.pdf](http://www.socialprotection.eu/files_db/1230/asisp_ANR12_FINLAND.pdf).

<sup>221</sup> Note that in general, pharmacies are privately owned.

which are the central hospitals in each of the five tertiary care regions. Tertiary care regions are formed by the combination of multiple hospital districts.

The largest share of physicians is employed by the municipalities and hospital districts and are in general paid a salary. However, over the last decade, it has become a trend to lease physicians from private firms. Moreover, it is estimated that approximately 30% of physicians that work fulltime in the public sector have a private practice outside regular working hours.

Indicators of the healthcare system, 2010 (or nearest year)		
Financing of the healthcare system (1)		
	Finland	EU average
Total health expenditure as % of GDP	8.9%	9%
Public expenditure as % of total health spending	75%	73%
Private insurance as % of total health spending	2%	4%
Private-out-of-pocket as % of total health spending	19%	21%
Organisation of the healthcare system (2)		
Social insurance or tax-based system?	Mixed	
Gatekeeping by a general practitioner (GP)?	Compulsory	
How are physicians paid? (e.g. salary, fee-for-service, capitation)	Salary/Capitation/FFS	
Patient organisation involvement (3=good, 2=intermediary, 1=not-so-good)	2	
Accessibility (3=good, 2=intermediary, 1=not-so-good) (3)		
Family doctor same day access	1	
Major surgery < 90 days	2	
Cancer therapy < 21 days	1	
CT scan < 7 days	3	

Sources: (1) OECD Health at a Glance Europe 2012<sup>222</sup>, (2) Joint Report on Health systems (2010)<sup>223</sup>, HEIDI WIKI<sup>224</sup> and EuroHealth Consumer Index 2012<sup>225</sup>, (3) EuroHealth Consumer Index 2012.

<sup>222</sup> <http://www.oecd.org/els/health-systems/HealthAtAGlanceEurope2012.pdf>.

<sup>223</sup> [http://europa.eu/epc/pdf/joint\\_healthcare\\_report\\_en.pdf](http://europa.eu/epc/pdf/joint_healthcare_report_en.pdf).

<sup>224</sup> [https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing\\_healthcare/Healthcare\\_financing\\_systems](https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing_healthcare/Healthcare_financing_systems).

<sup>225</sup> Health Consumer Powerhouse – EuroHealth Consumer Index 2012: <http://www.healthpowerhouse.com/index.php?Itemid=55>.

<b>Corruption in healthcare perceptions</b>		
<b>Do you think that the giving and taking of bribes, and the abuse of positions of power for personal gain, are widespread among people working in the public health sector?</b>		
	<i>Finland</i>	<i>EU average</i>
(% of respondents agree - Eurobarometer)	6%	30%
<b>Please indicate on a scale of 1 (= no problem) to 5 (= very serious problem) to what extent corruption is a serious issue in your country (average score of 7 interviewees<sup>226</sup>)</b>		
	<i>Finland</i>	
Informal payments in medical service delivery	1	
Certification and procurement of medical equipment	2	
Authorisation and procurement of pharmaceuticals	2	

Sources: Special Eurobarometer 374, table QC4 (fieldwork September 2011); own research (fieldwork February/March 2013).

### Types of healthcare corruption

Many corruption types were mentioned by the interviewees, mainly embezzlement, conflict of interest, trading in influence, revolving door, clientelism, nepotism and favouritism.

According to the country report, brotherhood networks and conflicts of interest are typical for a small country like Finland. The country rapporteur stated that besides conflicts of interest there is no systemic corruption in Finland.

As explained by one interviewee, conflict of interest is often compromised by the fact that people have double or multiple roles, e.g. as administrators and experts, and the roles may be confounded. Conflicts of interest arise particularly with a tendency to rely on domestic experts - this is however changing. The number of experts is small and this facilitates the brotherhood network, probably the most common form of corruption in Finland.

Informal payments are not seen as a problem, confirmed by all interviewees.

### Causes and risks

Many issues are mentioned by interviewees, but not considered not a problem, except for procurement related issues. For example:

- Procurement: On the one hand: there is (no) corruption, because when a device is marketed on false grounds, it will become apparent very soon. On the other hand, marketing and sales are very effective and all methods are used; a controlling authority cannot oversee marketing, and there is no legislation to back this up. Free marketing is encouraged and limiting marketing can be against EU laws;
- The marketing of pharmaceuticals is a problematic business. The relationship between (medical equipment and pharmaceuticals) buyers and purchasers are

<sup>226</sup> Note that one respondent did not answer the question about the certification and procurement of medical equipment and the question about the authorisation and procurement of pharmaceuticals, and that one respondent did not answer all of the three questions.

close, as Finland is a small country and professional circles are small. This bears also a risk for revolving doors;

- A special problem is the leading role of pharmaceutical companies in the continuing education of physicians. The problem has been recognised, but the employers still allocate insufficient funding for the training of their employees.

### **Actual and suggested policies and practices**

The following legislation is described in the country report:

*The Act on the Openness of Government Activities* This act defines the principle of openness meaning that official documents shall be in the public domain, unless specifically otherwise provided. It also contains provisions on the right of access to official documents in the public domain, officials' duty of non-disclosure, document secrecy and any other restrictions of access that are necessary for the protection of public or private interests, as well as on the duties of the authorities.

*The Administrative Procedure Act* promotes good administration, access to justice in administrative matters and the quality and productivity of administrative services. The Act spells out the grounds for disqualification in decision making.

*The Government Civil Servant Act* According to the Act, a civil servant may not request, accept or receive any financial or other benefit, if it can impair the public trust in the civil servant or public authority. The Act also includes provisions on conflict of interest.

*The Act on Public Contracts* the state and municipal authorities and other contracting authorities shall put their contracts out to tender. The purpose of the Act is to increase the efficiency of the use of public funds, promote high-quality procurement and safeguard equal opportunities for companies and other communities in offering supply, service and public works contracts under competitive bidding for public procurement.

*The Medicines Act and Decree* includes provisions on the marketing of medicinal products. The Pharma Industry Finland has published its own Code of Ethics in 2013. Actually already in the 1964 Medicines Act/Decree, conflict of interest was defined for the drug committee that evaluated efficacy and safety of pharmaceuticals.

According to the country expert, culture/customs and guidelines/practices in Finland may be as important as the actual legislation. These include:

- Close ties to other Nordic countries and their traditions like law obedience;
- Strong scientific ties to USA including the idea of avoiding the conflict of interest, a long US tradition. This has had impact in the grant giving (particularly government grants) as well as ethics committees and other research regulation;
- In scientific publishing medical journal requirements and the evaluation of papers have further reinforced the practices and the international requirements of transparency have been adopted by Finnish journals and practice guidelines.

## France

### General description of the healthcare system<sup>227</sup>

France has a healthcare system that is based on social insurance, with a single public payer and almost universal coverage. The statutory health insurance (SHI) is compulsory and covers approximately 75% of health spending.

The SHI is funded through employer and employee contributions. Additionally, over the last years, tax revenues are becoming a more important source of financing. The government negotiates with the healthcare providers on the statutory tariffs and the reimbursement rates are established by law. Coinsurance rates differ between services, but exist for both ambulatory and inpatient care (e.g. high co-payments on medicines and daily hospital fees). Many people in France buy voluntary health insurance for reimbursement of co-payments and better coverage.

In France, the responsibilities for policy making and regulation are shared by the state, the SHI and the local communities. Every three years the SHI and Ministry of Health sign a contract in which the objectives, the management and the governance of SHI is defined.

### Delivery of healthcare

In France there are both public and private providers. Private hospitals can be either for-profit or not-for-profit. Most outpatient services and services in private hospitals are provided by self-employed healthcare professionals that are paid fee-for-service. Pharmacists are in general also self-employed.

GPs play an important role in the coordination of care. A semi-gatekeeping system is set-up in which financial incentives are created such that visit their GP before seeing a specialist. Services for the elderly and disabled are provided in the social care sector rather than the healthcare sector.

In France, all hospitals are funded on the basis of hospital stay groups, a system which resembles the DRG system. Only long-term care and psychiatry are excluded from this system. Note, however, that the tariffs of this system are calculated differently for private then for public providers. The aim is to have the method of payment and tariffs harmonised by 2018.

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<sup>227</sup> Main sources for this section: Chevreul K, Durand-Zaleski I, Bahrami S, Hernández-Quevedo C and Mladovsky P. France: Health system review. *Health Systems in Transition*, 2010; 12(6): 1– 291. [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0008/135809/E94856.pdf](http://www.euro.who.int/__data/assets/pdf_file/0008/135809/E94856.pdf) and Morel N, Naczyk M, Palier B (2012). asisp Annual National Report 2012 France. Pensions, Health Care and Long-term Care. Downloaded from: [http://www.socialprotection.eu/files\\_db/1233/asisp\\_ANR12\\_FRANCE.pdf](http://www.socialprotection.eu/files_db/1233/asisp_ANR12_FRANCE.pdf).



<b>Indicators of the healthcare system, 2010 (or nearest year)</b>		
<b>Financing of the healthcare system (1)</b>		
	<i>France</i>	<i>EU average</i>
Total health expenditure as % of GDP	11.6%	9%
Public expenditure as % of total health spending	77%	73%
Private insurance as % of total health spending	14%	4%
Private-out-of-pocket as % of total health spending	7%	21%
<b>Organisation of the healthcare system (2)</b>		
Social insurance or tax-based system?	Social insurance	
Gatekeeping by a general practitioner (GP)?	Financially encouraged	
How are physicians paid? (e.g. salary, fee-for-service, capitation)	FFS	
Patient organisation involvement (3=good, 2=intermediary, 1=not-so-good)	3	
<b>Accessibility (3=good, 2=intermediary, 1=not-so-good) (3)</b>		
Family doctor same day access	2	
Major surgery < 90 days	2	
Cancer therapy < 21 days	2	
CT scan < 7 days	2	

Sources: (1) OECD Health at a Glance Europe 2012<sup>228</sup>, (2) Joint Report on Health systems (2010)<sup>229</sup>, HEIDI WIKI<sup>230</sup> and EuroHealth Consumer Index 2012<sup>231</sup>, (3) EuroHealth Consumer Index 2012.

<b>Corruption in healthcare perceptions</b>		
<b>Do you think that the giving and taking of bribes, and the abuse of positions of power for personal gain, are widespread among people working in the public health sector?</b>		
	<i>France</i>	<i>EU average</i>
(% of respondents agree - Eurobarometer)	20%	30%
<b>Please indicate on a scale of 1 (= no problem) to 5 (= very serious problem) to what extent corruption is a serious issue in your country (average score of 3 interviewees)</b>		
	<i>France</i>	
Informal payments in medical service delivery	1	
Certification and procurement of medical equipment	3	
Authorisation and procurement of pharmaceuticals	4	

Sources: Special Eurobarometer 374, table QC4 (fieldwork September 2011); own research (fieldwork February/March 2013).

## Types of healthcare corruption

### **Corruption linked to the pharmaceutical industry:**

- The interviewees point out the close relationship between the pharmaceutical companies and medical practitioners as a risk factor;

<sup>228</sup> <http://www.oecd.org/els/health-systems/HealthAtAGlanceEurope2012.pdf>.

<sup>229</sup> [http://europa.eu/epc/pdf/joint\\_healthcare\\_report\\_en.pdf](http://europa.eu/epc/pdf/joint_healthcare_report_en.pdf).

<sup>230</sup> [https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing\\_healthcare/Healthcare\\_financing\\_systems](https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing_healthcare/Healthcare_financing_systems).

<sup>231</sup> Health Consumer Powerhouse – EuroHealth Consumer Index 2012: <http://www.healthpowerhouse.com/index.php?Itemid=55>.

- Other corruption types that are mentioned are bribery and kickbacks between pharmaceutical companies and hospital pharmacists (especially when the latter is responsible for the supply of pharmaceuticals);
- Price arrangements between pharmaceutical companies are also mentioned. (In this way the same prices are applied to different pharmacies and competition is avoided);
- The lobby of pharmaceuticals is reported to be one of the most powerful lobbies in France and their influence has important impact on political decisions for the health sector. The infiltration of people linked to pharmaceutical laboratories into the main health agencies and health administration bodies is very common.

### **Causes and risks**

Below follow causes and risks derived from the interview reports.

#### ***Conflict of interests***

According to one interviewee, conflict of interest constitutes the most serious risk for healthcare corruption, since they play a key role in the malfunction of regulatory and administrative authorities which are supposed to ensure the transparency, correctness and effectiveness of the procurement decisions of pharmaceuticals (and their consequent placement on the market). According to the interviewee, such malfunction often takes two different forms:

- Decisions are taken too late or not taken at all, with consequent human losses and/or health damages for several individuals;
- If decisions are taken, there is a lack of control concerning its effective application and/or sanctioning mechanisms.

#### ***The conflicts of interest originate from several elements:***

- The lack of transparency in the decision-making processes in the health sector the responsibility of the experts who are supposed to support the regulatory decisions;
- Lobbying of pharmaceutical companies;
- The fact that whistle-blowers are not protected well enough.

#### ***Companies in pharmaceuticals and medical devices:***

- Lack of moral values of those who are involved in the business of pharmaceuticals and medical equipment;
- Economic power of pharmaceutical companies: this relates to the productive resources available that give them the capacity to influence (and sometimes make) and enforce economic decisions such as the allocation of resources. Through this power, laboratories might be able to influence the decision making.

## **Legal framework**

Legal sanctions are considered to have only a minor deterrent effect.

## **Actual and suggested policies and practices**

### **Laws**

A legislative initiative on whistle blowing is announced. The legislation should protect individuals who make wrongdoings public. The measure is meant to strengthen accountability and bolster the fight against corruption and mismanagement, both in the public and private sectors.

Creation of a new type of offence within the French Commercial Code: The abuse of corporate assets (the use of private assets for other aims than those listed among the objectives of the private company) which can be applied to private individuals. Since 10 years, and for conviction purposes, the time limitation has been extended to what is referred as to 'infraction continue'. This means that, for conviction purposes, there is no need any more to prove the existence of a criminal pact or a criminal conspiracy preceding the actual offence. Training of police officers and 'gendarmes' to detect corruption, notably in procurement procedures (see for more information the policies report -The Central Brigade for the Fight Against Corruption).

Specifically in the health sector, a 2011 law was enacted to require a declaration of interest to be published by all independent health experts employed by regulatory bodies, doctors and national agencies' employees. Health companies must also disclose all financial agreements they have with health professionals and independent health experts. The act further aims to guarantee the independence of public authorities dealing with the assessment of pharmaceutical products. One example of a good policy is the establishment of a national list provided on the online website of Cnamed (National Commission for Medical Accidents), for experts in emergency medicine.

Other measures within regulatory agencies include:

- The creation of publicly available lists of experts employed by regulatory agencies. One example is the national list provided through the online website of Cnamed (National Commission for Medical Accidents) for experts in emergency care;
- The establishment of ad hoc committees for ex-ante and ex-post evaluations and the management of activities according to internal codes of conduct; the recent creation of an ad hoc committee (*'comité de réflexion'*) on conflicts of interests in the French public administration and the disclosure of its final report.

### **Code of conduct**

The development of deontological codes. These are codes of conduct, developed by professional associations such as pharmacists, dentists, family doctors, etc., to guide their professional behaviour and their relations towards the patients, ensure transparency and prevent possible conflicts of interests.

***Control mechanism***

The Central Brigade for the Fight Against Corruption (BCLC) is a national inter-ministerial institution involving police, gendarmes and tax inspectors, created in 2004. The BCLC has jurisdiction on all acts relating to corruption and related offenses such as trafficking of influence, unlawful taking of interest, misappropriation of public funds, but also misuse of corporate assets or false financial accounting. The problem of corruption, its complexity and its international aspects give this brigade numerous missions outside the strict sense of the judiciary investigations in the field of information exchange, operational documentation and training, the latter provided in partnership with the Central corruption Prevention department (SCPC).

***Suggestions of the interviewees***

Elements which could further improve the level of transparency, while ensuring a balance between the prevention of conflicts of interest and the necessary resources of expertise:

- Strengthened role of civil society associations which might be involved – at different levels and degrees – in evaluations and decision-making procedures;
- Creation of a legally recognised health expert status which reflects his/her background and his/her professional qualification (industrial, administrative, research and academic);
- Creation of a lobbyist status and register including all the information regarding the financial interests of the lobbyist.

***Bad policies and practices***

Some of the following examples were mentioned:

- The anti-corruption legislation in France is rather limited, as corruption is still too hard to detect, with extremely long and complicated judicial inquiries. Moreover, the penal code has not been evolved in recent years and corruption offences have short limitation periods (délai de prescription). Overall, it seems that one big hurdle to the effectiveness of anti-corruption measures is that they do not have a sufficiently powerful deterrent effect – the risk to be caught is considered not high enough;
- Conflicts of interest between public offices and the private sector are a serious concern. As of 2012, France has no law that obliges elected public officials to disclose potential conflicts of interest arising from business relationships or positions. In addition, there is a lack of clear and precise code of conduct for public servants on CoI, as well as the fragmentation across levels within the government concerning the prevention mechanisms;
- Rules to regulate political lobbying and to implement codes of ethics are generally considered unsatisfactory. No guidelines have been adopted to direct Members of Parliament's (MPs) dealings with lobbyists. There is considered to be a lack of transparency between the work of MPs and lobbyists.

## Germany

### General description of the healthcare system<sup>232</sup>

Germany has a statutory health insurance system (SHI) that covers a wide range of services. There are more than 200 public insurance funds, also called sickness funds, and these cover almost the entire population. Enrolment in the SHI is mandatory for people whose salary does not exceed a defined ceiling. Non-earning spouses and children are also insured without any surcharges. When your salary exceeds the ceiling you can decide to voluntarily stay in the SHI or to opt-out. Once you opt-out and take out private health insurance, it is very difficult to return to the SHI. Self-employed people and civil servants also have to take out private health insurance. Part of the healthcare expenses for civil servants are covered by the support fund of the civil service.

The German healthcare system is mainly financed through insurance premiums paid by SHI enrollees, tax subsidies and other insurance contributions. Private sources of funding are out-of-pocket payments and private health insurance. Note that while in the SHI the premiums are based on an individual's income, the premiums for private health insurance are based on an individual's risk profile.

Tasks and responsibilities within the German healthcare system are shared between the federal government and the regional Land governments. The Federal Ministry of Health is responsible for the legislative framework and general supervision. The Land governments are responsible for, amongst other things, hospital infrastructure and public health. Another important stakeholder is the Federal Joint Committee (G-BA), which is the most important corporate body in Germany. It is formed by the umbrella organisations for doctors, dentists, hospitals and SHI funds. They have broad regulatory powers, such as quality assurance of hospital treatment and regulation of pharmaceuticals (with the exception of market licensing).

### Healthcare delivery

There is a strong separation between the hospital and ambulatory care system. In general, ambulatory healthcare is provided by private for-profit providers and patients are free in their choice for a physician. Although there is no formal gatekeeping system in place, it is financially encouraged to seek a referral by your family doctor before visiting a specialist.

Acute and long term care is provided by both for-profit and not-for-profit providers that employ staff. Each hospital can decide independently on what services will be offered to patients. Most types of services in acute hospitals are financed through a DRG-type system.

<sup>232</sup> Main sources for this section: Busse R, Riesberg A. Health care systems in transition: Germany. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2004. [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0018/80703/E85472.pdf](http://www.euro.who.int/__data/assets/pdf_file/0018/80703/E85472.pdf) and Schmähl W, Augurzyk B, Mennicken R (2012). asisp Annual National Report 2012 Germany. Pensions, Health Care and Long-term Care. Downloaded from: [http://www.socialprotection.eu/files\\_db/1215/asisp\\_ANR12\\_Germany.pdf](http://www.socialprotection.eu/files_db/1215/asisp_ANR12_Germany.pdf).

Indicators of the healthcare system, 2010 (or nearest year)		
Financing of the healthcare system (1)		
	Germany	EU average
Total health expenditure as % of GDP	11.6%	9%
Public expenditure as % of total health spending	77%	73%
Private insurance as % of total health spending	9%	4%
Private-out-of-pocket as % of total health spending	13%	21%
Organisation of the healthcare system (2)		
Social insurance or tax-based system?	Social insurance	
Gatekeeping by a general practitioner (GP)?	Financially encouraged	
How are physicians paid? (e.g. salary, fee-for-service, capitation)	FFS/Capitation	
Patient organisation involvement (3=good, 2=intermediary, 1=not-so-good)	3	
Accessibility (3=good, 2=intermediary, 1=not-so-good) (3)		
Family doctor same day access	2	
Major surgery < 90 days	3	
Cancer therapy < 21 days	3	
CT scan < 7 days	2	

Sources: (1) OECD Health at a Glance Europe 2012<sup>233</sup>, (2) Joint Report on Health systems (2010)<sup>234</sup>, HEIDI WIKI<sup>235</sup> and EuroHealth Consumer Index 2012<sup>236</sup>, (3) EuroHealth Consumer Index 2012.

<sup>233</sup> <http://www.oecd.org/els/health-systems/HealthAtAGlanceEurope2012.pdf>.

<sup>234</sup> [http://europa.eu/epc/pdf/joint\\_healthcare\\_report\\_en.pdf](http://europa.eu/epc/pdf/joint_healthcare_report_en.pdf).

<sup>235</sup> [https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing\\_healthcare/Healthcare\\_financing\\_systems](https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing_healthcare/Healthcare_financing_systems).

<sup>236</sup> Health Consumer Powerhouse – EuroHealth Consumer Index 2012: <http://www.healthpowerhouse.com/index.php?Itemid=55>.

<b>Corruption in healthcare perceptions</b>		
<b>Do you think that the giving and taking of bribes, and the abuse of positions of power for personal gain, are widespread among people working in the public health sector?</b>		
	<i>Germany</i>	<i>EU average</i>
(% of respondents agree - Eurobarometer)	19%	30%
<b>Please indicate on a scale of 1 (= no problem) to 5 (= very serious problem) to what extent corruption is a serious issue in your country (average score of 3 interviewees<sup>237</sup>)</b>		
	<i>Germany</i>	
Informal payments in medical service delivery	3.25	
Certification and procurement of medical equipment	4 <sup>238</sup>	
Authorisation and procurement of pharmaceuticals	5 <sup>239</sup>	

Sources: Special Eurobarometer 374, table QC4 (fieldwork September 2011); own research (fieldwork February/March 2013).

### Types of healthcare corruption

The general consensus of all the interviewees has been that corruption in Germany is very low. They also highlighted that procurement of medical equipment has a very high level of oversight, meets all EU requirements and is viewed as functioning well and free of corruption. The procurement of pharmaceuticals is also transparent when it comes to ordering large quantities, however the problems lie in the individual relationship between the pharmaceutical companies and doctors. It is this form of corruption that has been said to be the most prevalent with isolated cases of informal payments.

### Pharmaceuticals

According to one interviewee, currently 16.000 representatives of pharmaceutical companies are active in Germany. They undertake more than a million visits to doctors each year to promote the usage of medicaments produced by the company they work for. Promotion activities certainly include gifts, trainings (in exotic locations) and economic benefits to stimulate doctors to prescribe a medicament.

One of the most prominent scandals in the history of the German health sector was the Globudent Skandal (2004)<sup>240</sup>. This scandal was caused by a trading company 'Globudent' that imported cheap dentures from Turkey and Hong Kong and sold them overpriced to dentists and other dental firms. Dentists would subsequently invoice the cheap dentures to the health insurance companies as if these were high-end dentures 'made in Germany'. The profits enabled Globudent to pay these dentists and other dental firms reimbursements in cash (kick-backs). In some cases these reimbursements added up to over 200,000 Euro for individual dentists. Under normal proceedings, these reimbursements would be provided to patients and health insurance companies.

<sup>237</sup> Note that 1 respondent did not answer these three questions and that 1 respondent only answered the question on informal payments in medical service delivery.

<sup>238</sup> Based on 1 response.

<sup>239</sup> Based on 1 response.

<sup>240</sup> As identified in one of the national cases.

All managers confessed and even though the total damage for insurance companies and patients amounted about 50 million Euro, they were held responsible for three million only. Two of the three managers were sentenced to prison for three years without probation and the third one for two years under probation by the Court in Duisburg. Also dentists were punished. Over 40 of them lost their licence.

Another form of corruptive practice, observed by an interviewee, follows from the practice to reward observations of applicants of new medicaments (*Anwendungsbeobachtungen*). Pharmaceutical companies ask doctors to observe patients when they start taking new medicaments and to fill out questionnaires. Doctors may likely receive a financial reward for each completed questionnaire, even though their observations are little useable for drawing scientific conclusions on the effects of a certain medicine.

### **Causes and risks**

According to the interviews, causes of corruption in the German healthcare system follow mainly from an attitude to maximise individual profit. The turnover of the German health system equals 180 billion Euro p.a. and actors continuously try to secure a share as large as possible for themselves. Equally the opportunity to gain personal prestige amongst its peers or patients is another motivation.

### **Actual and suggested policies and practices**

As identified in interviews or national cases:

#### ***Increasing transparency***

The area of pharmaceuticals has recently become one of the most transparent areas of the German health sector. At the moment it is visible to retrieve data on the marketing, usage and the medicaments that individual doctors prescribe. The existence of this data limits the informative and financial power of pharmaceutical companies significantly. By exploring these datasets, the ZES Bremen is able to contact individual doctors and request information on their particular prescriptions. In these cases the ZES can for example point to research that has shown that the medication in question is too expensive and/ or ineffective. According to the interviewee most doctors react positively to the feedback of the ZES since it enables them to improve their service delivery.

#### ***Focused investigative and independent authority***

There exist several public prosecutors and police units specialised in detecting and counteracting corruption in the health sector. These are divided among different federal states and part of broader units that deal with economic crime.



**Self-governance**

Organisation of self-governance is perceived to function quite well in the medical sector and is perceived by the interviewees as effective in combatting fraudulent invoicing: Invoices from doctors are usually first checked on their plausibility by doctors' associations (*Kassen (zahn) ärztlichen vereinigungen*) and afterwards by the health insurance companies. Health insurance companies are legally obliged to have an operational unit in their organisation that deals with (suspected) cases of fraud and/or corruption.

**Pharmaceuticals**

The ruling of the Federal Court in 2012, that measures are needed in the criminal law to reduce corruptive behaviour (i.e. kickbacks) in the German health system, has forced the Ministry to set out its case of fighting corruption in the Bundestag by the end of summer 2013.

According to some of the interviewees already a positive outcome of a ruling was that the issue of corruption in the health sector caused an increase in activities from a range of actors in the field to increase awareness of doctors. For example, the number of representatives of pharmaceutical companies (Pharmareferent) has been reduced over the last years. The German Doctors leading Association (the self-administrative representative body of doctors) has increased its awareness campaigns to warn doctors about (illegal) corruptive practices. Finally, the new electronic health insurance card (+/- EPD) is geared towards reducing fraud and corruption from patients (i.e. fraudulent declarations) as it now includes a picture of the holder of the card and a link to a central database.

**Media attention**

The attention of the media to (alleged) case of corruption and the quality as well as independence of the reporting has been views as a strong instruments to trace cases of corruption and to call account of those involved. In past cases newspaper such as: Frankfurter Allgemeine Zeitung, Die Zeit, Sueddeutsche Zeitung, Der Spiegel, have reported closely on both scandals as well as the recent court ruling.

## Greece

### General description of the healthcare system<sup>241</sup>

In Greece there is a mixed healthcare system: a NHS type system, the ESY, coexists with a social health insurance model. The latter mentioned consists of large number of different insurance funds and membership of such a fund is compulsory for all employees. The health insurance funds enter into contracts with private healthcare providers.

Statutory financing is based on taxes and social insurance contributions (that may differ across insurance companies) by employees and employers. These two financing methods are approximately equal in size. The third source of financing of the Greek healthcare system is private expenditure, mainly in the form of out-of-pocket payments on for example pharmaceuticals.

The regulation of healthcare services is rather centralised in Greece. The Ministry of Health and Solidarity is responsible for the regulation and management of the ESY and the regulation of the private sector. The social health insurance schemes fall under the authority of the Ministry of Employment and Social Protection. There exist no statutory links between the two parts of the Greek healthcare system and there also no institutional bodies to coordinate common issues.

After the economic downturn in Greece in 2010 many reforms have been adapted, also in the healthcare sector. Probably the most significant reform was Law 3918/2011 as it introduced a major restructuring of the system<sup>242</sup>. All major social insurance funds together form EOPYY, which will act as the sole buyer of healthcare services and pharmaceuticals. This increase in bargaining power is accompanied by the introduction of regional planning of procurement of health supplies through the development of Regional Programs for Goods and Services.

### Healthcare delivery

In Greece primary healthcare is provided by both public and private providers. For primary healthcare provided through social insurance funds, patients can only choose between the contracted providers. Primary care physicians currently do not have a gatekeeping function, however, people covered by private health insurance schemes are often obliged to visit a first-contact service for referral to specialist care.

Secondary and tertiary care is provided in three different setting: ESY hospitals, public non-ESY hospitals and private clinics (which play an important role in the provision). People can choose any public hospital for getting treatment – there are no restrictions on this choice. All ESY personnel is paid a salary.

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<sup>241</sup> Main sources for this section: Economou C. Greece: Health system review. *Health Systems in Transition*, 2010, 12(7):1–180. [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0004/130729/e94660.pdf](http://www.euro.who.int/__data/assets/pdf_file/0004/130729/e94660.pdf) and Petmesidou M (2012). asisp Annual National Report 2012 Greece. Pensions, Health Care and Long-term Care. Downloaded from: [http://www.socialprotection.eu/files\\_db/1224/asisp\\_ANR12\\_Greece.pdf](http://www.socialprotection.eu/files_db/1224/asisp_ANR12_Greece.pdf).

<sup>242</sup> Source: interviews for country report on Greece.

Indicators of the healthcare system, 2010 (or nearest year)		
Financing of the healthcare system (1)		
	Greece	EU average
Total health expenditure as % of GDP	10.2%	9%
Public expenditure as % of total health spending	59%	73%
Private insurance as % of total health spending	2%	4%
Private-out-of-pocket as % of total health spending	38%	21%
Organisation of the healthcare system (2)		
Social insurance or tax-based system?	Mixed system	
Gatekeeping by a general practitioner (GP)?	Not necessary	
How are physicians paid? (e.g. salary, fee-for-service, capitation)	Salary	
Patient organisation involvement (3=good, 2=intermediary, 1=not-so-good)	1	
Accessibility (3=good, 2=intermediary, 1=not-so-good) (3)		
Family doctor same day access	2	
Major surgery < 90 days	2	
Cancer therapy < 21 days	2	
CT scan < 7 days	3	

Sources: (1) OECD Health at a Glance Europe 2012<sup>243</sup>, (2) Joint Report on Health systems (2010)<sup>244</sup>, HEIDI WIKI<sup>245</sup> and EuroHealth Consumer Index 2012<sup>246</sup>, (3) EuroHealth Consumer Index 2012.

<b>Corruption in healthcare perceptions</b>		
<b>Do you think that the giving and taking of bribes, and the abuse of positions of power for personal gain, are widespread among people working in the public health sector?</b>		
	<i>Greece</i>	<i>EU average</i>
(% of respondents agree - Eurobarometer)	75%	30%
<b>Please indicate on a scale of 1 (= no problem) to 5 (= very serious problem) to what extent corruption is a serious issue in your country (average score of 4 interviewees)</b>		
	<i>Greece</i>	
Informal payments in medical service delivery	5	
Certification and procurement of medical equipment	5	
Authorisation and procurement of pharmaceuticals	4.5	

Sources: Special Eurobarometer 374, table QC4 (fieldwork September 2011); own research (fieldwork February/March 2013).

## Types of healthcare corruption

Corruption is considered to be deeply embedded in the Greek healthcare system. 'In many ways, the health-care system is a microcosm of Greece itself. Big debts in the public hospital system helped usher in Greece's financial crisis in 2009, and health

<sup>243</sup> <http://www.oecd.org/els/health-systems/HealthAtAGlanceEurope2012.pdf>.

<sup>244</sup> [http://europa.eu/epc/pdf/joint\\_healthcare\\_report\\_en.pdf](http://europa.eu/epc/pdf/joint_healthcare_report_en.pdf).

<sup>245</sup> [https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing\\_healthcare/Healthcare\\_financing\\_systems](https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing_healthcare/Healthcare_financing_systems).

<sup>246</sup> Health Consumer Powerhouse – EuroHealth Consumer Index 2012: <http://www.healthpowerhouse.com/index.php?Itemid=55>.

care is now a key battleground as the country struggles to escape it.<sup>247</sup> There is relative big tolerance towards corruption in Greek society. One interviewee pointed out that the cultural crisis came first, and then a social crisis and a financial crisis followed. All these issues are interconnected.

*Informal payments.* Informal payments to get access to healthcare are a generally accepted practice. Tariff: 50 EUR for admission to a hospital to 3.000 EUR for surgery. Motivations: access to healthcare, bypass waiting lists, secure healthcare from a specific provider (for example a professor of medicine) or to have access to surgery. This practice is common, but few reports or complaints take place because patients are reluctant to report health professionals.

*Procurement.* In procurement offering kickbacks (money and non-monetary kickbacks) and collusion (supply companies collude and divide the market) is common. Both corruption related to certification and procurement of medical equipment and that related to authorization and procurement of pharmaceuticals, are very serious issues. The difference is that the effort to reduce spending for drugs is more focused and systematic.

*Procurement of medical equipment.* The predominant type is the practice of setting up technical standards and specifications in such a way as to favour a single supplier and put obstacles to market competition – what is commonly called ‘photograph tendering’. Kickbacks often take the form of offers by supply companies to donate equipment, in order to secure that they will supply the hospital with the necessary consumable materials for the equipment’s operation. There are (insufficient) legal restrictions to this practice.

*Procurement and authorisation of pharmaceuticals.* Until recently there were very serious problems. Pharmaceutical companies made contacts with directors of clinical departments and doctors and influenced hospital drug committees, asking their products to enter the hospital. In return money or other benefits were given. The most common form is that pharmaceutical companies pay travel expenses of healthcare providers to attend medical congresses, sometimes hosted abroad, or expenses of electronic equipment etc.

*What is offered in exchange is not always money* Financing medical conferences in popular travel destinations is still common practice (offering leisure trips (to relatives), jobs for relatives, hospital expenses). In other cases suppliers offer jobs to relatives.

*Shift to influencing opinion leaders* With respect to pharmaceutical self-promotion and prescription influencing: *there is a shift from influencing individual doctors to influencing opinion leaders in the medical community, in particular academics.* Only small and medium sized pharmaceutical companies still bribe doctors to prescribe their products. Another interviewee had similar observations: ‘The practice of pharmaceutical companies paying kickbacks to individual healthcare practitioners, in order to influence drug prescription was probably something that occurred frequently

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<sup>247</sup> Source: Wall Street Journal, November 12, 21011, Health System Reflects Greece's Ills .<http://online.wsj.com>.

in the past but he believes that nowadays is significantly reduced. The introduction of electronic prescription contributed to that reduction because detection of foul prescription patterns is much easier by this IT application.'

*Revolving doors.* One interviewee observed that revolving door phenomena have appeared in healthcare. High level officials of the Ministry of Health have taken, after their service, key positions in the industry (private sector). Revolving door practices could be fought with legislation that would ban officials regulating a certain sector or industry to be employed by the industry for a certain period of time after leaving their service as regulators.

### **Causes and risks:**

- Root cause is social values. High tolerance towards corruption. Corruption is part of business ethics. Inefficiencies in regulatory and policy framework are a result of these root causes;
- Limited transparency and information concerning patients' rights and standards for the provision of services in healthcare;
- Low level of medical professionals' wages. The issue of unofficial payments is directly related to the low salaries of healthcare providers and particularly doctors;
- Control mechanisms are fragmented and not independent (sometimes corrupted). There are also more technical and operational inefficiencies. For the personal data protection law can be an obstacle to investigate;
- Weaknesses in the judicial system. High degree of impunity;
- Legislation on maximum prices to medical devices turned out to be counter-effective. Prices increased (to the maximum level, which is 3 to 4 times higher than in other European countries), the list of devices on the list grew to 2/3 of all medical materials, and trade in medical devices through Cyprus (huge profits) was stimulated;
- Complexity of the legal and regulatory framework concerning procurement of medical supplies ('The average time for a procurement process to conclude is 120 days in EU countries, in Greece it is approximately 3 years');
- Decentralization of medical procurement turned out to be counter effective as well. High degree of decentralization in the procurement of medical equipment favoured corruption. Hospital managers were not appointed according to professional qualifications also played a role.

### **Actual and suggested policies and practices:**

- Law obedience: One interviewee considered as key issue the strengthening of the idea that the law applies for everyone, no matter what his place in the system is, and that the law will be implemented;
- The Electronic Prescription System is a successful policy that has reduced corruption related to prescription and could reduce it even more if it is implemented 100%. The introduction of electronic prescription contributed to that reduction because detection of foul prescription patterns is much easier by this IT application;

- The formation of the Independent Authority for Public Contracts is a policy that enforces prevention of corruption related to public procurement. The creation of the Central Electronic Registry of Public Contracts is a useful tool that allows the monitoring of procurement procedures of the public sector;
- Other technical measures: Some other technical measures have been introduced, such as: The formation of the Committee of Health Procurement helped to combat corruption that was related to the high degree of decentralization; The introduction of the Health Supplies Price Watch is a successful practice that helped to reduce the prices in health supplies procurement; The introduction of active substance prescription can have a positive effect for reducing spending for drugs; The conducting of census by social security funds in order to detect abusers who unlawfully receive pensions and benefits is also a useful tool; The setup of a Certified Registry for health supplies as well as suppliers;
- Better control mechanisms: The strengthening of accountability through control (both internal and external); The implementation of double entry accounting system thoroughly in all NHS Hospitals. This is considered as vital because it can help hospital management to set objectives and monitor implementation;
- Better qualified hospital staff: Appointing qualified staff for managerial and finance services of government Hospitals through the Public Servants Mobility Scheme;
- Higher salaries in combination with better accountability mechanisms: Increase at the salaries of government medical doctors combined with control of the fixed budget of clinical departments by their directors. Accountability and assessment mechanisms should be in place;
- Modernization of procurement: 'Corruption could be significantly reduced if we could make good use of new forms of procurement processes, like competitive dialogue, electronic tendering, dynamic purchasing system.' Most of these forms are included in national and EU legislation and if implemented, combined with simple, accountable and transparent procedures, corruption and waste could be significantly contained. These forms could be used for the procurement of medical equipment, biotechnology products and pharmaceuticals. The effort of introducing these new forms for the procurement of the health sector has been intensified recently. The initiation of the Electronic Registry of Public Contracts is part of this effort.

## Hungary

### General description of the healthcare system<sup>248</sup>

Hungary has a system of mandatory health insurance that offers a comprehensive benefit package. Voluntary health insurance is available, but does not play a significant role in the financing of healthcare.

The public expenditure on health in Hungary is financed by a combination of insurance contributions and transfers of general tax revenues. The Tax Office is the agency that collects the contributions and these are then pooled in the Health Insurance Fund (HIF) by the National Health Insurance Fund Administration (NHIFA)<sup>249</sup>. The HIF contribution rates are annually set by the National Assembly and the central government decides upon the benefit packages and the contracting.

The central government is the most important regulator of the healthcare sector: it has direct control over the NHIFA and has thus the responsibility of administering health(care) financing, resource allocation and provider payment methods. Moreover, it has some direct functions related to healthcare financing such as the covering of the HIF deficit and the paying of HIF contributions for certain non-contributing social groups.

### Delivery of healthcare

Most of the healthcare facilities in Hungary are owned by the local governments. Moreover, the State Secretariat of Health (which is part of the Ministry of National Resources) runs state hospitals. The majority of these hospitals are sanatoria for medical rehabilitation. The municipalities are responsible for primary healthcare. The gatekeeping function of the primary care physicians has not proven to be particularly successful according to the Health Systems in Transition report<sup>250</sup> for Hungary. The provision of secondary and tertiary care is shared among municipalities, counties, the central government and private providers.

Physicians in Hungary are either employees that receive a salary or private entrepreneurs that are contracted by the NHIFA. The services provided by family doctors are paid on the basis of capitation, outpatient specialist care based on a fee-for-service point system, acute inpatient care based on DRGs and chronic care based on per diem rates.

<sup>248</sup> Main sources for this section: Gaál P, Szigeti S, Csere M, Gaskins M, Panteli D. Hungary: Health system review. *Health Systems in Transition*, 2011; 13(5):1–266. [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0019/155044/e96034.pdf](http://www.euro.who.int/__data/assets/pdf_file/0019/155044/e96034.pdf), Hungarian Health System Scan (2011): [http://www.eski.hu/new3/hirlevel\\_en/2011/health\\_system\\_scan\\_2011\\_1.pdf](http://www.eski.hu/new3/hirlevel_en/2011/health_system_scan_2011_1.pdf) and Gal R I (2012). asisp Annual National Report 2012 Hungary. Pensions, Health Care and Long-term Care. Downloaded from: [http://www.socialprotection.eu/files\\_db/1239/asisp\\_ANR12\\_Hungary.pdf](http://www.socialprotection.eu/files_db/1239/asisp_ANR12_Hungary.pdf).

<sup>249</sup> Note that the NHIFA is the single-payer in the healthcare system in Hungary.

<sup>250</sup> Gaál P, Szigeti S, Csere M, Gaskins M, Panteli D. Hungary: Health system review. *Health Systems in Transition*, 2011; 13(5):1–266. [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0019/155044/e96034.pdf](http://www.euro.who.int/__data/assets/pdf_file/0019/155044/e96034.pdf).

Indicators of the healthcare system, 2010 (or nearest year)		
Financing of the healthcare system (1)		
	Hungary	EU average
Total health expenditure as % of GDP	7.8%	9%
Public expenditure as % of total health spending	65%	73%
Private insurance as % of total health spending	2%	4%
Private-out-of-pocket as % of total health spending	26%	21%
Organisation of the healthcare system (2)		
Social insurance or tax-based system?	Social insurance	
Gatekeeping by a general practitioner (GP)?	Compulsory	
How are physicians paid? (e.g. salary, fee-for-service, capitation)	Capitation/fee-for-service/salary	
Patient organisation involvement (3=good, 2=intermediary, 1=not-so-good)	1	
Accessibility (3=good, 2=intermediary, 1=not-so-good) (3)		
Family doctor same day access	3	
Major surgery < 90 days	2	
Cancer therapy < 21 days	2	
CT scan < 7 days	1	

Sources: (1) OECD Health at a Glance Europe 2012<sup>251</sup>, (2) Joint Report on Health systems (2010)<sup>252</sup>, HEIDI WIKI<sup>253</sup> and EuroHealth Consumer Index 2012<sup>254</sup>, (3) EuroHealth Consumer Index 2012.

<b>Corruption in healthcare perceptions</b>		
<b>Do you think that the giving and taking of bribes, and the abuse of positions of power for personal gain, are widespread among people working in the public health sector?</b>		
	<i>Hungary</i>	<i>EU average</i>
(% of respondents agree - Eurobarometer)	50%	30%
<b>Please indicate on a scale of 1 (= no problem) to 5 (= very serious problem) to what extent corruption is a serious issue in your country (average score of 3 interviewees)</b>		
	<i>Hungary</i>	
Informal payments in medical service delivery	5	
Certification and procurement of medical equipment	4	
Authorisation and procurement of pharmaceuticals	3	

Sources: Special Eurobarometer 374, table QC4 (fieldwork September 2011); own research (fieldwork February/March 2013).

<sup>251</sup> <http://www.oecd.org/els/health-systems/HealthAtAGlanceEurope2012.pdf>.

<sup>252</sup> [http://europa.eu/epc/pdf/joint\\_healthcare\\_report\\_en.pdf](http://europa.eu/epc/pdf/joint_healthcare_report_en.pdf).

<sup>253</sup> [https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing\\_healthcare/Healthcare\\_financing\\_systems](https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing_healthcare/Healthcare_financing_systems).

<sup>254</sup> Health Consumer Powerhouse – EuroHealth Consumer Index 2012: <http://www.healthpowerhouse.com/index.php?Itemid=55>.



## **Types of healthcare corruption**

### ***Informal payments***

All interviewees mention the problem of informal payments in Hungary. According to a recent study the size of informal payments has not changed dramatically in the last 20 years, after the change of the socialist regime, in spite of several arrangements by the governments trying to deal with these payments. The results show that in 2010 (among a representative sample of 1037 respondents) 21% of those who visited physicians paid informally for these visits, on average 16 900 Ft (60 EUR) during a one year period (Baji, Gulácsi 2012). In hospital care informal payments are more widespread, almost half of the respondents (44%) had informal payments on average 37 300 Ft (131 EUR) a one year period. The highest payments were recorded to have been paid by the oldest age group and by health care users with the worst health status.

In Hungary informal payments are not necessarily perceived as a corruptive practice. The regulations do not explicitly forbid these payments.

### ***Procurement***

Also mentioned by interviewees, is that public procurement of both medical equipment and pharmaceuticals frequently experiences corrupt techniques. They use intermediary companies, who purchase all the equipment for the hospitals from different manufacturers, before selling the equipment as one to the hospital for a different price. They are the so so-called 'packaging companies' or 'facilitators'. Their activity is mostly hidden and they receive a fee for their services both from the hospital as well as the company that supplies the assets. Often this will involve tailored TOR and very specific requirements to ensure a preferred supplier 'winning' the bid.

These intermediaries then ensure that the right people involved are rewarded for their support as well as silence. In Hungary the corruption in public procurements is strongly associated with the financing of political parties. Most of the cases the money goes through different companies (law firms, PR companies) most of the cases via fictive invoices for fictive services, till it reaches the target which is either a private person or a political party or in some cases a certain Foundations).

### ***State Capture***

One interviewee also explained that large scale corruption is partly the resultant of the interference of the political and business elite. This is a growing problem in Hungary and particularly during the past few years when the government has an absolute majority (2/3) in the parliament and is therefore conducting even constitutional changes. Previously more control mechanisms – e.g. opposition, independent controlling institutions – existed (although their efficiency was also questioned). In the current environment dominant and growing political influence is stripping institutions

of their independence. These include: the judiciary, media, Audit Office, even the public prosecution.

This influence of political and business groups is what is called 'state capture' and is a very serious issue as checks and balances are eroded.

### **Causes and risks**

Various risks were mentioned:

*Lack of transparency* is currently increasing as the government is in the process of nationalising all hospitals and also setting up a central procurement system. Such centralised and enclosed system as is being enacted in Hungary increases the non-transparent dealings and hides them.

*Lack of independent media* as currently all media is controlled/owned by the state. Furthermore the governments active meddling in the media has destroyed any notion of independent investigative journalism and as a consequence has increased the silence and lack of knowledge about the corruption activities in Hungary.

*Lack of regulation* is currently being reviewed and efforts are being made to strengthen the legislation and clarify the fact that corruption is a crime (previously a more grey area).

*Lack of police, state prosecutor and judicial independence*, leading to a lot of activities even if discovered never being punished, thus decreasing the risk of being caught and encouraging more corrupt activities.

*Lack of information/data* is a serious issue as the fewer reliable data there is on the corrupt practices the harder it is to identify corrupt practices.

When one takes into account these factors that diminish the risks of corruption together with a dire economic situation (where doctors are rather underpaid) and personal greed one can observe that Hungary's environment is very susceptible to corruption.

The Ethic Codex of the Medical Chamber declares that '...one of the explanations of the existence of informal payments is the low salary of the physicians and the dysfunction of the health system. and because of this informal payments are tolerated' (Ethical Codex of the Hungarian Medical Chamber). A recent study indicated that most of the consumers 'legitimate' the existence of informal payments as they consider these payments are inevitable because of the low funding of the health system. (Baji, Gulácsi 2012)

### **Actual and suggested policies and practices**

Recently the government has implemented a comprehensive anti-corruption policy (i.e. comprehensive anticorruption legislation, the introduction of Ethical Codex in

public services, and the introduction of 'integrity packs/agreements during public procurements, the establishment of databases on public procurements, educational programs), which followed international recommendations.

However according to the experts involved in the study, there is a high risk, that the regulations will not be implemented correctly. Also, the experts highlighted the risks of state-capture in Hungary, as most of the institutions responsible for the controlling mechanisms, are not independent anymore.

## Ireland

### General description of the healthcare system<sup>255</sup>

The current healthcare system of Ireland is subject to the most fundamental reform in the country's history, which is called 'Future Health: A Strategic Framework for Reform of the Health Service' and which takes place between 2012 and 2015. The main reforms concern the introduction of a single-tier health service supported by a Universal Health Insurance (UHI) to be introduced in 2016, which aims to provide access to healthcare according to patients' need instead of patients' ability to pay.

Currently, healthcare in Ireland can be characterised by a centralised system regulated by the Department of Health Care (DOHC) under the supervision of the Minister of Health Care (MOHC). Since 2005 the Health Service Executive (HSE) is responsible for the provision of health services. Another important actor is the Department of Finance (DoF) which is the main actor in the distribution of general taxation across different government departments, including health and social care.

The main source of funding is taxation, including social payroll taxes and consumer-taxes. Complementary sources of funding are out-of-pocket payments and contributions to private health insurers. The latter have always been an important source of healthcare financing in Ireland.

### Delivery of healthcare

Healthcare in Ireland is centred around primary care in which the general practitioner acts as the gatekeeper of the system. The general practitioner is a patient's first contact point in accessing the healthcare system. Patients are required to receive a referral from their general practitioner to visit a specialist. Secondary care is provided by voluntary as well as HSE hospitals and is delivered on different regional levels (district/county/regional).

Access to healthcare in Ireland is seen as a major challenge, as significant regional differences are prevalent. Patients are free to choose their preferred general practitioner. However the choice of patients with Medical Cards is limited to general practitioners working under the Primary Care Reimbursement Scheme (PCRS).

GPs contracted by the National Shared Services (PCRS), which is part of the HSE, are mainly paid on a capitation basis. Additional services and services provided to privately insured patients are reimbursed by a fee-for-service system. Payments to specialists employed in hospitals are salary-based. Only specialists active in private hospitals are paid on a fee-for-service basis.

<sup>255</sup> Main sources for this section: McDaid D, Wiley M, Maresso A and Mossialos E. Ireland: Health system review. *Health Systems in Transition*, 2009; 11(4): 1 – 268. [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0004/85306/E92928.pdf](http://www.euro.who.int/__data/assets/pdf_file/0004/85306/E92928.pdf), Considine M and Burke S (2012). asisp Annual National Report 2012 Ireland. Pensions, Health Care and Long-term Care. Downloaded from: [http://www.socialprotection.eu/files\\_db/1242/asisp\\_ANR12\\_IRELAND.pdf](http://www.socialprotection.eu/files_db/1242/asisp_ANR12_IRELAND.pdf) and [http://www.tca.ie/images/uploaded/documents/Future\\_Health.pdf](http://www.tca.ie/images/uploaded/documents/Future_Health.pdf).

Indicators of the healthcare system, 2010 (or nearest year)		
Financing of the healthcare system (1)		
	Ireland	EU average
Total health expenditure as % of GDP	9.2%	9%
Public expenditure as % of total health spending	70%	73%
Private insurance as % of total health spending	13%	4%
Private-out-of-pocket as % of total health spending	17%	21%
Organisation of the healthcare system (2)		
Social insurance or tax-based system?	Tax-based	
Gatekeeping by a general practitioner (GP)?	Financially encouraged	
How are physicians paid? (e.g. salary, fee-for-service, capitation)	Capitation/salary	
Patient organisation involvement (3=good, 2=intermediary, 1=not-so-good)	2	
Accessibility (3=good, 2=intermediary, 1=not-so-good) (3)		
Family doctor same day access	3	
Major surgery < 90 days	2	
Cancer therapy < 21 days	2	
CT scan < 7 days	1	

Sources: (1) OECD Health at a Glance Europe 2012<sup>256</sup>, (2) Joint Report on Health systems (2010)<sup>257</sup>, HEIDI WIKI<sup>258</sup> and EuroHealth Consumer Index 2012<sup>259</sup>, (3) EuroHealth Consumer Index 2012.

<b>Corruption in healthcare perceptions</b>		
<b>Do you think that the giving and taking of bribes, and the abuse of positions of power for personal gain, are widespread among people working in the public health sector?</b>		
	<i>Ireland</i>	<i>EU average</i>
(% of respondents agree - Eurobarometer)	15%	30%
<b>Please indicate on a scale of 1 (= no problem) to 5 (= very serious problem) to what extent corruption is a serious issue in your country (average score of 2 interviewees<sup>260</sup>)</b>		
	<i>Ireland</i>	
Informal payments in medical service delivery	NA	
Certification and procurement of medical equipment	2	
Authorisation and procurement of pharmaceuticals	2	

Sources: Special Eurobarometer 374, table QC4 (fieldwork September 2011); own research (fieldwork February/March 2013).

<sup>256</sup> <http://www.oecd.org/els/health-systems/HealthAtAGlanceEurope2012.pdf>.

<sup>257</sup> [http://europa.eu/epc/pdf/joint\\_healthcare\\_report\\_en.pdf](http://europa.eu/epc/pdf/joint_healthcare_report_en.pdf).

<sup>258</sup> [https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing\\_healthcare/Healthcare\\_financing\\_systems](https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing_healthcare/Healthcare_financing_systems).

<sup>259</sup> Health Consumer Powerhouse – EuroHealth Consumer Index 2012: <http://www.healthpowerhouse.com/index.php?Itemid=55>.

<sup>260</sup> Note that one respondent did not answer all of the three questions, and that one respondent did not answer the question about the informal payments in medical service delivery.

## **Types of healthcare corruption**

### ***Informal payments***

From the interviews conducted it appears that rather than corruption per se, unwanted practices take the form of fraudulent behaviour. For instance by conducting double accounting where doctors do work on a private basis, and then resubmit the invoice and claim a payment back from the Health Service Executive (HSE).

### ***Procurement***

The general consensus of the interviewees is that there is a lot of regulation around the procurement of medical equipment, therefore substantially limiting the scope for corruption. On top of that there is a lot of oversight, by the control mechanism of the country as well as investigative journalists and members of the public that ensure transparent and efficient procurement procedures.

According to the same sources, there is a less of an issue with corruption in relation to procurement of pharmaceuticals, this is because of local policies at Primary Care Trust level, there is now more scrutiny of drug companies and gifts etc. that are given to Doctors. Currently the corporate sponsorship of research and training is a big issue, or is potentially important. This involves drug companies funding medical trainings and practices with the intention to educate medical staff and in return ensure their brand loyalty in using the drugs in their later careers.

### **Causes and risks**

The main reason that have come out of the interviews is: the greed of individuals that are financially comfortable, but try to illegally acquire more.

### **Actual and suggested policies and practices**

The general cultural aversion to corruption together with strong institutions and tight regulation has ensured that Ireland has, according to the interviewees, very low levels of corruption. Nevertheless the government continues its work to ensure the continuation of such good practices. From our research and interviews it becomes apparent that the government does this by independent institutions, regulations and information management.

### ***Independent institutions***

A number of bodies exist to regulate medical equipment and pharmaceutical distribution in Ireland. The Irish Medicines Board (IMB) was established in 1995 to, *'To protect and enhance public and animal health through the regulation of medicines, medical devices and healthcare products'*<sup>261</sup>.

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<sup>261</sup> <http://www.imb.ie/>.

The IMB also carries out enforcements for regulations including investigations of potential breaches of medical standards, and prosecutions of individuals and companies where the law has been broken. The IMB also plays a role tackling cyber fraud in healthcare; this includes the monitoring of websites for the illegal supply of drugs into Ireland.

There is a Standards in Public Office Commission (SIPO), 'SIPO oversees political finance regulations and enforces the Ethics Acts, which regulate conflicts of interest at national level, largely through disclosure rules<sup>262</sup>.' There have been calls such as those from the Mahon Tribunal<sup>263</sup> to increase SIPO powers. The Mahon Tribunal of Inquiry Into Certain Planning Matters and Payments was set up to investigate allegations of corrupt payments to politicians regarding political decisions.

Using a European Commission grant, in May 2011, Transparency International Ireland launched Western Europe's first, 'free ethics and anti-corruption helpline.' The service is called Speak Up and offers, 'free guidance and information to individuals who are faced with ethical dilemmas or reporting concerns at work as well as victims of wrongdoing.'

### **Health Information Quality Authority**

The Health Information Quality Authority is an independent authority established in 2007 to drive continuous improvement in Ireland's health and social care services. *'Our independence within the health system is key and central to us being successful in undertaking our functions.'*

The Health Services Executive (HSE) has published a framework for the Corporate and Financial Governance of the Health Service Executive. This document sets out the HSE policy on fraud. *'The HSE is determined that the culture and tone of the organization will continue to one of honesty and opposed to fraud and corruption.'*

### **Regulation**

The Irish Medicines Board Enforcement Strategy 2012-2016 is aimed at maximising the impact of Enforcement activities on illegal and counterfeit/ falsified product supply. One of the main aims of the strategy is to deter illegal activity by increasing the risk of reputational, economic and criminal sanctions to those involved in the illegal manufacture, supply and distribution of authorised and illegal and counterfeit / falsified healthcare products.

The Pharmaceutical Society of Ireland (PSI) was established as the statutory regulator of pharmacy in Ireland under the **Pharmacy Act (2007)**, *'It is charged with, and is accountable for, the effective regulation of pharmacy services in Ireland, including responsibility for supervising compliance with the Act.'*

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<sup>262</sup> NIS Irish Appendum.

<sup>263</sup> <http://www.planningtribunal.ie/images/finalReport.pdf>.

## Italy

### General description of the healthcare system<sup>264</sup>

Italy has a regionally based National Health Service (SSN) that provides universal coverage. Most services are free of charge at the point of use. The SSN covers a comprehensive package of services. This is one of the reasons why private health insurance, although available, does not play a big role.

The SSN is primarily funded through regional taxation. This is complemented with general tax revenues. Private sources of funding are cost-sharing (e.g. co-payments on pharmaceuticals and diagnostic procedures), fixed co-payments for unwarranted access to hospital emergency departments and direct payment by users (either to purchase private healthcare services or over-the-counter drugs).

The national government is responsible for regulating and ensuring the general objectives of the healthcare system. The regional health departments of the regional governments are responsible for ensuring the delivery of healthcare services.

### Healthcare delivery

Primary healthcare is provided by GPs, paediatricians and self-employed and independent physicians working under a government contract. Primary healthcare providers are mainly paid on a capitation basis. There is a formal gatekeeping system in place, however, for some services patients can directly book an appointment for themselves through a central booking point.

Specialist outpatient care is provided by either 'local health enterprises' (ASLs) or by accredited public and private facilities that have a contract with ASLs. Hospital care is delivered by both public facilities and private facilities (of which most are not-for-profit). Physicians that work in a hospital earn a monthly salary.

In Italy there is a substantial difference between the north and south in the quality of healthcare facilities and the services provided.

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<sup>264</sup> Main sources for this section: Lo Scalzo A, Donatini A, Orzella L, Cicchetti A, Profi li S, Maresso A. Italy: Health system review. *Health Systems in Transition*, 2009; 11(6)1-216.  
[http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0006/87225/E93666.pdf](http://www.euro.who.int/__data/assets/pdf_file/0006/87225/E93666.pdf) and Jessoula M and Pavolini E (2012). asisp Annual National Report 2012 Italy. Pensions, Health Care and Long-term Care. Downloaded from: [http://www.socialprotection.eu/files\\_db/1249/asisp\\_ANR12\\_\\_ITALY.pdf](http://www.socialprotection.eu/files_db/1249/asisp_ANR12__ITALY.pdf).



<b>Indicators of the healthcare system, 2010 (or nearest year)</b>		
<b>Financing of the healthcare system (1)</b>		
	<i>Italy</i>	<i>EU average</i>
Total health expenditure as % of GDP	9.3%	9%
Public expenditure as % of total health spending	80%	73%
Private insurance as % of total health spending	1%	4%
Private-out-of-pocket as % of total health spending	18%	21%
<b>Organisation of the healthcare system (2)</b>		
Social insurance or tax-based system?	Tax-based	
Gatekeeping by a general practitioner (GP)?	Compulsory	
How are physicians paid? (e.g. salary, fee-for-service, capitation)	Capitation (primary care) & salary (secondary care)	
Patient organisation involvement (3=good, 2=intermediary, 1=not-so-good)	3	
<b>Accessibility (3=good, 2=intermediary, 1=not-so-good) (3)</b>		
Family doctor same day access	2	
Major surgery < 90 days	1	
Cancer therapy < 21 days	2	
CT scan < 7 days	1	

Sources: (1) OECD Health at a Glance Europe 2012<sup>265</sup>, (2) Joint Report on Health systems (2010)<sup>266</sup>, HEIDI WIKI<sup>267</sup> and EuroHealth Consumer Index 2012<sup>268</sup>, (3) EuroHealth Consumer Index 2012.

<b>Corruption in healthcare perceptions</b>		
<b>Do you think that the giving and taking of bribes, and the abuse of positions of power for personal gain, are widespread among people working in the public health sector?</b>		
(% of respondents agree - Eurobarometer)	<i>Italy</i>	<i>EU average</i>
	40%	30%
<b>Please indicate on a scale of 1 (= no problem) to 5 (= very serious problem) to what extent corruption is a serious issue in your country (average score of 7 interviewees<sup>269</sup>)</b>		
	<i>Italy</i>	
Informal payments in medical service delivery	4	
Certification and procurement of medical equipment	4	
Authorisation and procurement of pharmaceuticals	3	

Sources: Special Eurobarometer 374, table QC4 (fieldwork September 2011); own research (fieldwork February/March 2013).

## Types of healthcare corruption

### *Corruption in the public sector in Italy is perceived to be high*

Specifically related to health, the European Court of Justice estimates that the total amount of waste, malpractice and corruption is 56 billion euro and 20 billion just in

<sup>265</sup> <http://www.oecd.org/els/health-systems/HealthAtAGlanceEurope2012.pdf>.

<sup>266</sup> [http://europa.eu/epc/pdf/joint\\_healthcare\\_report\\_en.pdf](http://europa.eu/epc/pdf/joint_healthcare_report_en.pdf).

<sup>267</sup> [https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing\\_healthcare/Healthcare\\_financing\\_systems](https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing_healthcare/Healthcare_financing_systems).

<sup>268</sup> Health Consumer Powerhouse – EuroHealth Consumer Index 2012: <http://www.healthpowerhouse.com/index.php?Itemid=55>.

<sup>269</sup> Note that one respondent did not answer the question about the certification and procurement of medical equipment, and that two respondents did not answer the question about the authorisation and procurement of pharmaceuticals.

Italy. According to the country expert, this estimate appears to be too high and includes also inefficiencies and disorganizations. (A Country profile – by Elio Borgonovi).

According to the country expert, corruption in the health sector can be related to:

- Market authorization procedures to commercialize drugs and medical devices (this aspect was very critical at the end of the '80 and beginning of the '90 of the last century, but nowadays it is less relevant because of the centralised procedure for drugs and CE standard for medical devices);
- Definition of prices for patent drugs or for innovative medical devices;
- Inclusion of drugs and devices in the positive list for reimbursement by the National Health System (both at national and regional level). For this decision the risk of corruption is still fairly high, even if some interventions have been adopted to address it;
- Over prescription of drugs and medical examinations by GPs or specialists. For example, some representatives or promoters of pharmaceutical companies (in Italian 'informatore farmaceutici') push general practitioners and specialists to prescribe more drugs than appropriate and guarantee them black payments or financial support to false scientific associations or foundations;
- Outsourcing public health care services to private hospitals, ambulatories, laboratories with weak control on the activities actually performed;
- Accreditation of private institutions that do not respect minimum standards for patient safety and quality of services;
- Reimbursement of hospital treatment at DRGs tariffs higher than the appropriate ones. Once again this occurs in many regions, because they do not apply effective controls (even the best one, Lombardy, audits no more than 5% of discharges).

Other prevailing corruption types that have been identified by the interviewees:

- Bribery to skip waiting lists;
- Reimbursement for services that are never actually performed;
- Within the procurement process: Corruption of the commissioner of public tenders (not further specified); attempt to influence tender criteria and evaluation procedures;
- Complex and elaborate systems of favouritism, both contractually and financially, towards private health care providers (not further specified).

## **Actual and suggested policies and practices**

### ***Content of the government's anti-corruption policy:***

In sum, the anti-corruption strategy of the government is based on:

1. A national commission to address corruption;
2. A three years plan for each administration and the public sector as a whole;
3. A national observatory on the corruption phenomena;
4. An annual report to the Parliament on the effectiveness of anti-corruption policies;

5. Controls of the respect of transparency in public procurement, tendering and personnel recruitment;
6. Appointment of managers to implement these policies in each administration. In case of repeated violations of the plan, the person responsible responds with penalties of a disciplinary offense (variably sized);
7. More severe penalties for public administrators and managers involved in corruption investigation or who are already condemned.

The anticorruption strategy not started yet, because other decrees are needed to make it entirely functional.

***Other measures related to the health system:***

- In the last 10 years, some local health care delivery organizations and hospitals introduced codes of conduct and code of ethics. Only in very few cases they have been really effective. In other cases they are only documents that have been presented to employees, without substantial changes in terms of actual behaviour;
- At individual level, many new appointed administrators and managers in healthcare organizations adopted the 'open door and transparency' policy for contacts with suppliers. This means that they reduced the risk to be captured by corruptors of any kind;
- On October 31<sup>st</sup> 2012 a national law was approved for reorganization of the national health system. It requires that each region must define a list of selected potential managers for local health care delivery organizations. One of the fundamental requirements is to verify that nobody is involved in corruption investigations.

Other measures to prevent and contrast corruption have been adopted, but very few of them have been really effective. Also, the formal and bureaucratic use of the laws became an obstacle to prevent and address corruption.

## Latvia

### General description of the healthcare system<sup>270</sup>

Latvia has a rather unique health system which is tax-funded but has a social insurance institutional characteristics in which there is a purchaser-provider split and a mix of public and private providers. Next to taxes, the system is financed through direct payments and voluntary health insurance. The Ministry of Health is responsible for the overall organisation and functioning of the health system.

The taxes are collected by the Ministry of Finance and subsequently the Treasury allocates the budget for health to the State Compulsory Health Insurance Agency (SCHIA). SCHIA is state-run institution and is responsible for the pooling of the funds and the purchasing of health services for all Latvia's citizens. It has a Central Office and five territorial branches. The Central office is responsible for the contracting of providers of inpatients and emergency services. Secondary outpatient care and primary care are contracted by the five territorial branches.

The system provides coverage for a basic package for all its citizens, however, there are substantial user charges, especially for pharmaceuticals<sup>271</sup>. People that meet the criteria for the formal status of 'low-income person' are exempted from paying co-payments.

### Delivery of care

Primary care physicians and dentists are generally self-employed or work in health centres which may have public, private or mixed ownership. Other health personnel is employed by primary care physicians, dentists or health centres. Secondary care mostly has ownership at the local government level. Tertiary care is exclusively publically owned at the state level. All hospital staff is employed on a salary basis by the hospital administration.

The payment methods that are used are mixed and rather complex. For hospitals the plan is to introduce a diagnosis-related group based payment system by 2014.

<sup>270</sup> Main sources for this section: Mitenbergs U, Taube M, Misins J, Mikitis E, Martinsons A, Rurane A, Quentin W. Latvia: Health system review. 2012; 14(8): 1 – 191. [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0006/186072/e96822.pdf](http://www.euro.who.int/__data/assets/pdf_file/0006/186072/e96822.pdf) and Bite I (2012). asisp Annual National Report 2012 Latvia. Pensions, Health Care and Long-term Care. Downloaded from: [http://www.socialprotection.eu/files\\_db/1261/asisp\\_ANR12\\_LATVIA.pdf](http://www.socialprotection.eu/files_db/1261/asisp_ANR12_LATVIA.pdf).

<sup>271</sup> For non-prescription drugs and a significant share of prescribed drugs in the outpatient sector patients have to pay the full price. Pharmaceuticals are free of charge for inpatient care.

Indicators of the healthcare system, 2010 (or nearest year)		
Financing of the healthcare system (1)		
	Latvia	EU average
Total health expenditure as % of GDP	6.8%	9%
Public expenditure as % of total health spending	60%	73%
Private insurance as % of total health spending	1%	4%
Private-out-of-pocket as % of total health spending	36%	21%
Organisation of the healthcare system (2)		
Social insurance or tax-based system?	Tax-based	
Gatekeeping by a general practitioner (GP)?	Mixed system	
How are physicians paid? (e.g. salary, fee-for-service, capitation)	Mixed system	
Patient organisation involvement (3=good, 2=intermediary, 1=not-so-good)	3	
Accessibility (3=good, 2=intermediary, 1=not-so-good) (3)		
Family doctor same day access	1	
Major elective surgery < 90 days	1	
Cancer therapy < 21 days	1	
CT scan < 7 days	2	

Sources: (1) OECD Health at a Glance Europe 2012<sup>272</sup>, (2) and Joint Report on Health systems (2010)<sup>273</sup>, HiT report<sup>274</sup> and EuroHealth Consumer Index 2012<sup>275</sup>, (3) EuroHealth Consumer Index 2012.

<b>Corruption in healthcare perceptions</b>		
<b>Do you think that the giving and taking of bribes, and the abuse of positions of power for personal gain, are widespread among people working in the public health sector?</b>		
	<i>Latvia</i>	<i>EU average</i>
(% of respondents agree - Eurobarometer)	57%	30%
<b>Please indicate on a scale of 1 (= no problem) to 5 (= very serious problem) to what extent corruption is a serious issue in your country (average score of 3 interviewees<sup>276</sup> - own research)</b>		
	<i>Latvia</i>	
Informal payments in medical service delivery	4.5	
Certification and procurement of medical equipment	2.5	
Authorisation and procurement of pharmaceuticals	3.5	

Sources: Special Eurobarometer 374, table QC4 (fieldwork September 2011); own research (fieldwork February/March 2013).

## Types of healthcare corruption

The following types were mentioned by the interviewees:

- Lobbying of pharmaceutical companies: systematic corruption related to 'revolving doors and trading in influence';
- It is suspected that pharmaceutical companies are influencing regulatory decisions favourable to their own company;

<sup>272</sup> <http://www.oecd.org/els/health-systems/HealthAtAGlanceEurope2012.pdf>.

<sup>273</sup> [http://europa.eu/epc/pdf/joint\\_healthcare\\_report\\_en.pdf](http://europa.eu/epc/pdf/joint_healthcare_report_en.pdf).

<sup>274</sup> [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0003/95124/E91375.pdf](http://www.euro.who.int/__data/assets/pdf_file/0003/95124/E91375.pdf).

<sup>275</sup> Health Consumer Powerhouse – EuroHealth Consumer Index 2012:  
<http://www.healthpowerhouse.com/index.php?Itemid=55>.

<sup>276</sup> Note that one respondent did not answer the question about informal payments in medical service delivery, and that one respondent did not answer the question about certification and procurement of medical equipment and the question about the authorisation and procurement of pharmaceuticals.

- Conflict of interests are often observed, generally between heads or professional associations with pharmaceutical companies. CoI's are suspected between physicians and pharmaceutical companies when companies paid for attending conferences with luxury arrangements. Competing pharmaceutical companies could influence the prescription decisions as well;
- Procurement-related corruption prevails. For some years collusion in procurement often took place in the field of construction works;
- Kickbacks and bribery: According to population surveys, illegal patient payments to physicians and specialists seems to be a systematic type of corruption.

**Causes and risks:**

Various causes and risks were mentioned:

- There exists a certain tolerance towards some forms of corruption among the population, such as expressing gratitude to doctors in the form of giving gifts;
- There are some limitations to access to healthcare, which leads to illegal payments in order to receive early treatment;
- Generally, low salaries of physicians are perceived as a risk, though another interviewee stated that the level of wages is such an important risk factor;
- A lack of clarity about what is considered to be the basic package of services for the patients;
- There are also cases in which physicians claim to have delivered services which they did not carried out at all. Better internal control would be needed;
- It is very difficult to prove the criminal component in corruption cases which makes actual judicial follow –up difficult.

**Actual and suggested policies and practices*****Control and punishment, legislation:***

- Routine checks made by the Health Inspectorate have become much more efficient. For instance, since 2011 Latvian patients are able to check the data about their healthcare paid by the state. The patients can complain to the Health Inspectorate when information about medical services (reported by physicians) is inaccurate;
- The procurement monitoring bureau has a complaint committee, currently approximately 100 out of 1000 complaints go to the court;
- Corruption Prevention and Combating Bureau (KNAB): The institution is in charge of procurement, combating corruption and promoting competition through open tendering. This Bureau has prioritised corruption issues in healthcare.

***Improvement of public procurement:***

- Improvement in public procurement rules and procedures are likely to be observed, because of the introduction of an e-procurement system and expanding functions of

the procurement monitoring bureau. Though no systematic external evaluation is available;

- It can be observed, that since the last 3-4 years in which centralized procurement for all healthcare institutions was applied, the prices of purchases have been reduced and no new cases of corruption in procuring construction works have appeared.

***Setting boundaries and limitations: bribery and vertical integration patterns:***

- KNAB has introduced recommendations on the terms and boundaries for acceptable gifts to physicians; setting limitations on parallel physician employment in public and private facilities as well as on possibilities for physician to conduct the second job in companies- suppliers of equipment or pharmaceuticals;
- Owners of healthcare institutions are sometimes at the same time owners of pharmacies, or wholesalers.

***Bad practice***

Physician associations regard that the importance of anti-corruption activities regarding patient-physicians relationship is overestimated. A recent public campaign against bribes had got a controversial assessment from the Latvian Physicians Association stating that such campaigns could deteriorate physician-patient relationship.

## Lithuania

### General description of the healthcare system<sup>277</sup>

Lithuania has a mixed system of compulsory statutory health insurance, providing universal coverage. The National Health Insurance Fund (NHIF), a semi-autonomous state monopoly under the Ministry of Health, is the third-party payer in this system. All basic services are covered and provided free of charge. The benefit package, as well as the contributions and prices paid to providers are established by law.

The NHIF is funded through a combination of social insurance contributions and allocations from the state budget. The funds are managed by the State Patient Fund. Another source of funding is out-of-pocket payments, mainly for pharmaceuticals and excluded services. Although private health insurance is available in Lithuania, it is not purchased by many people. One of the main reasons for this are the high insurance premiums.

The healthcare system in Lithuania is organised at two levels: national and municipal. The Ministry of Health plays an important role in the system and is responsible for the regulation and general supervision of the healthcare system. The municipalities are responsible for providing primary and social care, public health activities, and running polyclinics and small to medium sized hospitals within their jurisdiction.

### Healthcare delivery

In Lithuania healthcare is provided by public providers (either state-managed or under municipal governments) and private providers. Primary care is provided by GPs or primary care teams and is mainly financed through capitation. The majority of the healthcare institutions are not-for-profit. The public providers are financed by the NHIF. In 2012 a new hospital financing system using DRGs was introduced.

Private healthcare institutions provide mostly outpatient services. They can be contracted by the NHIF or are paid by patients out-of-pocket. In general these private providers have the potential to offer higher quality treatments and/or treatments that are not available in public healthcare institutions.

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<sup>277</sup> Main sources for this section: Murauskiene L, Janoniene R, Veniute M, van Ginneken E, Karanikolos M. Lithuania: health system review. *Health Systems in Transition*, 2013; 15(2):1–150. [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0016/192130/HiT-Lithuania.pdf](http://www.euro.who.int/__data/assets/pdf_file/0016/192130/HiT-Lithuania.pdf) and Jankauskienė D and Medaiskis T (2012). asisp Annual National Report 2012 Lithuania. Pensions, Health Care and Long-term Care. Downloaded from: [http://www.socialprotection.eu/files\\_db/1255/asisp\\_ANR12\\_LITHUANIA.pdf](http://www.socialprotection.eu/files_db/1255/asisp_ANR12_LITHUANIA.pdf).



<b>Indicators of the healthcare system, 2010 (or nearest year)</b>		
<b>Financing of the healthcare system (1)</b>		
	<i>Lithuania</i>	<i>EU average</i>
Total health expenditure as % of GDP	7%	9%
Public expenditure as % of total health spending	72%	73%
Private insurance as % of total health spending	1%	4%
Private-out-of-pocket as % of total health spending	27%	21%
<b>Organisation of the healthcare system (2)</b>		
Social insurance or tax-based system?	Mixed system	
Gatekeeping by a general practitioner (GP)?	Financially encouraged	
How are physicians paid? (e.g. salary, fee-for-service, capitation)	Capitation/FFS/Bonus	
Patient organisation involvement (3=good, 2=intermediary, 1=not-so-good)	3	
<b>Accessibility (3=good, 2=intermediary, 1=not-so-good) (3)</b>		
Family doctor same day access	2	
Major surgery < 90 days	2	
Cancer therapy < 21 days	3	
CT scan < 7 days	2	

Sources: (1) OECD Health at a Glance Europe 2012<sup>278</sup>, (2) Joint Report on Health systems (2010)<sup>279</sup>, HEIDI WIKI<sup>280</sup> and EuroHealth Consumer Index 2012<sup>281</sup>, (3) EuroHealth Consumer Index 2012.

<b>Corruption in healthcare perceptions</b>		
<b>Do you think that the giving and taking of bribes, and the abuse of positions of power for personal gain, are widespread among people working in the public health sector?</b>		
	<i>Lithuania</i>	<i>EU average</i>
(% of respondents agree - Eurobarometer)	64%	30%
<b>Please indicate on a scale of 1 (= no problem) to 5 (= very serious problem) to what extent corruption is a serious issue in your country (average score of 4 interviewees)</b>		
	<i>Lithuania</i>	
Informal payments in medical service delivery	4	
Certification and procurement of medical equipment	3	
Authorisation and procurement of pharmaceuticals	3	

Sources: Special Eurobarometer 374, table QC4 (fieldwork September 2011); own research (fieldwork February/March 2013).

## Types of healthcare corruption

The interview reports reveal that informal payments and cases of corruption related to public procurement processes are of most concern in Lithuania.

The following other patterns were described:

<sup>278</sup> <http://www.oecd.org/els/health-systems/HealthAtAGlanceEurope2012.pdf>.

<sup>279</sup> [http://europa.eu/epc/pdf/joint\\_healthcare\\_report\\_en.pdf](http://europa.eu/epc/pdf/joint_healthcare_report_en.pdf).

<sup>280</sup> [https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing\\_healthcare/Healthcare\\_financing\\_systems](https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing_healthcare/Healthcare_financing_systems).

<sup>281</sup> Health Consumer Powerhouse – EuroHealth Consumer Index 2012: <http://www.healthpowerhouse.com/index.php?Itemid=55>.

***Bribery: removing barriers for treatment:***

- Corruption in patient-physician relationship occurs in the form of illegal payments (confirmed by surveys of State Health Insurance Fund (SHIF) and Ministry of Health);
- Paying bribes in order to obtain proper help from physicians: *'After paying money, all barriers for comprehensive treatment are surprisingly removed'*;
- Examples of such *barriers* include:
  - A physician says that during the hospitalization only some treatment will be provided;
  - Another part of the treatment could be provided during the next hospitalization.

***Major problems are linked to public procurement arrangements***

Kickbacks are perceived as a form of corruption regarding healthcare providers in the field of public procurement.

***Conflict of interest and trading of influence***

Mostly present among pharmaceutical companies, who are influencing physicians. One of the interviewees mentioned the following case: There was a chain of representatives of pharmaceutical companies influencing physicians (with trips, or so-called, 'scientific events') which in their turn prescribed certain medicines for their patients. In addition, nepotism and favouritism were mentioned in the reports as types of health care corruption as well.

***Causes and risks***

The following points were mentioned by the interviewees:

- Lack of information with regard to health care and financial services and for the patients;
- Gaps in control and audit mechanisms;
- No involvement of the civil society in both policy and decision-making, even feedback is not assured for monitoring and assessing the changes in the sector;
- Social structure of the country seems to accept nepotism/favouritism;
- The scope of actual bribery is varying a lot among different public healthcare facilities, and is considered to mostly depend on the preferences/attitudes/values of the head of institution;
- Low wages are considered main cause for corruption among physicians.

The following causes, related to procurement processes, are mentioned in the interview reports:

***Procurement and authorization of medical suppliers:***

- Poor procurement processes are mostly caused by a low competence of purchasers in procurement: 95% of the procurement procedure is based on the lowest price criteria and purchasers do not have enough skills to apply 'best-value-criteria' for selecting the economically most beneficial proposal;
- No flexible public procurement provisions: an intention to avoid purchasing from the single source is considered as a precaution against corruption, only a few providers of medical suppliers that are interested to participate in the tenders and some of them are lobbying the physicians and administrators.

***Causes linked to policy, legal and regulatory framework:***

- There are some gaps in legislation/regulation, allowing different interpretation of legal provisions which creates opportunities for improper extension of patient charges and other kinds of illegal payments;
- There are only a few, sometimes even one expert, in a particular field of health care in the country. There are no clear rules to prevent participation of vested interest in decision-making processes (e.g. including medicine into reimburses medicines list).

***Actual and suggested policies and practices******Raise public awareness and transparency:***

- The State Health Insurance Fund (SHIF) is providing more information about rules, prices and funding of the services (in the nearest future it plans to provide individual information about the publicly reimbursed services);
- All patients should get information about the *actual* payments to hospitals for their treatment from the SHIF (it has been suggested that the more patients are aware about actual expenditure, the less they are willing to pay illegally);
- Better access to information for the patients (already improved by the Internet);
- The more patients are aware about actual expenditure, the less they will be in favour of paying illegally in the future;
- Regular studies of patient payments are conducted and published.

***Control on income***

Administrators and physicians conducting certain functions where a risk of illegal payments is relatively high, for example issuing sick leaves or participation in RCTs, etc., have the obligation to fill out an annual declaration on their income to the State Tax Inspectorate. Such control on income could decrease the interest informal payments.

***Prescribing the active substance, no brand names:***

- Physicians may only prescribe the main active substances of pharmaceuticals on the reimbursement list, which is perceived as a good practice;
- The situation partially changed but physicians can still strongly influence patient decisions, thus a patient has a choice while buying the medicine;
- Pharmacies have an obligation to provide comparative information (such as on their prices) on medicines on monitors to inform the patient choice of reimbursed medicine;
- Although these are considered good practices, it was noticed in the country study that it would be worthwhile to have more capacities to monitor an enforcement of these and other requirements. However, nobody can control oral recommendations given to patients.

**Policies with regard to public procurement**

Successful:

- As a successful policy, centralized public procurement directly from manufacturers (if there are two or more manufacturers in the market) could be mentioned;
- Major brand pharmaceutical companies are accepting ethic codes;
- An increasing participation of the state agencies in the purchase of medical equipment;
- Usage of centralized internet-based procurement arrangements tender (e.g. checking tender documentation by representatives of public administration before tendering, more detailed comparisons of the medical devices) and increasing share of centrally procured equipment could be judged as positive as well;

And less successful:

- An intention to buy more and more medicines through the central public procurement agency is not a panacea, but many big hospitals prefer to do the procurement by themselves, and they manage to buy cheaper than the central agency.

***Lithuanian Medicines Marketing Ethics Code:***

- Adopted in 2003 and amended in 2012;
- The amendments assure more transparency in contacts between physicians and patients' organizations, and the sponsoring of scientific events.

## Luxembourg

### General description of the healthcare system<sup>282</sup>

Luxembourg has a system of mandatory health insurance that provides universal coverage. The National Health Insurance Fund, Caisse Nationale de Santé (CNS), covers the majority of essential healthcare services. Complementary health insurance is also available and purchased by a substantial number of people.

The health system is financed through a combination of compulsory social insurance contributions and state contributions. The social insurance contributions are split equally between employees and employers. The state funding is mainly based on general tax revenues and is either a contribution to the CNS budget or an investment (e.g. through for example the hospital investment fund, set-up by the Ministry of Health).

The Ministry of Health and the Ministry of Social Security share responsibilities for the healthcare system in Luxembourg. The Ministry of Health is responsible for health policy, public health and healthcare providers, whereas financing issues and the supervision of health insurance fall under the responsibility of the Ministry of Social Security. They are co-responsible for primary healthcare.

Fees for medical services are established in a national fee schedule. Authorised healthcare providers are allowed to charge these fees after they enter into collective contracting with the CNS. In general, people first have to pay for the healthcare services and can then later apply for reimbursement. Several services are offered as a benefit in kind, such as hospitalisation, medicines and surgeries. Note, however, that the doctor's bill related to hospitalisation has to be pre-paid by the patient.

### Healthcare delivery

Patients are free to choose among healthcare providers. In 2010 Luxembourg stressed the priority given to primary care by introducing a GP model. Although it is encouraged to seek a referral from your GP before accessing secondary care, it is not mandatory.

There is one large hospital in Luxembourg in which the physicians are employees of the hospital, but all physicians working in other hospitals are independent. Most GPs and physicians that have a private practice are also independent.

<sup>282</sup> Main sources for this section: Hohmann J and Ludwig K (2012). asisp Annual National Report 2012 Luxembourg. Pensions, Health Care and Long-term Care. Downloaded from: [http://www.socialprotection.eu/files\\_db/1258/asisp\\_ANR12\\_LUXEMBOURG.pdf](http://www.socialprotection.eu/files_db/1258/asisp_ANR12_LUXEMBOURG.pdf), [http://ehealth-strategies.eu/database/documents/Luxembourg\\_CountryBrief\\_eHStrategies.pdf](http://ehealth-strategies.eu/database/documents/Luxembourg_CountryBrief_eHStrategies.pdf) and [http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/US\\_CHS\\_LUXEMBOURG2011ConsumerSurvey\\_110311.pdf](http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/US_CHS_LUXEMBOURG2011ConsumerSurvey_110311.pdf).

Indicators of the healthcare system, 2010 (or nearest year)		
Financing of the healthcare system (1)		
	Luxembourg	EU average
Total health expenditure as % of GDP	7.9%	9%
Public expenditure as % of total health spending	84%	73%
Private insurance as % of total health spending	3%	4%
Private-out-of-pocket as % of total health spending	12%	21%
Organisation of the healthcare system (2)		
Social insurance or tax-based system?	Social insurance	
Gatekeeping by a general practitioner (GP)?	Not compulsory	
How are physicians paid? (e.g. salary, fee-for-service, capitation)	FFS	
Patient organisation involvement (3=good, 2=intermediary, 1=not-so-good)	3	
Accessibility (3=good, 2=intermediary, 1=not-so-good) (3)		
Family doctor same day access	3	
Major surgery < 90 days	2	
Cancer therapy < 21 days	3	
CT scan < 7 days	3	

Sources: (1) OECD Health at a Glance Europe 2012<sup>283</sup>, (2) Joint Report on Health systems (2010)<sup>284</sup>, HEIDI WIKI<sup>285</sup> and EuroHealth Consumer Index 2012<sup>286</sup>, (3) EuroHealth Consumer Index 2012.

<b>Corruption in healthcare perceptions</b>		
<b>Do you think that the giving and taking of bribes, and the abuse of positions of power for personal gain, are widespread among people working in the public health sector?</b>		
	<i>Luxembourg</i>	<i>EU average</i>
(% of respondents agree - Eurobarometer)	13%	30%
<b>Please indicate on a scale of 1 (= no problem) to 5 (= very serious problem) to what extent corruption is a serious issue in your country (average score of 4 interviewees<sup>287</sup>)</b>		
	<i>Luxembourg</i>	
Informal payments in medical service delivery	1	
Certification and procurement of medical equipment	3	
Authorisation and procurement of pharmaceuticals	3	

Sources: Special Eurobarometer 374, table QC4 (fieldwork September 2011); own research (fieldwork February/March 2013).

### General remark

According to the interview reports, corruption is not perceived as a major problem in Luxembourg. This is also confirmed by Transparency International Corruption Perception Index and the last Eurobarometer on corruption published in February 2012.

<sup>283</sup> <http://www.oecd.org/els/health-systems/HealthAtAGlanceEurope2012.pdf>.

<sup>284</sup> [http://europa.eu/epc/pdf/joint\\_healthcare\\_report\\_en.pdf](http://europa.eu/epc/pdf/joint_healthcare_report_en.pdf).

<sup>285</sup> [https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing\\_healthcare/Healthcare\\_financing\\_systems](https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing_healthcare/Healthcare_financing_systems).

<sup>286</sup> Health Consumer Powerhouse – EuroHealth Consumer Index 2012: <http://www.healthpowerhouse.com/index.php?Itemid=55>.

<sup>287</sup> Note that two respondents did not answer all of the three questions.

## **Types of healthcare corruption**

Conflict of interest is the one key issue related to corruption in health care, since the small size of the country and the population. Other types of corruption, mentioned by the interviewees, are:

### ***Receiving gifts: should not be seen as a type of corruption....***

According to one of the interviewees, 1/6 of the doctors receive gifts, free trips and other kinds 'presents' from pharmaceutical companies. This should, however, not be seen as a type of corruption, but only as a professional relation between doctors and pharmaceutical industry which aims at prescribing labelled pharmaceuticals. What is also contributing to the close relationships between the pharmaceutical industry and doctors is the limited number of individuals comprising the scientific community in Luxembourg.

### ***Rumours about hospital's invoicing....***

There can be differences between the price of a hospital service and what is actually invoiced by the hospital to the national health fund. The 'difference' between the two is rather kept within the hospital finances or is 'stolen' by the personnel. These are only rumours, as the behaviour of the hospital personnel has never been put into doubt and no concrete cases have been identified so far by the competent authorities.

## **Causes and risks**

### ***Transparency and information & Control and Audit mechanisms***

According to an interviewee, public hospitals in Luxembourg are not completely transparent when it comes to their financial budgets.

## **Good practices and policies**

### ***Rules for public procurement:***

- The OECD has pointed out that Luxembourg has specific reporting requirements for using exemptions to competitive procedures;
- Appropriately budgeting procurement is a key element of transparency and accountability in the way public funds are managed. (In Luxembourg, the first step is the control of the commitment and the order to pay all expenses, the verification of the availability of credits, the correctness of the budgetary commitment, the regularity of proofs and the correct execution of internal controls. Public agencies are also required to justify expense and show that they fit into the objectives of the budget allocated.);

- In Luxembourg the ex-ante control in the financial services unit and the financial transaction process must be conducted separately. In particular, the duty of authorising officer and accounting officer cannot be combined in one person;
- Luxembourg has encouraged the rotation of officials involved in procurement;
- Luxembourg has set up a body for dispute resolution to encourage informal problem solving;
- Stakeholders may be involved in monitoring the whole process from the pre-bidding to the contract management and payment. This takes an institutionalised form with the members of the Chamber of Commerce and of the Association of Professions being systematically invited to attend the opening of bids.

### ***Actual and suggested policies and practices***

One of the three interviewees pointed out some personal suggestions, which could help strengthen transparency within public hospitals:

- Public access to hospital budgets;
- A greater control over public hospitals' administrative councils;
- A greater share of health professionals (notably doctors) in the composition of the administrative councils, because many representatives are not familiar at all with health practices and standards;
- Additional audit systems are put in place by the National Health Fund or by the inspectorate services of the Social Security.



## Malta

### General description of the healthcare system<sup>288</sup>

In Malta the statutory health system provides universal coverage. Participation in the system is mandatory and it is funded through taxation (a progressive tax based on income) and national insurance.

The financing of the health system is complemented with out-of-pocket payments and a small amount of private health insurance. There are no user charges or co-payments and hence the health services in Malta are free of charge at the point of use. The observed out-of-pocket payments can be attributed to expenditures in the private healthcare sector.

While healthcare in the public sector in Malta is highly centralised and regulated, the private healthcare sector is largely unregulated.

### Healthcare delivery

Primary healthcare is offered by both the public and private system. The physicians working in the public sector are considered civil servants and hence, paid a salary. The fees for physicians in the private sector are determined by the Minister of Health, with advice from the Medical Council. The voluntary health insurance agencies pay for the healthcare fee-for-service. There is a gatekeeping system in place, however, as this is not functioning effectively there is an overutilization of secondary services.

Secondary and tertiary healthcare services are mainly provided by public hospitals. In Malta, there is one main teaching hospitals which provides all specialised, ambulatory, inpatient care and intensive care services. Public hospitals are owned and regulated by the state and are paid global budgets. Private hospitals are paid by out-of-pocket payments and reimbursement consisting of a combination of fee-for-service and per diems.

Over the last years, public hospital care in Malta has been upgraded substantially. This has lead to a shift in hospital care from the private to the public sector. As a results, several private hospitals were forced to close.

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<sup>288</sup> Main sources for this section: Cordina G and Borg A (2012). asisp Annual National Report 2012 Malta. Pensions, Health Care and Long-term Care. Downloaded from: [http://www.socialprotection.eu/files\\_db/1267/asisp\\_ANR\\_2012\\_MALTA.pdf](http://www.socialprotection.eu/files_db/1267/asisp_ANR_2012_MALTA.pdf) and [http://www.pwc.com/en\\_MT/mt/publications/healthcare/assets/healthcare\\_delivery\\_august\\_2012.pdf](http://www.pwc.com/en_MT/mt/publications/healthcare/assets/healthcare_delivery_august_2012.pdf).

Indicators of the healthcare system, 2010 (or nearest year)		
Financing of the healthcare system (1)		
	Malta	EU average
Total health expenditure as % of GDP	8.6%	9%
Public expenditure as % of total health spending	65%	73%
Private insurance as % of total health spending	2%	4%
Private-out-of-pocket as % of total health spending	32%	21%
Organisation of the healthcare system (2)		
Social insurance or tax-based system?	Tax-based	
Gatekeeping by a general practitioner (GP)?	Meant to be compulsory	
How are physicians paid? (e.g. salary, fee-for-service, capitation)	NHS: Salary / Private: FFS	
Patient organisation involvement (3=good, 2=intermediary, 1=not-so-good)	3	
Accessibility (3=good, 2=intermediary, 1=not-so-good) (3)		
Family doctor same day access	3	
Major surgery < 90 days	1	
Cancer therapy < 21 days	3	
CT scan < 7 days	2	

Sources: (1) OECD Health at a Glance Europe 2012<sup>289</sup>, (2) Joint Report on Health systems (2010)<sup>290</sup>, HEIDI WIKI<sup>291</sup> and EuroHealth Consumer Index 2012<sup>292</sup>, (3) EuroHealth Consumer Index 2012.

<sup>289</sup> <http://www.oecd.org/els/health-systems/HealthAtAGlanceEurope2012.pdf>.

<sup>290</sup> [http://europa.eu/epc/pdf/joint\\_healthcare\\_report\\_en.pdf](http://europa.eu/epc/pdf/joint_healthcare_report_en.pdf).

<sup>291</sup> [https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing\\_healthcare/Healthcare\\_financing\\_systems](https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing_healthcare/Healthcare_financing_systems).

<sup>292</sup> Health Consumer Powerhouse – EuroHealth Consumer Index 2012: <http://www.healthpowerhouse.com/index.php?Itemid=55>.

<b>Corruption in healthcare perceptions</b>		
<b>Do you think that the giving and taking of bribes, and the abuse of positions of power for personal gain, are widespread among people working in the public health sector?</b>		
	<i>Malta</i>	<i>EU average</i>
(% of respondents agree - Eurobarometer)	29%	30%
<b>Please indicate on a scale of 1 (= no problem) to 5 (= very serious problem) to what extent corruption is a serious issue in your country (average score of 4 interviewees<sup>293</sup>)</b>		
	<i>Malta</i>	
Informal payments in medical service delivery	1	
Certification and procurement of medical equipment	3	
Authorisation and procurement of pharmaceuticals	2	

Sources: Special Eurobarometer 374, table QC4 (fieldwork September 2011); own research (fieldwork February/March 2013).

## Types of healthcare corruption

The interviewees mentioned various types of corruption:

### *Gifts, tips, fees...:*

- Doctors tend to prescribe more medicines from companies who offer them gifts, conferences and other incentives;
- It is known that patients, or relatives of the patients, 'tip' nurses to look after them at the hospital in order to receive better care.

### *Doctors working in private and public spheres:*

- In order to jump the queue for medical services provided at public hospitals, patients are making use of private services offered by the doctors;
- Doctors or pharmacy suppliers working in the public and in the private sector at the same time, may influence their patients in such a way that they will make use of their private services, which might lead to 'conflicts of interest'.

### *Corruption by intermediaries:*

- While local pharmaceutical representatives of global companies may be obliged to follow strict codes of conduct, any intermediaries they may engage do not have the same obligations;
- Sometimes, bonuses in various forms are offered by intermediary companies to promote medicines of particular companies.

<sup>293</sup> Note that one respondent did not answer the question about informal payments in medical service delivery, and that one respondent did not answer the question about certification and procurement of medical equipment and the question about the authorisation and procurement of pharmaceuticals.

### ***Corruption and tendering of medical equipment:***

- Another form of corruption observed in Malta is the so called 'tailoring' of the tender specifications for medical equipment, which facilitates the awarding of government tenders for particular importers only;

### ***Corruption at pharmacy level:***

- Bonuses are often offered by pharmacy suppliers in order to give an unfair advantage in the promotion of their supplies over those of competitors;
- A form of collusion sometimes exists among players involved in the local pharmacy import and sales;
- A common practice among pharmacy retailers is preferring suppliers who are offering the best bonuses.

### ***'Corrupted' medicines at Malta:***

- There have been cases of falsified medicine incidents, where medical supply transshipments have not been declared, or declared incorrectly;
- Another example is the local import of medicines for (so-called) personal use, but are actually re-sold for a higher price;
- *Internet Pharmacies* – Patients can buy medicines much cheaper from unregulated sources of the Internet.

### **Causes and risks**

According to the interview reports, transparency and economic factors are the main risks of corruption in the health sector. Other important risks mentioned in the report are:

### ***The Government of Malta (innovation of medicines):***

- One of the interviewees stated that the limited expenditure by the state on the innovation of medicines is one of the main causes of corruption;
- There is an unclear picture of the government regarding its own storage, consumption and procurement procedures of pharmaceuticals;
- The current annual budget for pharmaceuticals for the Maltese government is 40 million euro. This is not sufficient to procure, through a transparent system with EU regulations, novel medicines for patients.

### ***Malta, it's a small country:***

- A form of collusion exists between a limited number of players involved in the local purchase and sale of pharmaceuticals;
- In Malta, most of the time agents directly represent the supplier, which creates little or no room for competition;

- Monopolies exist within the local pharmaceutical market and it is ruled by people with multiple hats, interests and roles, e.g. the same person is importer, agent and pharmacy owner as well;
- Experts are actually needed for setting up specifications for tenders. Due to the size and limited human resources of Malta, it is often not possible to have different experts performing these jobs.

## **Good policies and practices**

### ***Regulation & legislation:***

- A number of mechanisms and (new Government Procurement) regulations have come into play over recent years, which have apparently brought substantial reductions in corrupt practices;
- There is a new legislation which controls the infiltration of falsified medicines. This legislation addresses a specific lacunae in the previous legislation.

### ***Setting up departments, committees, boards...:***

- The certification of medical equipment is regulated by the Malta Competition and Consumer Affairs Authority (MCCAA) resulting in a more transparent process;
- Government tenders for medical equipment and medicines are nowadays handled independently by the state's Department of Contracts;
- An Appeal board exists for unsuccessful bids, which is handled by another independent authority;
- The current tendering approval boards consists of numerous members which, as a result, limits the chance of corruption;
- The Pharmaceutical Research and Development Malta Association (PRIMA) has a compliance board in Malta whose role it is to promote good policies and practices by pharmaceutical companies. It ensures that there is a degree of compliance by its members on a code of ethics laid out;
- The Medicines Authority has its own code of ethics. The strictest among these various codes of ethics is the one applied by parent companies generally on all its local representatives.

## The Netherlands

### General description of the healthcare system<sup>294</sup>

Since 2006, the Netherlands has a mandatory private insurance scheme, which is regulated by the Health Insurance Act (Zvw). The mandatory basic health insurance provides coverage for essential very comprehensive package of healthcare services. People are free to choose between insurance companies and have the right to switch at the end of each year. Insurers cannot refuse applicants and they are not allowed to differentiate premiums based on risk profiles<sup>295</sup>. There is a risk-adjustment scheme in place to compensate the insurance companies for the risk profile of their insured population.

All insured people older than 18<sup>296</sup> contribute to the Zvw scheme through an income-dependent employer contribution and by paying an individual flat-rate premium (that may differ across insurance companies) to the insurance company. People with a low income are financially compensated for the flat-rate premium. There is a yearly deductible, which is subject to several exemptions<sup>297</sup>. There is a separate mandatory scheme covering long-term care (AWBZ), which is mainly financed through income-dependent contributions. A third financing scheme in the Netherlands is complementary voluntary health insurance.

The Dutch healthcare system is highly regulated to ensure efficient, high quality and affordable care. The Ministry of Health, Welfare and Sports is responsible for the availability of this care. The benefit package for the basic insurance is determined by the government, but health insurers can negotiate with healthcare providers on price, volume and quality. The Netherlands Health Care Authority (NZa) is responsible for supervising the insurance companies.

### Healthcare delivery

In the Netherlands, many of the healthcare providers are (at least partly) private. GPs and other individual providers work in private practices. The GPs have a gatekeeping function and are paid through a combination of capitation and fee-for-service. Secondary care, both in- and outpatient, is mainly provided by hospitals and mental care facilities and to a lesser extent by independent treatment centres. Approximately 30% of the medical specialists are employed by hospitals, whereas the remaining 70% are self-employed. Hospital and mental care is financed through an elaborated DRG-like system (DBC system).

<sup>294</sup> Main sources for this section: Schäfer W, Kroneman M, Boerma W, van den Berg M, Westert G, Devillé W and van Ginneken E. The Netherlands: Health system review. *Health Systems in Transition*, 2010; 12(1):1-229. [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0008/85391/E93667.pdf](http://www.euro.who.int/__data/assets/pdf_file/0008/85391/E93667.pdf) and Donders P and Maarse H(2012). asisp Annual National Report 2012 The Netherlands. Pensions, Health Care and Long-term Care. Downloaded from: [http://www.socialprotection.eu/files\\_db/1270/asisp\\_ANR12\\_THE\\_NETHERLANDS.pdf](http://www.socialprotection.eu/files_db/1270/asisp_ANR12_THE_NETHERLANDS.pdf).

<sup>295</sup> Note that these provisions only apply to basic health insurance, not to complementary insurance.

<sup>296</sup> The state pays for children younger than 18.

<sup>297</sup> The deductible does not apply to GP medicine, mother and childcare and dental care for individuals under the age of 18.

In principle, patients are free to choose their provider, however, this choice may be restricted by conditions set by the insurers.

Indicators of the healthcare system, 2010 (or nearest year)		
Financing of the healthcare system (1)		
	<i>The Netherlands</i>	<i>EU average</i>
Total health expenditure as % of GDP	12%	9%
Public expenditure as % of total health spending	86%	73%
Private insurance as % of total health spending	5%	4%
Private-out-of-pocket as % of total health spending	6%	21%
Organisation of the healthcare system (2)		
Social insurance or tax-based system?	Social insurance	
Gatekeeping by a general practitioner (GP)?	Compulsory	
How are physicians paid? (e.g. salary, fee-for-service, capitation)	FFS/Capitation	
Patient organisation involvement (3=good, 2=intermediary, 1=not-so-good)	3	
Accessibility (3=good, 2=intermediary, 1=not-so-good) (3)		
Family doctor same day access	3	
Major surgery < 90 days	3	
Cancer therapy < 21 days	3	
CT scan < 7 days	2	

Sources: (1) OECD Health at a Glance Europe 2012<sup>298</sup>, (2) Joint Report on Health systems (2010)<sup>299</sup>, HEIDI WIKI<sup>300</sup> and EuroHealth Consumer Index 2012<sup>301</sup>, (3) EuroHealth Consumer Index 2012.

<b>Corruption in healthcare perceptions</b>		
<b>Do you think that the giving and taking of bribes, and the abuse of positions of power for personal gain, are widespread among people working in the public health sector?</b>		
	<i>The Netherlands</i>	<i>EU average</i>
(% of respondents agree - Eurobarometer)	17%	30%
<b>Please indicate on a scale of 1 (= no problem) to 5 (= very serious problem) to what extent corruption is a serious issue in your country (average score of 4 interviewees<sup>302</sup>)</b>		
	<i>The Netherlands</i>	
Informal payments in medical service delivery	NA	
Certification and procurement of medical equipment	NA	
Authorisation and procurement of pharmaceuticals	NA	

Sources: Special Eurobarometer 374, table QC4 (fieldwork September 2011); own research (fieldwork February/March 2013).

### Types of healthcare corruption

Two interviewees mentioned that in the Netherlands the general perception of corruption in the healthcare sector is really low. This results from the fact that many

<sup>298</sup> <http://www.oecd.org/els/health-systems/HealthAtAGlanceEurope2012.pdf>.

<sup>299</sup> [http://europa.eu/epc/pdf/joint\\_healthcare\\_report\\_en.pdf](http://europa.eu/epc/pdf/joint_healthcare_report_en.pdf).

<sup>300</sup> [https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing\\_healthcare/Healthcare\\_financing\\_systems](https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing_healthcare/Healthcare_financing_systems).

<sup>301</sup> Health Consumer Powerhouse – EuroHealth Consumer Index 2012: <http://www.healthpowerhouse.com/index.php?Itemid=55>.

<sup>302</sup> Note that all respondents did not answer these three questions.

people have a rather idealistic view of individuals working in the sector. However, if corruption prevails in other parts of society, it most likely also prevails in the healthcare sector.

The types of corruption that were identified by the interviewees and the cases are:

- Integrity violations, such as inducement and conflict of interest, in relation to both medical devices and the pharmaceutical sector. These types of corruption are the results of (improper) interactions between the industry and healthcare professionals/opinion leaders;
- In the Netherlands different types of fraud and/or corruption are related to the fact that people use rather broad interpretations of the law and rules in order to maximize personal gain;
- Hard corruption cases are hardly heard of. Judicial judgements support this statement.

The Ministry of Health, Welfare and Sports (VWS) has been thoroughly researching different types of fraud in healthcare over the last years. VWS basically defines fraud in healthcare as the money earmarked for healthcare being used for other purposes. They identified the following types of fraud:

- So-called 'upcoding', which refers to physicians using the system with a multitude of codes to maximize their income. According to the Dutch Healthcare Authority (NZa), this is increasingly becoming a problem;
- Fraud with Personal Healthcare Budgets (PGB) and AWBZ care in kind. This has been documented relatively well now as a result of large investments in the detection of this type of fraud. For PGBs and AWBZ care in kind more or less the same problems prevail such as the exaggeration of health conditions to inflate entitlement to care/money and the cashing of PGB payments of people who need care by functioning as an intermediary;
- The filing of fake or too high claims by different medical professionals like dentists and physical therapists.

At this point fraud with PGBs has been investigated in most depth. Topics that are high on the agenda for more in-depth research are mental health care and medical specialists. With regard to pharmaceuticals VWS has the idea that counterfeit drugs are a serious problem as well as the off-label use of medication.

### ***Causes and risks***

Various causes and risks were mentioned:

### ***Beliefs, attitudes, social value system***

The so-called 'graaicultuur': people are increasingly focused on personal gain.



***Political, legal and regulatory framework:***

- The balancing act of providing room for own initiative and the risks associated with too broadly formulated rules. In order to facilitate the functioning of the (free) market, rules and regulations cannot be too narrow. However, this creates room for interpretation which could lead to fraudulent and/or corrupt practices, such as upcoding. These types of fraud/corruption are difficult to prosecute as the rules allow for a certain degree of interpretation;
- The fact that we have a fragmented and gradual monitoring system in the Dutch healthcare system might also pose a risk.

***Procurement and authorisation of medical supplies***

Ties between the industry and healthcare professionals: there exists a tension between the necessity of contact between the industry and healthcare professionals and the risk for integrity violations because of that contact.

***Other***

There has been a shift toward privatisation over the last years. The idea was that this would create more opportunities for own initiative. However, it also opened the door to 'healthcare entrepreneurs' looking to making some quick money.

***Actual and suggested policies and practices******Implemented policies: pharmaceuticals:***

- Pharmaceutical advertising targeted at medical professionals is regulated through a system of conditioned self-regulation. This means that self-regulation is enforced within the boundaries set by the government. Self-regulation is organised through the 'Code Pharmaceutical Advertising'. This code exists parallel to the Pharmaceutical Act<sup>303</sup> (Geneesmiddelenwet) and the supervisory rules (beleidsregels) on inducement. Supervision and enforcement are the tasks of the Inspectorate for Healthcare. When the code is violated, a complaint can be filed and is dealt with by the Code Committee;
- In 2012 a new self-regulation code for the pharmaceutical sector was introduced: the 'Code for the prevention of improper influence due to conflicts of interest'. It was set-up by the KNAW, KNMG, CBO, NHG and OMS and signed by more than 30 other organisations<sup>304</sup>. It aims to prevent improper influencing in the creation of scientific opinion reports and clinical treatment guidelines. The basic idea is that any relationships between medical professionals and the industry should be made transparent by filling out a so-called declaration of interest. As this code is relatively new, evaluations of its effectiveness are not yet available;
- The Transparency Register Healthcare is a database that facilitates financial disclosure by registering the financial ties that exist between the industry and the

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<sup>303</sup> <http://wetten.overheid.nl/cgi-bin/deeplink/law1/title=Geneesmiddelenwet>.

<sup>304</sup> For a list of these organisation see the code:  
[http://www.knaw.nl/Content/Internet\\_KNAW/publicaties/pdf/code\\_digitaal\\_2012\\_ENG\\_def\\_interactief3.pdf](http://www.knaw.nl/Content/Internet_KNAW/publicaties/pdf/code_digitaal_2012_ENG_def_interactief3.pdf).

medical professionals. It specifies how much a medical professional received from whom and for what<sup>305</sup>. Relationships have to be disclosed within 3 months following the year in which it took place and will stay in the Register for 3 years<sup>306</sup>. This initiative can be considered the Dutch version of implementing the Sunshine Act. The Foundation Transparency Register Healthcare is financially supported by VWS and has an independent secretary. As of 10 April 2013 everyone is able to access it.

### ***Implemented policies and practice: medical devices***

On 1 January 2012 the 'Code of Conduct Medical Devices' (GMH) came into effect. It has been set-up by SOMT, who has as its members 6 professional organisations for medical devices<sup>307</sup> that together represent over 400 suppliers. An independent Code Committee that handles all requests for advice and complaints. Possible sanctions are established in the Code. All advices and complaints issued by the Code Committee are available on the Foundation's website<sup>308</sup>.

### ***Implemented policies and practices: cooperation between different parties:***

- The responsibility of checking the filed claims lies primarily with health insurance companies. On 14 March 2012 the 'Knowledge centre Fraud control' was launched by Zorgverzekeraars Nederland (ZN), which is the industry organisation for health insurance companies in the Netherlands<sup>309</sup>. The primary aim of the Knowledge centre is to inform and offer services to health insurance companies. It receives all signals of fraud and ensures that all information and signals reach the relevant people/institutions. It aims to have a leading role in prevention. Moreover, the Knowledge centre has set-up a website providing up-to-date information and news on fraud in Dutch healthcare and tools for insurance companies<sup>310</sup>;
- In March 2013 the Taskforce Integrity in Healthcare was launched. Nine parties<sup>311</sup> signed an agreement<sup>312</sup> and adopted a policy agenda. The goal is to make prevention, detection and repression of fraud and corruption in healthcare work as effective and efficient as possible through more intense collaboration. Moreover, the Taskforce aims to share information on fraud in healthcare in a quick and effective way to achieve a better understanding of the current situation;
- Note that the Knowledge centre and the Taskforce analyse aim to complement each other. The fact that ZN is a partner in the Taskforce ensures collaboration between the two initiatives.

<sup>305</sup> Note that not all financial relationships are included, e.g. clinical research. For an overview of what exactly is and is not included in the Register see <http://www.transparantieregister.nl/Wat-wel-en-niet-geregistreerd>.

<sup>306</sup> <http://www.nefarmaonline.nl/english/transparency/qa-healthcare-transparency-register>.

<sup>307</sup> Nefemed, FHI, Diagned, Firevaned, Holland Health Tech and Gain.

<sup>308</sup> [www.gmh.nu](http://www.gmh.nu).

<sup>309</sup> <http://www.zorgvisie.nl/Financien/Nieuws/2012/3/ZN-lanceert-Kenniscentrum-Fraudebeheersing-ZVS013514W/>.

<sup>310</sup> <https://www.zn.nl/beleidsthemas/kenniscentrum-fraudebeheersing/>.

<sup>311</sup> VWS, NZa, the Inspectorate for Healthcare, ZN, Inspectorate for Social Affairs and Employment, Fiscal Intelligence and Investigation services, Tax Authority, Public Prosecution Service, and the Centre for Assessment of Healthcare Indications (CIZ).

<sup>312</sup> Which can be downloaded via this link: <http://www.rijksoverheid.nl/documenten-en-publicaties/convenanten/2013/03/07/convenant-verbetering-van-bestrijding-zorgfraude.html>.

***Suggested policies and practices:***

- One interviewee suggested that a good model for new policies would be a barrier model. Such a model should make the required effort to misuse the system bigger than the expected gains in order to discourage fraudulent and corrupt behaviour. The difficulty is to come up with a policy or initiative that tackles the underlying causes such as a lack of morals and ethical standards;
- An area that should receive more focus is monitoring. In preventing and controlling corruption there are four steps: prevention, detection, monitoring, and prosecution. The monitoring step is overlooked too often and the step from detection to prosecution is made too quickly, while criminal law should only be used in extreme cases (of course there are exceptions to this). It is important that after detection there is monitoring and feedback of this into prevention. The problem is that in the Netherlands there is currently no adequate monitoring as it is highly fragmented<sup>313</sup> and when everybody has the responsibility of monitoring, ultimately no one has it. To deal with this it would be advisable that the Ministry of Health would take charge. However, current policy seems to go the exact opposite direction.

It was noted by one of the interviewees that it is of great importance to document as much as possible about fraudulent and corruptive behaviour in the healthcare sector; this is the only way to get a clear image of what is actually happening.

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<sup>313</sup> Current situation: Inspectorate for Healthcare monitors quality, Dutch Central Bank monitors solvability, Dutch Healthcare Authority monitors tariffs, Dutch Competition Authority monitors the functioning of the market and health insurance companies monitor budgets.

## Poland

### General description of the healthcare system<sup>314</sup>

Poland has a system of mandatory health insurance that is complemented by financing from the state and the territorial self-government budgets. Almost 98% of the population is covered by the insurance that ensures access to a wide range of healthcare services. Voluntary health insurance can be purchased, but this does not play a big role in the Polish health system.

Within the health system there is a clear separation between financing and provision: the National Health Fund (NFZ) is the sole payer in the system and contracts, through its 16 regional branches, both public and non-public providers. Employees pay health insurance contributions that are collected by two intermediary organisations, pooled by the NFZ, and then divided among the 16 regional branches of the NFZ. The health insurance contributions are proportional and the budgetary subsidies progressive, however, the high level of out-of-pocket expenditures is extremely regressive.

The health system in Poland is highly decentralised: the Ministry of Health is the key policy maker and regulator and all three levels of territorial administration and self-government (gmina, powiat, voivodeship) have their own tasks and responsibilities with regard to healthcare (e.g. prevention and healthcare infrastructure). Because of the independence of the territorial self-governments, coordination of activities can sometimes prove difficult.

### Healthcare delivery

In Poland most hospitals are public and most primary and ambulatory care provision is private. In order to access specialist care (both ambulatory and inpatient), patients require a referral by a primary care physician. People can choose to register with any primary care physician that is contracted by the NFZ and are allowed to switch twice every year.

Primary care is financed using annual capitation whereas specialist ambulatory care uses fee-for-service payments. For inpatient care a DRG like system is used, regardless of whether it is at public or private hospital and which services the hospital provides.

Note that in Poland certain types of patients, such as war veterans and honorary blood and organ donor, have a priority status within the waiting list system.

<sup>314</sup> Main sources for this section: Sagan A, Panteli D, Borkowski W, Dmowski M, Domanski F, Czyzewski M, Gorynski P, Karpacka D, Kiersztyn E, Kowalska I, Ksiezak M, Kuszewski K, Lesniewska A, Lipska I, Maciag R, Madowicz J, Madra A, Marek M, Mokrzycka A, Poznanski D, Sobczak A, Sowada C, Swiderek M, Terka A, Trzeciak P, Wiktorzak K, Wlodarczyk C, Wojtyniak B, Wrzesniewska-Wal I, Zelwianska D, Busse R. Poland: Health system review. *Health Systems in Transition*, 2011, 13(8):1–193. [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0018/163053/e96443.pdf](http://www.euro.who.int/__data/assets/pdf_file/0018/163053/e96443.pdf) and Zukowski M (2012). asisp Annual National Report 2012 Poland. Pensions, Health Care and Long-term Care. Downloaded from: [http://www.socialprotection.eu/files\\_db/1276/asisp\\_ANR12\\_POLAND.pdf](http://www.socialprotection.eu/files_db/1276/asisp_ANR12_POLAND.pdf).

Indicators of the healthcare system, 2010 (or nearest year)		
Financing of the healthcare system (1)		
	Poland	EU average
Total health expenditure as % of GDP	7%	9%
Public expenditure as % of total health spending	72%	73%
Private insurance as % of total health spending	1%	4%
Private-out-of-pocket as % of total health spending	22%	21%
Organisation of the healthcare system (2)		
Social insurance or tax-based system?	Social insurance	
Gatekeeping by a general practitioner (GP)?	Compulsory	
How are physicians paid? (e.g. salary, fee-for-service, capitation)	Capitation & Fee-for-service	
Patient organisation involvement (3=good, 2=intermediary, 1=not-so-good)	2	
Accessibility (3=good, 2=intermediary, 1=not-so-good) (3)		
Family doctor same day access	2	
Major surgery < 90 days	1	
Cancer therapy < 21 days	1	
CT scan < 7 days	1	

Sources: (1) OECD Health at a Glance Europe 2012<sup>315</sup>, (2) Joint Report on Health systems (2010)<sup>316</sup>, HEIDI WIKI<sup>317</sup> and EuroHealth Consumer Index 2012<sup>318</sup>, (3) EuroHealth Consumer Index 2012.

<b>Corruption in healthcare perceptions</b>		
<b>Do you think that the giving and taking of bribes, and the abuse of positions of power for personal gain, are widespread among people working in the public health sector?</b>		
	<i>Poland</i>	<i>EU average</i>
(% of respondents agree - Eurobarometer)	48%	30%
<b>Please indicate on a scale of 1 (= no problem) to 5 (= very serious problem) to what extent corruption is a serious issue in your country (average score of 4 interviewees<sup>319</sup>)</b>		
	<i>Poland</i>	
Informal payments in medical service delivery	2.75	
Certification and procurement of medical equipment	4	
Authorisation and procurement of pharmaceuticals	4.5	

Sources: Special Eurobarometer 374, table QC4 (fieldwork September 2011); own research (fieldwork February/March 2013).

## Types of healthcare corruption

### Procurement

According to the interviewees: The main area of corruption in healthcare involves public procurements. Unfortunately Poland does not use sectoral procurement – each

<sup>315</sup> <http://www.oecd.org/els/health-systems/HealthAtAGlanceEurope2012.pdf>.

<sup>316</sup> [http://europa.eu/epc/pdf/joint\\_healthcare\\_report\\_en.pdf](http://europa.eu/epc/pdf/joint_healthcare_report_en.pdf).

<sup>317</sup> [https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing\\_healthcare/Healthcare\\_financing\\_systems](https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing_healthcare/Healthcare_financing_systems).

<sup>318</sup> Health Consumer Powerhouse – EuroHealth Consumer Index 2012: <http://www.healthpowerhouse.com/index.php?Itemid=55>.

<sup>319</sup> Note that two respondents did not answer the question about informal payments in medical service delivery, one respondent did not answer the question about certification and procurement of medical equipment and that two respondents did not answer the question about the authorisation and procurement of pharmaceuticals.

hospital, healthcare centre, clinic organises its own tender. In terms of purchasing highly specialised equipment, the doctors know what functionalities they need, but do not know much about technical solutions (subcomponents, processors, tubes, etc.). Because small and medium hospitals do not have any specialists, who can describe the scope of the order, correctly formulate the tender requirements, and therefore they use ready-made ones. The companies providing the equipment reach persons responsible for preparing tender offers and provide technical information to the tender committee, either by bribing them or by using their incompetence. Hence the tenders are prepared for specific equipment from a specific producer.

Another mechanism for passing competitive purchase is based on companies offering a donation of one device if the hospital purchases another one. The interviewees suggested that hospitals were very eager to agree to such donations, and only later it came out that the device requires reagents or other consumables which are much more expensive at that given company as compared to others, and that in several years' perspective, the hospital loses on such donation. Several years ago such situations were very common, and often mentioned in the press; therefore, hospitals are much more careful now.

### ***Informal payments***

From the social point of view, according to the interviewees, informal payments for medical services are a serious problem. The effects are usually suffered by the underprivileged, as the wealthier can use private extra-paid healthcare. This is a grey/non-transparent area – bribes take the form of over-paid visits to private practices of doctors from public hospitals, which allow to 'skip' the queue for procedures. However, this type of corruption is reducing – it can be noted in the conducted studies, media coverage and the number of cases submitted to the Batory Foundation from people asking for an intervention.

In 2011 <sup>320</sup> the average amount spent on informal fees in healthcare, which were an attempt to acquire better or faster services (e.g. bigger interest in patient's problems, more care for his health, selection of the operating doctor, hastening the medical service), amounted to 311 PLN per household. In terms of expensiveness it is the third type of health expenses: treatment and diagnostic tests, and purchasing medicine. 1,7% Polish households admitted to giving bribes in healthcare services. The value of a gift of gratitude given after care was provided amounted to 142 PLN on average; 1.6% of households confirmed this expense. Every year the Regional Spokesman for Professional Liability of Chamber of Doctors of Medicine receives over 100 complaints on doctors accepting a material gain; several of them reaches the Doctors' Court, which in single cases ends in penalties.

### ***Nepotism and conflict of interest***

Nepotism is a great problem, which is clearly visible in university clinics, where greater family clans exist and pass on departments or institutes. In Poland, mainly among

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<sup>320</sup> highlighted to in the national case and by the interviewees.

doctors, there is a conviction that medicine is a family trade; „passing’ of medical skills from parents to children is seen as an obvious and positive phenomenon.

A lack of sensitiveness to a potential conflict of interest is quite characteristic for the Polish healthcare. In one such occasion the vice-minister met (in formal and informal situations) with representatives of a company that wants to introduce their product onto the refunded medicine list, even though the product was considered as unsuitable. Eventually the product was approved by the ministry, pointing to at least clear conflict of interest.

### **Causes and risks**

There was a general consensus among the interviewees that the main factor causing corruption – although its scale is much smaller than some years ago – is the mentality of Polish society, i.e. social acceptance and not seeing anything very wrong in corruption.

### ***Actual and suggested policies and practices:***

- Non-governmental organisations are very active in terms of corruption. The Batory Foundation is the most active and for many years it has been dealing with the topic of corruption, it publishes reports which have much valuable knowledge as well as helps patients that have suffered or been subjected to corrupt practices;
- Legislative activity has, according to the interviewees, focused on deterrence as well as ensuring that the legal basis as complete as possible. This effort now means that incoherence of law that creates the space for corruption is minimal. Furthermore legislative acts introduced a series of solutions limiting corruption, e.g. the public procurement law;
- According to one interviewee: The actions of the Central Anti-Corruption Bureau against corrupt doctors have scared some of them off – mostly those, who took small bribes for small infringements of the rules. Although at times the Bureau has been criticised for heavy handedness, there is little doubt that it has worked as a deterrent to petty corruption. Currently, the Governmental Programme for Counteracting Corruption for the next planning period is being developed in order to strengthen and support the initiatives and fight against corruption.

### ***Market developments***

The problem with informal payments in medical service delivery has recently, according to the interviewees, significantly decreased, but is not eliminated yet. It has been limited due to development of private healthcare services – the patients officially pay for medical services which are free-of-charge in public hospitals, instead offering bribes to GPs in public institutions.

## Portugal

### General description of the healthcare system<sup>321</sup>

The health system in Portugal consists of three elements: the NHS that provides universal coverage, private voluntary health insurance, and the health subsystems for certain professionals (special public and private insurance schemes covering 0.2-0.25% of the population).

The NHS is financed through taxation: the Ministry of Finance allocates a global budget for the NHS to the Ministry of Health. This budget is then distributed amongst the different (regional) institutions within the NHS. The health subsystems are financed through both employee and employer contributions and the private expenditures on health mainly consist of out-of-pocket payments.

Each of the five Portuguese regions has a regional health administration board (RHA) which is responsible for the management of the NHS, including contracting with hospitals and private sector providers and management of NHS primary care centres. The Ministry of health is the regulator of the health system and the key policy maker.

### Delivery of healthcare

Primary healthcare is delivered by both public and private providers. Groups of Primary Care Centres (ACES) are responsible for primary healthcare delivery in a geographical area and they (not the individual healthcare centres) negotiate the contracts with the RHA. For people in the NHS it is mandatory to register with a GP that functions as a gatekeeper for access to secondary care. Patients can only choose from GPs within a certain area, based on where they live. People within a health subsystem or that have voluntary health insurance often have more providers to choose from than people who are only covered by the NHS.

Secondary and tertiary care is mainly provided in hospitals and all hospitals that belong to the NHS are under the jurisdiction of the Ministry of Health. The budgets for these hospitals is defined and allocated centrally, but note that DRGs are increasingly starting to play an important role. Health subsystems and voluntary health insurance schemes already (exclusively) use DRGs to pay hospitals.

All NHS doctors and nurses are government employees and are paid salaries. As these salaries are considered rather low by the doctors themselves, they augment their income through activities in the private sector.

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<sup>321</sup> Main sources for this section: Barros P, Machado S, Simões J. Portugal: Health system review. *Health Systems in Transition*, 2011, 13(4):1-156. [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0019/150463/e95712.pdf](http://www.euro.who.int/__data/assets/pdf_file/0019/150463/e95712.pdf) and Mendes F R with the assistance of Neto I (2012). asisp Annual National Report 2012 Portugal. Pensions, Health Care and Long-term Care. Downloaded from: [http://www.socialprotection.eu/files\\_db/1279/asisp\\_ANR2012\\_PORTUGAL.pdf](http://www.socialprotection.eu/files_db/1279/asisp_ANR2012_PORTUGAL.pdf).



Indicators of the healthcare system, 2010 (or nearest year)		
Financing of the healthcare system (1)		
	Portugal	EU average
Total health expenditure as % of GDP	10.7%	9%
Public expenditure as % of total health spending	66%	73%
Private insurance as % of total health spending	4%	4%
Private-out-of-pocket as % of total health spending	26%	21%
Organisation of the healthcare system (2)		
Social insurance or tax-based system?	Tax-based system	
Gatekeeping by a general practitioner (GP)?	Compulsory	
How are physicians paid? (e.g. salary, fee-for-service, capitation)	Salary (public) & fee-for-service (private)	
Patient organisation involvement (3=good, 2=intermediary, 1=not-so-good)	1	
Accessibility (3=good, 2=intermediary, 1=not-so-good) (3)		
Family doctor same day access	1	
Major surgery < 90 days	2	
Cancer therapy < 21 days	2	
CT scan < 7 days	1	

Sources: (1) OECD Health at a Glance Europe 2012<sup>322</sup>, (2) Joint Report on Health systems (2010)<sup>323</sup>, HEIDI WIKI<sup>324</sup> and EuroHealth Consumer Index 2012<sup>325</sup>, (3) EuroHealth Consumer Index 2012.

<b>Corruption in healthcare perceptions</b>		
<b>Do you think that the giving and taking of bribes, and the abuse of positions of power for personal gain, are widespread among people working in the public health sector?</b>		
	<i>Portugal</i>	<i>EU average</i>
(% of respondents agree - Eurobarometer)	28%	30%
<b>Please indicate on a scale of 1 (= no problem) to 5 (= very serious problem) to what extent corruption is a serious issue in your country (average score of 4 interviewees<sup>326</sup> - own research)</b>		
	<i>Portugal</i>	
Informal payments in medical service delivery	3.5	
Certification and procurement of medical equipment	3	
Authorisation and procurement of pharmaceuticals	4.5	

Sources: Special Eurobarometer 374, table QC4 (fieldwork September 2011); own research (fieldwork February/March 2013).

### Types of healthcare corruption

Corruption in the Portuguese healthcare sector is a serious issue: 'Portugal leads EU member states in terms of wasted expenditures due to fraud and corruption in the

<sup>322</sup> <http://www.oecd.org/els/health-systems/HealthAtAGlanceEurope2012.pdf>.

<sup>323</sup> [http://europa.eu/epc/pdf/joint\\_healthcare\\_report\\_en.pdf](http://europa.eu/epc/pdf/joint_healthcare_report_en.pdf).

<sup>324</sup> [https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing\\_healthcare/Healthcare\\_financing\\_systems](https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing_healthcare/Healthcare_financing_systems).

<sup>325</sup> Health Consumer Powerhouse – EuroHealth Consumer Index 2012: <http://www.healthpowerhouse.com/index.php?Itemid=55>.

<sup>326</sup> Note that two respondents did not answer the three questions.

healthcare sector (approximately 800 million per year which represents 2,5 million nurse wages for an entire year)<sup>327</sup>.

As for the health sector in particular, from the several interviews and desk research done for the country study, informal payments in medical service delivery (including also informal payments in the shape of favours and presents) and conflicts of interest in the purchase of medicaments and medical equipment are the main typologies of corruption in the health sector in Portugal. Those types of corruption have been mentioned in all interviews but their importance differs depending on the organization interviewed.

As also mentioned by an interviewee, a very extended type of corruption is that doctors are receiving presents or sponsorship to participate in congresses etc. by the pharmaceutical representatives. This is difficult to proof however. Portuguese doctors regularly receive sponsorships from pharmaceutical companies expecting prescriptions or recommendations of their products in return.

In terms of economic and social impact, corruption in the medical equipment procurement was said to be the most serious practice, as it entails an enormous waste of public resources. For example, a recently discovered case of transnational corruption concerning medical material procurement revealed that many hospitals provide themselves with expensive medical material that they barely use.

### **Causes and risks**

Various causes and risks were mentioned by the interviewees:

#### ***Cooperation between public and private entities***

Lack of transparency and conflict of interest as a result of the cooperation between public entities and private enterprises (pharmaceutical or medical equipment suppliers).

#### ***Weakness in the healthcare sector***

One of the main weaknesses in the healthcare sector emerges from the recent restructuring of the internal management system to a private management model, stamped with cost reduction policies and a profit above quality philosophy.

#### ***Purchase of medicines***

Medicines are purchased on wholesale, instead of unit sale. This creates opportunities for the oversupply of medicines. This might lead to the reshipment of the surpluses to foreign countries, in order to obtain unlawful benefits.

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<sup>327</sup> Country Report Portugal and see [www.ipjournal.com](http://www.ipjournal.com).

**Control mechanisms and legal framework:**

- Weak control mechanisms – failure and underperformance of the supervisory and monitoring organisms;
- Confusing existing legislation on corruption – The Penal Code does not foresee any specific regulations on the matter;
- In Portugal, no actual investigation / research has been done on corrupt practices within the various healthcare sectors;
- The national ‘corruption prevention plan’ is purely formal, meaning that no factual anti – corruption measures are established and internal fraud management procedures are none existent.

**Cultural:**

- Culture of ‘cunhas’ – it is common to give presents in return for treatment of the doctor. Treatment is seen as a favour from the doctor to the patient;
- People in Portugal are not accustomed to report on corruption for various reasons: the report mechanisms are difficult to use; it is viewed as morally inappropriate; it can lead to reprisals; and in most of cases, reports are not followed up.

**Actual and suggested policies and practices****Organisations:**

- The ‘General Inspection of all activities in relation with the healthcare sector’ (IGAS) is a political organ integrated within the Portuguese Healthcare Ministry. Cumulating 30 years of experience in the field, it was established in order to take special care of disciplinary procedures in the health sector. Concretely, it aims to ensure that all parties (public or private) respect legislation foreseen in healthcare domains. In addition, they aim to prevent and detect corruption and fraud, for example by to discouraging potential perpetrators by promoting disciplinary procedures. The organization pays special attention to acquisitions and supplies procedures within the Portuguese public health hospitals;
- Intra organism’s coalition: A control and prevention group against medicine procurement corruption, consisting of: IGAS, the Judicial Police department and other organisms such as Infarmed (the National Authority of Medicines and Health Products). Improvements in control systems, risk analysis and implementation of uniformed methodologies (formation lessons to the controllers, adaptation to new corruption methods) are examples of procedures that have been undertaken by this intra organism’s coalition;
- The ‘Conselho de Prevenção da Corrupção’ is an independent administrative entity that collaborates with the Portuguese Court of Accounts aimed to prevent any kind of corruption or related activities at a national scope. This council has a preventive function over the entire public sector. They developed a ‘corruption and fraud prevention plan’. Each public entity needed to identify and report every plausible corruption risk that they could encounter, and consequently present what measures should be taken in order to reduce such risks. Although listed as a good practice in

the report, the measure has been strongly criticized during some of the interviews because many authorities seem to have delivered poor reports and the measures have not been followed up (mere formal practices);

- The 'Ordem dos médicos' (OM) is a national doctor's association with the objective to ensure a certain standard of quality, independence and regulation of Portuguese doctor's practices.

### ***Online reporting***

The OM has implemented an online reporting platform where all unusual or suspicious exchanges undertaken by any pharmaceutical boutique can be reported to Infarmed (the national authority of medicines and health products). The main purpose of this procedure is to reinforce control and prevention of improper or forbidden medicines exchanges at chemistries.

### ***Integrated management system for those subject to surgery***

In the surgical needs field, a program of 'maximum time of response' has been implemented at the national level. This system guarantees access of all citizens to the fundamental surgical needs, assuring a limited maximum waiting time until the needed treatment is concealed. According to the OECD this is a structural and exemplar program to be taken into account by the other members of the organization.

### ***Law: Decreto-Lei n.º 20/2013 de 14 de Fevereiro***

A new Decree Law has been passed recently (the 14<sup>th</sup> of February, 2013) in order to create more transparency in the Portuguese healthcare sector. According to the law, doctors need to report all kinds of assistance, direct or indirect, received by the pharmaceutical industry to Infarmed (the National Authority of Medicines and Health Products). In this way, Infarmed shall be more aware of possible conflicts of interests, have a more transparent overview of the general situation and help the Portuguese government prevent more easily corruption and fraud in this particular area.

## Romania

### General description of the healthcare system<sup>328</sup>

In 1998 Romania introduced universal mandatory social health insurance in which all insured people are entitled to a basic benefit package. The National Health Insurance Fund (NHIF), a central quasi-autonomous body, is the third-party payer in this system. Moreover, in 2002 two country wide insurance funds have been established. One belongs to the Ministry of Transport and the other belongs to the Ministries of Defence, Justice and Interior and the agencies related to national security.

The Romanian healthcare system is organised at two levels: national/central level and local level (judet). The Ministry of Public Health is responsible for the overall regulation, policy making and public health. The representative bodies of the Ministry at the district level are the 42 district public health authorities (DPHAs). There are also 42 District Health Insurance Funds (DHIFs), which are responsible for contracting services from public and private healthcare providers. The services to be contracted are stipulated in the Yearly Framework Contract that is agreed on between the NHIF, the Ministry of Public Health and the College of Physicians.

The social insurance contributions are collected by the Fiscal Administration National Agency of the Ministry of Finance. The contributions are allocated to the NHIF and subsequently distributed amongst the DHIFs, based on a risk-adjusted capitation system. The contributions of the self-employed are directly collected by the DHIFs. Another source of financing is taxes, which are also collected by the Ministry of Finance and allocated to the Ministry of Public Health. A third source of financing in the Romanian health system is out-of-pocket payments in the form of co-payments on covered services or direct payments to private providers and/or for uncovered services.

### Healthcare delivery

Healthcare delivery is based on a gatekeeping system, which assigns a primary role to the GP in the provision of healthcare access. Patients need a referral from their GP to be eligible for reimbursed hospital care. In the field of accessibility regional differences are noticed. The majority of institutions providing secondary and tertiary care are publicly owned and regulated. The current legislation assures free choice of provider for the patient, increasing patient participation in decision-making, patient safety and compensation measures.

General practitioners are paid by a mixed system of fee-for-services and per capita payments. Hospital services are compensated by predefined payments, which' calculation methods differ by service. Hospital payments for inpatient services are

<sup>328</sup> Main sources for this section: Vladescu C, Scintee G, Olsavszky V, Allin S and Mladovsky P. Romania: Health system review. *Health Systems in Transition*, 2008; 10(3): 1-172.  
[http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0008/95165/E91689.pdf](http://www.euro.who.int/__data/assets/pdf_file/0008/95165/E91689.pdf) and Zaman C (2012). asisp Annual National Report 2012 Romania. Pensions, Health Care and Long-term Care. Downloaded from: [http://www.socialprotection.eu/files\\_db/1282/asisp\\_ANR12\\_ROMANIA.pdf](http://www.socialprotection.eu/files_db/1282/asisp_ANR12_ROMANIA.pdf).

calculated per case based on a DRG system. Costs for outpatient services are reimbursed by fee for service.

Indicators of the healthcare system, 2010 (or nearest year)		
Financing of the healthcare system (1)		
	Romania	EU average
Total health expenditure as % of GDP	6%	9%
Public expenditure as % of total health spending	80%	73%
Private insurance as % of total health spending	0%	4%
Private-out-of-pocket as % of total health spending	19%	21%
Organisation of the healthcare system (2)		
Social insurance or tax-based system?	Social insurance	
Gatekeeping by a general practitioner (GP)?	Meant to be mandatory	
How are physicians paid? (e.g. salary, fee-for-service, capitation)	Capitation/FFS	
Patient organisation involvement (3=good, 2=intermediary, 1=not-so-good)	2	
Accessibility (3=good, 2=intermediary, 1=not-so-good) (3)		
Family doctor same day access	2	
Major surgery < 90 days	2	
Cancer therapy < 21 days	2	
CT scan < 7 days	2	

Sources: (1) OECD Health at a Glance Europe 2012<sup>329</sup>, (2) Joint Report on Health systems (2010)<sup>330</sup>, HEIDI WIKI<sup>331</sup> and EuroHealth Consumer Index 2012<sup>332</sup>, (3) EuroHealth Consumer Index 2012.

<b>Corruption in healthcare perceptions</b>		
<b>Do you think that the giving and taking of bribes, and the abuse of positions of power for personal gain, are widespread among people working in the public health sector?</b>		
	<i>Romania</i>	<i>EU average</i>
(% of respondents agree - Eurobarometer)	61%	30%
<b>Please indicate on a scale of 1 (= no problem) to 5 (= very serious problem) to what extent corruption is a serious issue in your country (average score of 6 interviewees<sup>333</sup>)</b>		
	<i>Romania</i>	
Informal payments in medical service delivery	4.5	
Certification and procurement of medical equipment	3	
Authorisation and procurement of pharmaceuticals	4	

Sources: Special Eurobarometer 374, table QC4 (fieldwork September 2011); own research (fieldwork February/March 2013).

<sup>329</sup> <http://www.oecd.org/els/health-systems/HealthAtAGlanceEurope2012.pdf>.

<sup>330</sup> [http://europa.eu/epc/pdf/joint\\_healthcare\\_report\\_en.pdf](http://europa.eu/epc/pdf/joint_healthcare_report_en.pdf).

<sup>331</sup> [https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing\\_healthcare/Healthcare\\_financing\\_systems](https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing_healthcare/Healthcare_financing_systems).

<sup>332</sup> Health Consumer Powerhouse – EuroHealth Consumer Index 2012: <http://www.healthpowerhouse.com/index.php?Itemid=55>.

<sup>333</sup> Note that two respondents did not answer the question about the certification and procurement of medical equipment and that one respondent did not answer the question about the authorization and procurement of pharmaceuticals.

***Types of healthcare corruption:***

- Various types were mentioned by the interviewees, mostly bribery, collusion in procurement and clientelism / favouritism / nepotism;
- Informal payments seems the largest problem. A national study conducted by the World Bank for the Romanian Ministry of Health in 2005 estimated the extent of informal payments in health at around \$360 million annually (World Bank, 2006), but Romanian health professionals and some officials, cited by media, commented that this level has been even underestimated;
- Pharmaceutical companies and medical equipment providers aim to influence decision makers by offering them expensive trips, bribes and considerable kickbacks. This was observed in the following processes:
  - To get approval to be included in the national list;
  - In the process of procurement for the National Health Programs;
  - The process for including a specific drug, health material or medical device on the list of compensations and/or gratuities covered from the National Social Health Insurance Fund;
- Recently, a media campaign has disclosed incredible, huge differences in the prices (up to 100 times more) for the same items in different hospitals for e.g. surgical gloves, syringes, bandages etc.

***Causes and risks******The following causes and risks were mentioned:***

- Health sector are weak or non-existent rules and regulations;
- Over-regulation;
- Lack of accountability;
- Low salaries;
- Limited offer of services (i.e., more demand than supply);
- A poor representation of the social partners at the decisional level of the National Health Insurance Fund which makes the anticorruption guaranties ineffective or even eliminates them;
- A broad asymmetry in information;
- Aspects of inequity in the use of healthcare use;
- Lack of transparency related to the health reforms and especially of the spending of public funds for health;
- Considerable distrust in public institutions;
- Poor access to health services in certain areas and groups;
- Lack of consensus between policy/decision makers;
- Service providers and patients regarding reforming measures;
- Incrimination of corruption;
- Disagreement with official co-payments because of existing informal payments.

## **Actual and suggested policies and practices**

The following practices were mentioned as good practices:

National Anti-Corruption Strategy 2012-2015 (NAS) is to reduce and prevent the phenomenon of corruption through a strict enforcing of the normative and institutional framework for all public institutions, business environment and civil society. In particular:

Prevention of corruption in public institutions:

- Increasing institutional transparency by enlarging availability of public open data;
- Consolidate integrity and transparency of judiciary system by promoting anti-corruption measures and the professional ethical standards;
- Increase the transparency of financing for political parties and political campaigns;
- Consolidate integrity among the members of Parliament;
- Increasing the efficiency of mechanisms for corruption prevention in public procurement;
- Promoting a competitive, correct and honest business environment;
- Consolidate integrity, efficiency and transparency at the level of local public administration.

Increasing the level of education anti-corruption;

Fight against corruption through administrative and criminal law;

Approving the sectoral plans and the national monitoring system for NAS.

In April 2012 an Integrity Structure within the Ministry of Health was set up, aimed to promote integrity at the health system level, to support the appliance of the anticorruption mechanisms and to limit the embezzlement and related corruption. In particular the unit supervises the following fields: public procurement, organizing exams, informal payments. (Viasu, 2012);

*The Project 'Good governance through integrity and accountability in the Romanian health system'* (2011 – 2013) co-funded by European Social Fund. The Ministry of Health is the beneficiary of the project. The objectives are i) to improve the quality and efficiency of public services of the Romanian health system through supporting the process of for sectoral decentralization of the health services and ii) to promote integrity and accountability in public spending. No information is available about the results of this project yet;

*The Agreement between the Romanian Government and the International Monetary Fund regarding the introduction of co-payments in the health system.* Resulting from this agreement a new co-payment law (no.220/28.11.2011) was issued in 2011 in line with IMF, World Bank and European Commission recommendations. According to this law, co-payments are to be calculated as a percentage of the value of health services received, while the total amount for an insured person should not exceed 1/12 of their annual net income. Exemptions are: children, young students, retired people having



low pensions, patients included in national health programs. However, the law is not entirely applicable yet (will be further implemented throughout 2013).

**Websites:**

- Infopoint website [www.medalert.ro](http://www.medalert.ro)

Infopoint was created in May 2012. It is a portal created in order to provide the general public and health professionals with a rapid tool for signalling the abuses and corruption in health care in Romania. However, there was a very low awareness among the public and professionals about this website. In addition, patients feared repercussions when complaining. Because of these reasons the portal was not used and is currently not functional anymore;

- The Alliance for a Clean Romania, an anti-corruption portal: [www.romaniacurata.ro](http://www.romaniacurata.ro)

The goal of this initiative is to build participation to increase impact of anti-corruption, to educate people about corruption and encourage them to speak out on corruption. No impact study is published on the portal, not even simply reports of the number of readers and posts.

**Procurement of medicines**

The Ministry of Health has recently proposed a law for re-centralization of the public procurement of medicines, health materials, medical devices and medical equipment to the Parliament. It has already been approved by the Senat. Before, only the procurement of drugs and medical devices/materials of the National Health Programs were centralized. Several aspects of corruption related to public procurement of health items are signalled by the media, but few become subjects of audits/controls and sanctioned as such.

## Slovakia

### General description of the healthcare system<sup>334</sup>

The Slovakian healthcare system is highly centralized. Since the biggest health insurance company and some healthcare institutions are state-owned, the government acts in both the financing and provision of healthcare. Only a few administrative tasks have been delegated to the local governments. Whereas the double role of the central government might lead to conflict of interests, the Health Care Surveillance Authority (HCSA) has been appointed in 2004 to take over the government's responsibility in monitoring and supervising the health system. The health insurance companies, as the healthcare purchasers, also play an important actor in the Slovakian health system. The agreements made between insurers and healthcare providers are based on contracts and supervised by the HCSA.

The financing of the Slovakian healthcare is characterised by a progressive system. The main sources of funding are Social Health Insurance (SHI) funds and direct taxes. The introduction of the Social Health Insurance scheme in 2010 provides universal coverage. The joint stock insurance companies are responsible for the collection of the contributions and operate on a profit-making basis. However profits should be utilised for the purchase of healthcare services. Patients are free to change their healthcare insurer once a year. The application of co-payments is limited.

### Healthcare delivery

Outpatient care (both primary and secondary) is largely privatised. The delivery of healthcare is based on a gatekeeping system, in which the GP is a patient's first contact point. Hospitals can be either publicly or privately owned and either general or specialised hospitals.

The patient's choice of specialist is restricted to the insurer's list of contracted specialists. Exceptions can be made after a patient's request to receive care from a non-contracted specialist. Only GPs can be chosen freely. Yet, changing from GP is only allowed per half year.

The payments for primary care are based on a mixed payment system, consisting of capitations and fees. The payments made to outpatient specialist are based on a fee-for-service system with honoraria that have to be kept within an overall budget ceiling. Hospitals are financed by a performance based payment system in which payments are case-based.

<sup>334</sup> Main sources for this section: Szalay T, Pažitný P, Szalayová A, Frisová S, Morvay K, Petrovic M and van Ginneken E. Slovakia: Health system review. *Health Systems in Transition*, 2011; 13(2):1–200. [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0004/140593/e94972.pdf](http://www.euro.who.int/__data/assets/pdf_file/0004/140593/e94972.pdf) and Vagac L with the assistance of Zachar D and Golias P(2012). asisp Annual National Report 2012 Slovakia. Pensions, Health Care and Long-term Care. Downloaded from: [http://www.socialprotection.eu/files\\_db/1295/asisp\\_ANR12\\_SLOVAKIA.pdf](http://www.socialprotection.eu/files_db/1295/asisp_ANR12_SLOVAKIA.pdf).

Indicators of the healthcare system, 2010 (or nearest year)		
Financing of the healthcare system (1)		
	<i>Slovakia</i>	<i>EU average</i>
Total health expenditure as % of GDP	9%	9%
Public expenditure as % of total health spending	64%	73%
Private insurance as % of total health spending	0%	4%
Private-out-of-pocket as % of total health spending	26%	21%
Organisation of the healthcare system (2)		
Social insurance or tax-based system?	Social insurance	
Gatekeeping by a general practitioner (GP)?	Compulsory	
How are physicians paid? (e.g. salary, fee-for-service, capitation)	Capitation	
Patient organisation involvement (3=good, 2=intermediary, 1=not-so-good)	3	
Accessibility (3=good, 2=intermediary, 1=not-so-good) (3)		
Family doctor same day access	3	
Major surgery < 90 days	1	
Cancer therapy < 21 days	3	
CT scan < 7 days	2	

Sources: (1) OECD Health at a Glance Europe 2012<sup>335</sup>, (2) Joint Report on Health systems (2010)<sup>336</sup>, HEIDI WIKI<sup>337</sup> and EuroHealth Consumer Index 2012<sup>338</sup>, (3) EuroHealth Consumer Index 2012.

<b>Corruption in healthcare perceptions</b>		
<b>Do you think that the giving and taking of bribes, and the abuse of positions of power for personal gain, are widespread among people working in the public health sector?</b>		
(% of respondents agree - Eurobarometer)	<i>Slovakia</i> 53%	<i>EU average</i> 30%
<b>Please indicate on a scale of 1 (= no problem) to 5 (= very serious problem) to what extent corruption is a serious issue in your country (average score of 3 interviewees)</b>		
	<i>Slovakia</i>	
Informal payments in medical service delivery	3	
Certification and procurement of medical equipment	4	
Authorisation and procurement of pharmaceuticals	3	

Sources: Special Eurobarometer 374, table QC4 (fieldwork September 2011); own research (fieldwork February/March 2013).

## Types of healthcare corruption

### **Cultural acceptance a degree of corruption and high-level corruption**

The environment allows for corruption to persist without punishment due to lack of attention by authorities and even greater lack of perseverance to conclude prosecutions. In the case that such prosecutions are successfully completed it is most often in relatively small cases of low ranking officials or individual doctors.

<sup>335</sup> <http://www.oecd.org/els/health-systems/HealthAtAGlanceEurope2012.pdf>.

<sup>336</sup> [http://europa.eu/epc/pdf/joint\\_healthcare\\_report\\_en.pdf](http://europa.eu/epc/pdf/joint_healthcare_report_en.pdf).

<sup>337</sup> [https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing\\_healthcare/Healthcare\\_financing\\_systems](https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing_healthcare/Healthcare_financing_systems).

<sup>338</sup> Health Consumer Powerhouse – EuroHealth Consumer Index 2012: <http://www.healthpowerhouse.com/index.php?Itemid=55>.

The political involvement in corrupt practices and even the involvement of organised crime organisation was brought to surface in a very large 'Gorilla' scandal. Recordings from secret police investigation implicated the highest politicians, individuals and gangsters in discussing kick-backs from procurements and privatisation. This scandal has contributed to a dramatic change of government, yet up to the date not a single person has been taken to court.

### ***Informal payments***

Paying and receiving bribes is fairly common in Slovak healthcare sector, both out- and in-patient. According to an opinion poll implemented by the agency Focus in 2012 on corruption in the Slovak Republic, healthcare is the most corrupted sector (61% of respondents believed that the healthcare was the most corrupt sector)<sup>339</sup>. However, when asked about paying bribes personally over the past two years, only 26 % of respondents responded affirmative. Only in 4 % reported that they were asked to pay a bribe or that paying a bribe was suggested.

### ***Procurement of medical equipment***

Most common types of a corruption within the inpatient sector are kickbacks – commissions for services, mostly for purchasing equipment and pharmaceuticals. Public procurement is often organized in such a way that the criteria fit one preselected bidder, equipment is often purchased for higher than market price and the difference between the purchased and 'normal' price ends up in pockets of those handling the procurement. Prices for purchased equipment are often by 50%-100% higher than the market price.

### ***Procurement and authorisation of pharmaceuticals***

A similar system applies in the procurement of pharmaceuticals, except that in one case the difference was 300% higher than the market price. Physicians' conflict of interest is also an issue resulting in corruption in healthcare in Slovakia. Evidence, albeit only anecdotal, suggests that physicians prescribe pharmaceuticals to their patients and may be directly influenced by pharmaceutical companies in what particular medicine to prescribe, in exchange for informal cash payments or more 'official' benefits, such as having a course or congress reimbursed by the pharmaceutical company, etc.

### ***Causes and risks***

A limited number of successful and timely prosecutions of corruption indicate a relative risk-free environment to conduct corruption. Lack of motivation to manage funds efficiently. In spite of rising healthcare expenditure, the quality of care fails to improve. (The hospitals in the Slovak Republic waste a large amount of entrusted resources, they are permanently in debt and they

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<sup>339</sup> [http://www.transparency.sk/wp-content/uploads/2010/01/FOCUS\\_Sprava-pre-TIS\\_jan2012.pdf](http://www.transparency.sk/wp-content/uploads/2010/01/FOCUS_Sprava-pre-TIS_jan2012.pdf).

know from experience that the debt of the facility will be annulled by the state. Therefore they are not motivated to manage the facility in a sound way. At the same time, there is no long-term continuity in management – the top managers of the largest hospitals in the country are political nominees and are being replaced with each major political change (change of government, minister, etc.). They know they will not be in the position to manage the facility for a long time – hence the lack of motivation for sound management.

### **Actual and suggested policies and practices**

*Application of formal payments* The formalisation of payments consists of physicians accepting payments for various services – e.g. prioritized examination ('skipping the line') of a patient that pays for it, examination on patient's request for certain purpose (for other authorities), etc. These payments are made publicly available through an 'official price list for extra services' – document with fees for services – that is publicly displayed in the waiting room.

*Improving transparency.* In 2000 the so-called 'Info-law' was adopted, that obliges all institutions to provide information to the public. This Act also obliges institutions that handle public funds to publish the contracts they sign. Still several ways exist and are used by health care organisations and their suppliers to cover corrupt practices. One of those is to publish the signed contract e.g. on the hospital website while afterwards changing the final price of the purchased by a contract amendment that is not published.

The outcomes of the meetings of the Categorization Committee for drugs at the Ministry of Health in Slovak Republic were made public (the Committee decides on the share public health insurance / patient's out-of-pocket co-payment on pharmaceutical and aids). The process documents are available on the web of the MoH <http://kategorizacia.mzsr.sk>, thus making the process more transparent than before. The law and the Directive on transparency set up a limit (in number of days) for making a final decision. This limit is not always kept.

## Slovenia

### General description of the healthcare system<sup>340</sup>

Slovenia has a mandatory social insurance system with a single insurer for statutory health. This insurer is administered by the Health Insurance Institute of Slovenia (HIIS), which is an autonomous public body that is also the main purchaser of health care services. The health insurance system provides universal coverage.

The contributions to the statutory health insurance are income-based and shared between employers and employees. Private funding plays a relatively important role in Slovenia and comes from both voluntary health insurance premiums and out-of-pocket payments. In an effort to equalise the variations in risk structures between private health insurance companies and to avoid cream-skimming, a risk-equalization scheme was introduced in 2005.

Regulation and management of the health system is rather centralised in Slovenia. The single insurer for statutory health is fully regulated by national legislation. The Ministry of Health is responsible for, amongst other things, the financing of health infrastructure for hospitals and health services and programmes at the national level. The role of municipalities is in general limited to the provision and maintenance of health infrastructure at the primary care level.

### Healthcare delivery

Primary care is provided by public primary care centres and health stations. Moreover, over the last years more and more private GPs have started to participate in the public healthcare network (and are also being reimbursed by the HIIS). Primary health services within the public healthcare network are paid for through a combination of capitation and fee-for-services. People can choose one personal physician without administrative and/or territorial constraints.

Access to secondary care requires referral by the patients' personal GP or paediatrician. Secondary care is provided by mainly hospitals (or polyclinics), but also by spa's and private facilities. Outpatient specialist care is paid for fee-for-service, acute inpatient care on the basis of a DRG system, and non-acute inpatient care on the basis of the number of bed days per stay.

All physicians in the public sector (both primary and secondary care) are paid salaries.

In Slovenia long waiting times for dental services, several specialised services and surgery exist.

<sup>340</sup> Main sources for this section: Albrecht T, Turk E, Toth M, Ceglar J, Marn S, Pribakovic Brinovec R, Schäfer M, Avdeeva O and van Ginneken E. Slovenia: Health system review. *Health Systems in Transition*. 2009; volume 11(3): 1-168. [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0004/96367/E92607.pdf](http://www.euro.who.int/__data/assets/pdf_file/0004/96367/E92607.pdf) and Stanovnik T, Turk E, Prevolnik Rupel V (2012). asisp Annual National Report 2012 Slovenia. Pensions, Health Care and Long-term Care. Downloaded from: [http://www.socialprotection.eu/files\\_db/1292/asisp\\_ANR12\\_SLOVENIA.pdf](http://www.socialprotection.eu/files_db/1292/asisp_ANR12_SLOVENIA.pdf).

<b>Indicators of the healthcare system, 2010 (or nearest year)</b>		
<b>Financing of the healthcare system (1)</b>		
	<i>Slovenia</i>	<i>EU average</i>
Total health expenditure as % of GDP	9%	9%
Public expenditure as % of total health spending	73%	73%
Private insurance as % of total health spending	13%	4%
Private-out-of-pocket as % of total health spending	13%	21%
<b>Organisation of the healthcare system (2)</b>		
Social insurance or tax-based system?	Social insurance	
Gatekeeping by a general practitioner (GP)?	Compulsory	
How are physicians paid? (e.g. salary, fee-for-service, capitation)	Salary	
Patient organisation involvement (3=good, 2=intermediary, 1=not-so-good)	2	
<b>Accessibility (3=good, 2=intermediary, 1=not-so-good) (3)</b>		
Family doctor same day access	3	
Major surgery < 90 days	1	
Cancer therapy < 21 days	2	
CT scan < 7 days	1	

Sources: (1) OECD Health at a Glance Europe 2012<sup>341</sup>, (2) Joint Report on Health systems (2010)<sup>342</sup>, HEIDI WIKI<sup>343</sup> and EuroHealth Consumer Index 2012<sup>344</sup>, (3) EuroHealth Consumer Index 2012.

<b>Corruption in healthcare perceptions</b>		
<b>Do you think that the giving and taking of bribes, and the abuse of positions of power for personal gain, are widespread among people working in the public health sector?</b>		
(% of respondents agree - Eurobarometer)	<i>Slovenia</i>	<i>EU average</i>
	59%	30%
<b>Please indicate on a scale of 1 (= no problem) to 5 (= very serious problem) to what extent corruption is a serious issue in your country (average score of 3 interviewees)</b>		
	<i>Slovenia</i>	
Informal payments in medical service delivery	2	
Certification and procurement of medical equipment	4	
Authorisation and procurement of pharmaceuticals	3	

Sources: Special Eurobarometer 374, table QC4 (fieldwork September 2011); own research (fieldwork February/March 2013).

### Types of healthcare corruption

The interview reports state that the Slovenian health system works well from the point of health care users. Since the salaries of doctors have increased, there remain almost no informal patient payments. Other types of corruption, mentioned by the interviewees, are summarized below.

<sup>341</sup> <http://www.oecd.org/els/health-systems/HealthAtAGlanceEurope2012.pdf>.

<sup>342</sup> [http://europa.eu/epc/pdf/joint\\_healthcare\\_report\\_en.pdf](http://europa.eu/epc/pdf/joint_healthcare_report_en.pdf).

<sup>343</sup> [https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing\\_healthcare/Healthcare\\_financing\\_systems](https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing_healthcare/Healthcare_financing_systems).

<sup>344</sup> Health Consumer Powerhouse – EuroHealth Consumer Index 2012: <http://www.healthpowerhouse.com/index.php?Itemid=55>.

**Public Procurement (pharmaceuticals and medical equipment):**

- Trading in Influence & Conflict of Interest: People with certain positions misuse them to gain additional benefits. Conflict of interest is also present among the public providers. People from the public sector are acting in favour of the private sector;
- Nepotism can occur in the public procurement of pharmaceuticals and medical equipment. Usually, people in the health sector are connected by family relations. Therefore, one of the interviewees stated that nepotism is the biggest problem with regard to corruption in the Slovenian health system;
- Collusion in procurement and embezzlement are mentioned by the interviewees as well as a prevailing corruption type.

**Causes and risks**

According to all interviewees, transparency and lack of information are perceived as the main cause for corruption in health care. Other causes and risks mentioned were for example:

**Slovenia: a small market**

The Slovenian health care market is too small to provide adequate and open competition between providers of health care.

**Lack of regulations for procurement processes:**

- The government is considered too *weak* to prevent corruption in an area like public procurement for medical equipment. There are no strong measures to detect the corruption. In addition, the law regarding the public tenders is not clear enough and very often is *not implemented* at all;
- Inadequate official law regulations, i.e., law regulations do not specify certain behaviour of public providers (like clientelism, trading in influence) as corruptive or illegal. In addition, there is a lack of regulation on lobbying by pharmaceutical companies.

**Centralization of medical devices**

In general, the health care market in Slovenia is small and it is very hard to provide free competition. The procurement processes of medical equipment are sometimes too much decentralised and even fragmented within one hospital, different departments (their chiefs) can have too much influence on final decisions. The purchasing prices of medical equipment are often not optimal ones. In certain cases the reason for non-optimal prices is corruptive behaviour of those that are involved.



### **Media**

Very often, companies that are selling medical equipment or pharmaceuticals donate money to the media, so the media will present them as the best candidate for a particular tender.

### **Private versus Public:**

- Private providers that are eligible for concessions are usually not supervised by any independent body;
- Doctors are allowed to have 'dual practice'. They can then very easily refer their patients to their private practise and patients can be exposed to additional direct payments.

### **Actual and suggested policies and practices**

#### ***'Upgrading the Healthcare System By 2020 – A Step Forward'***

In order to improve regulation on the purchase of medical equipment, the Slovenian government adopted a new policy: 'Upgrading the Healthcare System By 2020 – A Step Forward'. This document promotes the joint or united purchasing procedure for the same type of equipment for all health care units. This means that the price for a certain type of medical equipment (e.g. table for surgery) cannot be two times higher for one hospital in comparison with other ones. Although still in the implementation process, new policies regarding the purchasing of medical equipment are encouraging.

#### ***Regulation of donations to doctors and institutions***

This policy attempts to regulate the influence of pharmaceutical companies or other interest groups on health care providers. However, there are not enough control mechanisms yet that can provide full implementation of this policy.

#### ***National system of references prices for similar drugs***

Positive policy experiences regarding the pharmaceuticals is related to the existence of the national system of references prices for drugs (Albrecht et al., 2009). This national system of references prices regulates the price per product based on other observed prices in the market (also internationally) for the same product and puts a ceiling for the maximum price that will be reimbursed from health insurance.

#### ***Penalties for receiving informal payments***

According to the Slovenian regulations (Commission for the Prevention of Corruption of the Republic of Slovenia), the penalties for physicians that accept informal patient payments are very high (several thousand euros and a ban to perform the practice). However, any gift higher than 75 euro per year is not considered a bribe.

***Compulsory and Voluntary Health Insurance***

The wide coverage (98%) of the system of compulsory health insurance complemented voluntary health insurance (VHI) means that there are hardly any direct financial relations between providers and patients left, thereby reducing the scope for informal patients.

In 2008, Slovenia accepted the Amendment to the Health Care and Health Insurance Act, which allows exemption from co-payments for all low-income groups. Also, premiums for compulsory health insurance are adjusted regarding the income.

***Health Care (HC) frauds (insurance)***

Health care fraud prevention refers also to regular external controlling and auditing activities. Despite some systematic professional controlling activities in HC sector (including those performed by the interviewees' organisation) concrete policies on governmental level against frauds are still a challenge in Slovenia.

***Recommendations******Price mentioned in the contract***

During the negotiation process, the Ministry of Health, in the process of public procurement, selects the best offer—usually characterized by the lowest price. However, during the process of investments, this price is changed by the so called Annex of contract. When the public tender is once granted, there is no ceiling limit in the total costs. This regulation should be changed in future.

***Better regulations***

Weak regulations in the field of public procurement for pharmaceutical and medical equipment's are the main reason for corruption. The regulations are not clear and very often can be interpreted in different manner. Also, there are still no measures and tools that can be applied in monitoring this field. Future policy should focus on developing tools that can be used by independent supervisors. In addition, lobbying procedures are not regulated well enough.

***Auditing***

The great challenge in Slovenia is the lack of auditing teams, IT and other resources to perform more (and effective) activities in this specific area. The main reason is that fraud prevention is still not high enough on the public agenda.

## Spain

### General description of the healthcare system<sup>345</sup>

Spain has a National Health Service (SNS), which provides universal coverage. Except for most dental care, all services are free of charge at the point of delivery. Private insurance can be purchased for complementary coverage, but does not play a big role.

The system is mainly funded through general tax revenues. The central government is responsible for allocating these funds to the seventeen autonomous regions on the basis of demographic characteristics. Another source of funding are out-of-pocket payments; there are co-payments in place for both ambulatory- and over-the-counter drugs, optical care and dental services.

The health system in Spain is highly decentralized. The Ministry of Health and Consumer Affairs regulates and supervises the healthcare system. Moreover, it focusses on policy, regulation and legislation for the pharmaceutical market (e.g. product approvals and pricing and reimbursement).

The seventeen autonomous regions are responsible for healthcare organisation, financing, planning and delivery in their own jurisdiction. In most regions there are two executive organisations concerned with this: one for primary care and one for secondary (both out- and inpatient) care.

The National Health System Interterritorial Council (CISNS) is responsible for the coordination of the SNS. The CISNS comprises of representatives from every regional health services and the Minister of Health presides the Council. They are, amongst other things, responsible for approving the national catalogue of services that is mandatory for all regional health services. All decisions have to be adopted by consensus and serve as recommendations.

### Healthcare delivery

Each autonomous region is broken up into several health areas based on characteristics such as geography, socioeconomic standards and available health facilities. Each health area should cover between 200.000 and 250.000 inhabitants and provide both primary and secondary care. Moreover, it should be served by at least one general hospital.

Primary healthcare is provided through primary healthcare centres and multidisciplinary teams. For access to secondary care a mandatory gatekeeping system is in place. Secondary care is provided both in- and outpatient. Outpatient specialist care is mainly provided through community polyclinics that are integrated

<sup>345</sup> Main sources for this section: García-Armesto S, Abadía-Taira MB, Durán A, Hernández-Quevedo C, Bernal-Delgado E. Spain: Health system review. *Health Systems in Transition*, 2010, 12(4):1–295. [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0004/128830/e94549.pdf](http://www.euro.who.int/__data/assets/pdf_file/0004/128830/e94549.pdf) and Patxot C, Rentería E, Scandurra R and Souto G (2012). asisp Annual National Report 2012 Spain. Pensions, Health Care and Long-term Care. Downloaded from: [http://www.socialprotection.eu/files\\_db/1227/asisp\\_ANR12\\_SPAIN.pdf](http://www.socialprotection.eu/files_db/1227/asisp_ANR12_SPAIN.pdf).

with hospitals. The hospitals in Spain are funded through global budgets. All the healthcare professionals working in the SNS are salaried workers. GPs generally receive a salary plus a capitation component.

Indicators of the healthcare system, 2010 (or nearest year)		
Financing of the healthcare system (1)		
	Spain	EU average
Total health expenditure as % of GDP	9.6%	9%
Public expenditure as % of total health spending	74%	73%
Private insurance as % of total health spending	6%	4%
Private-out-of-pocket as % of total health spending	24%	21%
Organisation of the healthcare system (2)		
Social insurance or tax-based system?	Tax-based system	
Gatekeeping by a general practitioner (GP)?	Compulsory	
How are physicians paid? (e.g. salary, fee-for-service, capitation)	Salary/Capitation	
Patient organisation involvement (3=good, 2=intermediary, 1=not-so-good)	1	
Accessibility (3=good, 2=intermediary, 1=not-so-good) (3)		
Family doctor same day access	1	
Major surgery < 90 days	1	
Cancer therapy < 21 days	2	
CT scan < 7 days	1	

Sources: (1) OECD Health at a Glance Europe 2012<sup>346</sup>, (2) Joint Report on Health systems (2010)<sup>347</sup>, HEIDI WIKI<sup>348</sup> and EuroHealth Consumer Index 2012<sup>349</sup>, (3) EuroHealth Consumer Index 2012.

<b>Corruption in healthcare perceptions</b>		
<b>Do you think that the giving and taking of bribes, and the abuse of positions of power for personal gain, are widespread among people working in the public health sector?</b>		
	<i>Spain</i>	<i>EU average</i>
(% of respondents agree - Eurobarometer)	23%	30%
<b>Please indicate on a scale of 1 (= no problem) to 5 (= very serious problem) to what extent corruption is a serious issue in your country (average score of 3 interviewees<sup>350</sup>)</b>		
	<i>Spain</i>	
Informal payments in medical service delivery	NA	
Certification and procurement of medical equipment	NA	
Authorisation and procurement of pharmaceuticals	NA	

Sources: Special Eurobarometer 374, table QC4 (fieldwork September 2011); own research (fieldwork February/March 2013).

<sup>346</sup> <http://www.oecd.org/els/health-systems/HealthAtAGlanceEurope2012.pdf>.

<sup>347</sup> [http://europa.eu/epc/pdf/joint\\_healthcare\\_report\\_en.pdf](http://europa.eu/epc/pdf/joint_healthcare_report_en.pdf).

<sup>348</sup> [https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing\\_healthcare/Healthcare\\_financing\\_systems](https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing_healthcare/Healthcare_financing_systems).

<sup>349</sup> Health Consumer Powerhouse – EuroHealth Consumer Index 2012: <http://www.healthpowerhouse.com/index.php?Itemid=55>.

<sup>350</sup> Note that all respondents did not answer the three questions.

### **Types of healthcare corruption**

The following types were identified by the interviewees:

- The most common and severe types in Spanish healthcare are corruption and irregularities in the adjudication of public healthcare contracts to private companies. This not only concerns medical equipment and pharmaceutical procurement, but also other fields (all kinds of services in relation with public hospitals and other healthcare establishments);
- Informal payments in medical service delivery is seen as a common practice;
- It is assumed that big industrial pharmaceutical enterprises act as lobbying groups. They aim to influence regional Spanish law modifications in their favour. It is reported that this practice is taking place at a regional level, currently mainly in the Regions of Valencia and Madrid.

### **Causes and risks**

Various risks and causes were mentioned in the interviews:

- The prescription of drugs and medicines has always entailed a high risk of corruption in Spain, given the close relationship between medical representatives (pharmaceutical representatives) and doctors. For years these pharmaceutical representatives paid the medical doctors not only for attending congresses and conferences, but they also sponsored the travel costs of relatives or companions in trips with non-academic purposes. Sponsoring leisure trips is not allowed anymore;
- As medicines are provided in surplus instead of what is really needed according to the doctor's prescription, medicines end up accumulating in individuals homes. Consequently, besides the fact that public funds are wasted under these conditions, illegal resale can be undertaken by individuals;
- An important cultural feature is the relative social permissiveness towards some forms of corruption in the Healthcare sector.

### **Actual and suggested policies and practices**

According to one interviewee the controls and current legislation in Spain are not sufficient to prevent and control corruption. In addition, there is no national anti-corruption strategy in place for the Spanish Healthcare sector.

The country report describes the following measures which have recently been introduced:

#### ***Prescription and sale of the exact medicine dose that the patient needs***

There is a new medicines supply procedure that is going to be implemented soon. According to the procedure, one can only sell (or purchase) the exact dose of medicines which has been prescribed by a doctor. In this way the Government aims to save public funds and at the same time to reduce risks of the accumulation and waste of medicines.

***Centralized Purchase of medicines***

In order to reduce healthcare expenses and reduce the risk of fraud, the government has announced the centralized purchase of medicines. The central Government will purchase and negotiate directly with the pharmaceutical companies. In this way the influence of pharmaceutical companies on the supply of medicines should be reduced and the sale of medicines is monitored by the government under strict legislation.

***Obligation to prescribe the active chemical composition of medicines***

According to Royal Decree Law 9/2011, the prescription of medicines should be done on the basis of their active chemical composition. Pharmacists are also obliged to sell the lowest price unlabelled medicine ('generic medicines'). In this way the sale of generic medicines is being stimulated. As a result, pharmaceutical enterprises will be forced to reduce their product prices and to diminish their profit margins. This will also have a direct impact on pharmaceutical enterprises that favour doctors (financially or under service rendering) with the goal to persuade them to prescribe their medicines.

However, this last objective has not been achieved, since many of the brands seem to have adjusted their prices to the prices of 'generics' (unlabelled medicines) and doctors actually continue to prescribe brands, albeit at much lower costs.

***Strategy against counterfeit medicines 2012-2015 by the Spanish Medicines and Healthcare Products Agency***

The strategy foresees a strengthening of the control system. The strategy is seen by the interviewees as an effective measure to prevent the sale of counterfeit medicines.

***Collaboration mechanism between the Spanish Medicines and Healthcare Products Agency and the Autonomous Communities to solve cases of counterfeit medicines and health products***

Communication between the Agency and the Autonomous Communities is generally good and is an effective way of fighting and preventing corruption in a country where healthcare competences are decentralized.

***Conduct of code to avoid conflicts of interest and guarantee the integrity of all personnel working at the Spanish Medicines and Healthcare Products Agency***

The employees of the Agency are all subject to Law 7/2007, that establishes the Basic Statute of the Public Employee and settles the principles that must guide their conduct to ensure integrity and prevent the conflicts of interest.

## Sweden

### General description of the healthcare system<sup>351</sup>

Sweden has a healthcare system in which taxes are the main financing source and the healthcare services are highly subsidised.

Sweden has a decentralised healthcare system. There are three levels of government: national, regional and local. The Ministry of Health and Social Affairs is responsible for regulation and overall healthcare policy. The 21 county councils/regions are responsible for both the funding and the provision of healthcare services to their residents and the 290 municipalities are responsible for the provision of social services and long-term care for the elderly and disabled. The county councils/regions and the municipalities generate income through a combination of proportional income taxes, state grants and user charges.

In Sweden, the private expenditure on health mainly comprises of user charges, which are set at the regional and local level. Note, however, that there are national ceilings on out-of-pocket payments for healthcare visits and prescribed pharmaceuticals per calendar year. Another form of private expenditure is voluntary health insurance (VHI). The role of VHI is still rather small, but growing. Main reasons to purchase such insurance is quicker access to specialist ambulatory care and evasion of waiting lists for elective treatment. Note that in Sweden the lion share of private insurance premiums are paid for by employers and hence, it is closely related to occupational healthcare services.

### Healthcare delivery

Ownership of healthcare facilities in Sweden can be either public or private, however, the majority is in general publically funded. Hospitals can be categorised as either county council hospitals or regional/university hospitals. Secondary care is provided in both types of hospitals, whereas tertiary care is concentrated in the regional/university hospitals.

County councils have different methods of paying providers. Commonly used in hospitals are payments based on global budgets or a mix of global budgets, case-based and performance-based payments. In primary care mainly capitation complemented with fee-for-service and performance-based payments. Many health workers across public and private providers, nursing homes and home care are salaried employees.

<sup>351</sup> Main sources for this section: Anell A, Glenngård AH, Merkur S. Sweden: Health system review. *Health Systems in Transition*, 2012, 14(5):1–159. [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0008/164096/e96455.pdf](http://www.euro.who.int/__data/assets/pdf_file/0008/164096/e96455.pdf) and Baroni E and Axelsson R (2012). asisp Annual National Report 2012 Sweden. Pensions, Health Care and Long-term Care. Downloaded from: [http://www.socialprotection.eu/files\\_db/1289/asisp\\_ANR12\\_SWEDEN.pdf](http://www.socialprotection.eu/files_db/1289/asisp_ANR12_SWEDEN.pdf).

Indicators of the healthcare system, 2010 (or nearest year)		
Financing of the healthcare system (1)		
	Sweden	EU average
Total health expenditure as % of GDP	9.6%	9%
Public expenditure as % of total health spending	81%	73%
Private insurance as % of total health spending	0%	4%
Private-out-of-pocket as % of total health spending	17%	21%
Organisation of the healthcare system (2)		
Social insurance or tax-based system?	Tax-based system	
Gatekeeping by a general practitioner (GP)?	Not formally (can differ between county councils/regions)	
How are physicians paid? (e.g. salary, fee-for-service, capitation)	Salary	
Patient organisation involvement (3=good, 2=intermediary, 1=not-so-good)	2	
Accessibility (3=good, 2=intermediary, 1=not-so-good) (3)		
Family doctor same day access	1	
Major surgery < 90 days	2	
Cancer therapy < 21 days	1	
CT scan < 7 days	1	

Sources: (1) OECD Health at a Glance Europe 2012<sup>352</sup>, (2) Joint Report on Health systems (2010)<sup>353</sup>, HEIDI WIKI<sup>354</sup> and EuroHealth Consumer Index 2012<sup>355</sup>, (3) EuroHealth Consumer Index 2012.

<b>Corruption in healthcare perceptions</b>		
<b>Do you think that the giving and taking of bribes, and the abuse of positions of power for personal gain, are widespread among people working in the public health sector</b>		
(% of respondents agree - Eurobarometer)	<i>Sweden</i>	<i>EU average</i>
	14%	30%
<b>Please indicate on a scale of 1 (= no problem) to 5 (= very serious problem) to what extent corruption is a serious issue in your country (average score of 4 interviewees<sup>356</sup>)</b>		
	<i>Sweden</i>	
Informal payments in medical service delivery	2	
Certification and procurement of medical equipment	2	
Authorisation and procurement of pharmaceuticals	2	

Sources: Special Eurobarometer 374, table QC4 (fieldwork September 2011); own research (fieldwork February/March 2013).

<sup>352</sup> <http://www.oecd.org/els/health-systems/HealthAtAGlanceEurope2012.pdf>.

<sup>353</sup> [http://europa.eu/epc/pdf/joint\\_healthcare\\_report\\_en.pdf](http://europa.eu/epc/pdf/joint_healthcare_report_en.pdf).

<sup>354</sup> [https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing\\_healthcare/Healthcare\\_financing\\_systems](https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing_healthcare/Healthcare_financing_systems).

<sup>355</sup> Health Consumer Powerhouse – EuroHealth Consumer Index 2012: <http://www.healthpowerhouse.com/index.php?Itemid=55>.

<sup>356</sup> Note that one respondent did not answer the three questions.



**Types of healthcare corruption:**

- According to the report, both interviewees and official reports argue that trips and dinners offered by the pharmaceutical industry to doctors, are the most common type of corruption. However, thanks to efforts and regulations imposed by the sector itself, the problem is much less common today;
- An interviewee stated that procurement can be seen as the area in which corruption mostly occurs;
- According to another interviewee there are actually very few convictions for corruption. Those that do exist are cases on free benefits in connection to representation. There are no serious convictions on bribery and corruption.

**Causes and risks**

The following causes and risks were mentioned by the interviewees:

- An interviewee stated that there is always a risk in the field of procurement. The risk of corruption is not larger in the private sector compared to the public sector. The opposite may even be true, as in the private sector more control mechanisms to protect the profits might exist. In the public sector citizens are 'further away from the process' and therefore it is more difficult for them to make their case and to protect their interests;
- To the contrary, another interviewee said that the risk of corruption within healthcare has increased because the sector is increasingly privately owned. There are not the same robust systems for revision and intervention in place to identify and prevent such actions;
- The fact that corruption is not incorporated as a risk in internal audits;
- Lack of guidelines and monitoring in procurement;
- The relationship between the patient and medical staff: The patient tries to express its gratitude by offering gifts.

**Actual and suggested policies and practices*****Regulation on annual reports and budgets – prevention of corruption in state authorities (FISK 2000)***

The act applies to all authorities with an internal audit. There are 65 authorities in total who together are responsible for 90% of the state budget. The regulation states that each authority should monitor corruption internally. When it comes to corruption that does not involve financial transactions such as nepotism, the government refers to basic ethical values. According to this regulation, authorities are obligated to analyse the risks, take appropriate measures based on this analysis, follow up internal governance and control and to document their work. They do not have the obligation to actively look for corruption, nor does the Swedish national Audit office. The Government has not assessed the effect of the new act but the Swedish Agency for Public Management (Statskontoret) stated in their report on corruption that it has led to a considerable improvement in regard to regulations and control mechanisms.

***Regulation concerning bribes (Mutbrottslagstiftningen Prop 2011/12:79)***

In March 2009 the government initiated a study to assess the current regulations on bribery. The aim was to achieve a modern and efficient regulation with clear criteria on criminal liability. As a result, the government presented a new law on bribery in 2012 which states that all benefits can be classified as bribery regardless of their financial value, as long as they are to be considered inappropriate.

***Penal Code (1962:700)***

As of the first of July 2012, the legislation on offering and accepting bribes is included in chapter 10 of the penal code. It covers elected officials and all employees, public and private, regardless of their position or employment status. Rules on prosecution are also described in chapter 20. A crime is committed when an employer or employee receives a bribe or other unjustified benefits in connection to their official role. Furthermore it is considered a crime to request compensation or agree to compensation.

***Bribes and disqualification – A guide for Local Authorities and Regions Om mutor och jäv - vägledning för anställda i kommuner, landsting och regione, 2006***

In order to clarify the legal requirements regarding bribes and disqualification, the Ministry of Finance and the Swedish Association for Local Authorities and Regions published a guide on bribes and disqualification.

The revised version came into force on 1 July 2012 as a result of the new legislation on bribes. It states that elected officials and employees in local authorities and regions have an obligation to fight and prevent corruption and remain impartial so that the citizens trust in them is not jeopardised. The guidelines include definitions, legal context, recommendations, examples and a number of case studies on corruption.

## United Kingdom

### General description of the healthcare system<sup>357</sup>

The United Kingdom (UK) has a comprehensive healthcare system called the National Health Service (NHS). It provides universal access and covers a wide range of services which are mostly free of charge at the point of use. Small co-payments are required for several drugs, dental services and optical care. The NHS is mainly funded through central government taxation. People have the option to take out voluntary private insurance.

Healthcare policy in the UK is to a large extent the responsibility of the four devolved governments. The NHS consists of a four healthcare systems, all publicly funded: the NHS (England), NHS Scotland, NHS Wales and Health and Social Care in Northern Ireland. The Department of Health is responsible for the NHS and the overall health policy. The Secretaries of State for England, Scotland, Wales and Northern Ireland have separate responsibilities. In general, the upper levels in the hierarchal system are responsible for coordination and policy-making, whereas the lower levels are responsible for the management of health services<sup>358</sup>.

### Healthcare delivery

In the UK, the Primary Care Trusts (PCTs) are responsible for healthcare within a local area. Approximately 75% of the NHS budget is allocated to the PCTs. GPs are in general self-employed and contracted with PCTs. There is a strong focus on primary care and there is compulsory gatekeeping system in place.

The NHS owns the majority of hospitals (NHS trusts). The healthcare professionals working in these hospitals are salaried employees. There is a small private sector, which is financed through private voluntary insurance, out-of-pocket payments or funded by PCTs. These facilities mainly provide acute elective care.

<sup>357</sup> Main sources for this section: Seán Boyle: United Kingdom (England): Health system review. *Health Systems in Transition*, 2011; 13(1):1-486. [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0004/135148/e94836.pdf](http://www.euro.who.int/__data/assets/pdf_file/0004/135148/e94836.pdf), M Longley, N Riley, P Davies, C Hernández-Quevedo. United Kingdom (Wales): Health system review. *Health Systems in Transition*, 2012;14(11): 1 – 84. [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0006/177135/E96723.pdf](http://www.euro.who.int/__data/assets/pdf_file/0006/177135/E96723.pdf), Steel D, Cylus J. United Kingdom (Scotland): Health system review. *Health Systems in Transition*, 2012; 14(9): 1-50 [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0008/177137/E96722-v2.pdf](http://www.euro.who.int/__data/assets/pdf_file/0008/177137/E96722-v2.pdf), O'Neill C, McGregor P, Merkur S. United Kingdom (Northern Ireland): Health system review. *Health Systems in Transition*, 2012; 14(10): 1– 91. [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0007/177136/Northern-Ireland-HiT.pdf](http://www.euro.who.int/__data/assets/pdf_file/0007/177136/Northern-Ireland-HiT.pdf) and Seeleib-Kaiser M (2012). asisp Annual National Report 2012 United Kingdom. Pensions, Health Care and Long-term Care. Downloaded from: [http://www.socialprotection.eu/files\\_db/1301/asisp\\_ANR12\\_UK.pdf](http://www.socialprotection.eu/files_db/1301/asisp_ANR12_UK.pdf).

<sup>358</sup> Drummond M and Banta D (2009). 'Health technology assessment in the United Kingdom'. *International Journal of Technology Assessment in Health Care*, Vol. 25: Supplement 1, pp 178-181.

<b>Indicators of the healthcare system, 2010 (or nearest year)</b>		
<b>Financing of the healthcare system (1)</b>		
	<i>United Kingdom</i>	<i>EU average</i>
Total health expenditure as % of GDP	9.6%	9%
Public expenditure as % of total health spending	83%	73%
Private insurance as % of total health spending	3%	4%
Private-out-of-pocket as % of total health spending	9%	21%
<b>Organisation of the healthcare system (2)</b>		
Social insurance or tax-based system?	Tax-based system	
Gatekeeping by a general practitioner (GP)?	Compulsory	
How are physicians paid? (e.g. salary, fee-for-service, capitation)	Salary/Capitation/FFS	
Patient organisation involvement (3=good, 2=intermediary, 1=not-so-good)	3	
<b>Accessibility (3=good, 2=intermediary, 1=not-so-good) (3)</b>		
Family doctor same day access	2	
Major surgery < 90 days	2	
Cancer therapy < 21 days	2	
CT scan < 7 days	1	

Sources: (1) OECD Health at a Glance Europe 2012<sup>359</sup>, (2) Joint Report on Health systems (2010)<sup>360</sup>, HEIDI WIKI<sup>361</sup> and EuroHealth Consumer Index 2012<sup>362</sup>, (3) EuroHealth Consumer Index 2012.

<b>Corruption in healthcare perceptions</b>		
<b>Do you think that the giving and taking of bribes, and the abuse of positions of power for personal gain, are widespread among people working in the public health sector?</b>		
	<i>United Kingdom</i>	<i>EU average</i>
(% of respondents agree - Eurobarometer)	18%	30%
<b>Please indicate on a scale of 1 (= no problem) to 5 (= very serious problem) to what extent corruption is a serious issue in your country (average score of 2 interviewees<sup>363</sup>)</b>		
	<i>United Kingdom</i>	
Informal payments in medical service delivery	2.5	
Certification and procurement of medical equipment	1	
Authorisation and procurement of pharmaceuticals	2.5	

Sources: Special Eurobarometer 374, table QC4 (fieldwork September 2011); own research (fieldwork February/March 2013).

### **Informal payments**

From the interviews conducted it appears that rather than corruption per se, unwanted practices in the form of fraudulent behaviour. For instance double accounting in

<sup>359</sup> <http://www.oecd.org/els/health-systems/HealthAtAGlanceEurope2012.pdf>.

<sup>360</sup> [http://europa.eu/epc/pdf/joint\\_healthcare\\_report\\_en.pdf](http://europa.eu/epc/pdf/joint_healthcare_report_en.pdf).

<sup>361</sup> [https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing\\_healthcare/Healthcare\\_financing\\_systems](https://webgate.ec.europa.eu/sanco/heidi/index.php/Heidi/Healthcare/Financing_healthcare/Healthcare_financing_systems).

<sup>362</sup> Health Consumer Powerhouse – EuroHealth Consumer Index 2012: <http://www.healthpowerhouse.com/index.php?Itemid=55>.

<sup>363</sup> Note that one respondent did not answer the question about certification and procurement of medical equipment.

dentistry work with dentists doing work on a private basis, and then resubmitting the invoice and claiming payment back from the National Health Service (NHS).

### **Procurement**

The general consensus of the interviewees is that there is a lot of regulation around the procurement of medical equipment, therefore substantially limiting the scope for corruption. The NHS operates on the basis of open competition and will select on the basis of quality and price.

The interviewees pointed out that these days there is a less of an issue with corruption in relation to procurement of pharmaceuticals. This has been said in the interviews, to be because of local policies at Primary Care Trust level. There is now more scrutiny of drug companies and gifts etc. that are given to Doctors. There are individuals at a local trust level with responsibility to oversee procurement and detect any fraud at this level, therefore questions would be asked if activities were taking place which were potentially fraudulent / corrupt.

**Causes and risks.** The main reason that we have heard is: the greed of individuals that are financially comfortable, but try to illegally acquire more. At times the individual might be forced into corruption by being subject to 'pressure' or even extortion.

### **Actual and suggested policies and practices**

*Independent institution.* Healthcare is a strongly regulated industry within the UK. There are nine healthcare professional regulatory bodies<sup>364</sup> overseen by the Professionals Standards Authority. There are also a number of other professional bodies and auditors overseeing the provision of healthcare in the UK, and regulatory bodies for medicines and medical devices, procurement and competition within the healthcare industry. This has been identified in the research and interviews as a key successful aspect in the fight against corruption.

For instance: NHS Protect is based within the NHS Business Services Authority (NHSBSA), it aims to safeguard patients, staff and resources in the NHS. It ensures that the supplier may not offer services, gifts or benefits to NHSBSA employees in an attempt to influence that employee's conduct in representing the NHSBSA.

The Medicines and Healthcare products Regulatory Authority (MHRA) regulates the supply of medicines into the United Kingdom (UK), the MHRA Enforcement and Intelligence Group has responsibility for enforcing the law on medicines legislation, and can prosecute where the law has been broken. Operation Singapore, has been pointed out in the interviews as an example of a successful prosecution relating to unauthorised drugs entering the UK supply chain.

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<sup>364</sup> The General Chiropractic Council, General Dental Council, General Medical Council, General Optical Council, General Osteopathic Council, General Pharmaceutical Council, Health and Care Professions Council, Nursing and Midwifery Council, Pharmaceutical Society of Northern Ireland.

The Health and Social Care Act (2012) introduced changes to the way in which the National Health Service (NHS) budget is managed in England. A key element of the Bill relates to changes to commissioning processes for the NHS budget. From 2013 onwards, commissioning powers will move from Primary Care Trusts to General Practitioner-led consortia. These groups will control how around 60% of the overall NHS budget (around £65bn) is allocated, based on local needs. This includes commissioning private services as well as drugs and equipment.

Transparency International UK highlight the case of Special Advisors to Ministers, a code for Special Advisors has now been developed which states that:

‘Special advisers are subject to the Business Appointment Rules. Under the Rules, they are required to submit an application to the Head of their former Department for any appointments or employment they wish to take up within two years of leaving the Civil Service<sup>365</sup>.’

The related feature that bans special advisors from lobbying for two years after they leave their government position, has been identified as just as important.

*Control mechanisms.* All the interviewees agreed that the auditors, the judicial system, the police and public prosecution are all highly efficient and independent, with centuries of institutional experience and respectability together with a long history of very high quality investigative journalism.

*Precise and targeted laws.* To prevent any legal uncertainty several laws have been passed criminalising corruption. Such as the UK Bribery Act (2010).

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<sup>365</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/62451/special-advisers-code-of-conduct.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/62451/special-advisers-code-of-conduct.pdf).

## **Annex E Country profile template**

### **Study on corruption in the healthcare sector**

**Client: European Commission, DG Home Affairs**

#### **Background of the study**

The objectives of this study are to:

- Enable a better understanding of the extent, nature and impact of corrupt practices in the healthcare sector across the whole territory of the EU Member States (MSs) and Croatia;
- Assess the capacity **of** the MSs to prevent and control corruption within the healthcare system and the effectiveness of these measures in practice.

The study is focusing on three areas:

- Informal payments in medical service delivery;
- Certification and procurement of medical equipment;
- Authorisation and procurement of pharmaceuticals.

The study is part of the overall anti-corruption strategy of the European Commission.

#### **What we ask from you as country rapporteur**

##### **I. Conduct 3 to 4 interviews with different stakeholders**

Interviews can be individual or an interview with more stakeholders from the same group. See Box 1 for confidentiality agreements.

The interviews should focus on identifying:

- Prevailing types of healthcare corruption (see Checklist A);
- Causes and risks of corruption (see Checklist B);
- Successful policies and practices (government, healthcare sector, private sector);
- Negative practices or measures (negative impact as regards to the prevention or combatting of corruption in healthcare);
- Suggestions for other relevant experts, key documents (literature), statistics, data and databases and illustrative cases of corruption in (one of) the three areas.

##### **II. Collect and describe 3 to 6 cases of corruption in healthcare**

Cases can be identified through desk research and the interviews. The cases should cover the three areas mentioned above. Cases should have actually occurred (not theoretical, 'invented' cases or examples) preferably in the last 5-10 years. Cases should be based on reliable sources (e.g. actual court cases or cases described in the media or academic literature). Actual conviction is not required; suspicion of corruption is sufficient. See also Box 3 on how to start with identifying cases on corruption in healthcare.

### III. Collect and describe good and negative policies and practices to control corruption in healthcare

Policies and practices can be identified through desk research and the interviews. Please collect policies and practices (successes and failures), especially targeted at the three areas. We are interested in 'hard' and 'soft' measures and policies that involve various stakeholders (government, healthcare sector, private sector). In addition, suggested (future) policies should be identified.

#### Required output

The country profile should consist of:

- 3 to 4 interview reports (instructions in Box 4);
- 3 to 6 case descriptions (instructions in Box 4);
- Overview of good and negative policies and practices (instructions in Box 4);

Strict academic standards must apply to the research in terms of reliability of sources and referencing. The information must be up-to-date and balanced, making it possible to describe, analyse and compare the outputs from the different MS.

#### Sequence of activities

1. Briefing by Ecorys;
2. Identify list of potential interviewees and submit it to Ecorys on **February 20, 2013** at the latest (see Box 2);
3. Define final list of interviewees a.s.a.p. in consultation with Ecorys;
4. Conduct interviews and desk research (see Box 3);
5. Prepare draft country profile, submit it to Ecorys on March 11, 2013 at the latest; Feedback by Ecorys; Prepare Final country profile.

The final Country Profile should be submitted on March 22, 2013 at the latest.

#### Box 1. Confidentiality

Please inform each interviewee that:

Interview information will be treated confidential and only used for the purpose of this study;

The interview report will be send back to the interviewees for validation;

The interview reports will not be published in the final report;

Persons interviewed will not be named personally or by the name of the organisation they represent;

Quotes are not traceable to individual interviewees;

In the final report an overview will be given of the conducted interviews. The overview will comprise the Member State, general stakeholder category (e.g. civil society organisation, anti-corruption agency, medical device industry etc) and date of the interview.



## **Box 2. Practitioners, experts and other potential interviewees**

### *Corruption experts:*

- Representatives of national (government) anti-corruption agencies;
- Representatives of civil society organisations;
- Investigative journalists;
- Academic corruption experts.

### *Healthcare actors:*

- Government regulators (e.g. Ministry of Health, inspectorates, competent authority, notified body);
- Healthcare providers (institutional and individual practitioners – e.g. doctors organisations/association);
- Demanders of healthcare (consumers and patient organisations);
- Payers of healthcare (association of private and social insurance companies);
- Pharmaceutical suppliers;
- Medical equipment suppliers.

### *Relevant websites:*

- [http://www.ema.europa.eu/ema/index.jsp?curl=pages/medicines/general/general\\_content\\_000155.jsp&mid=WC0b01ac0580036d63](http://www.ema.europa.eu/ema/index.jsp?curl=pages/medicines/general/general_content_000155.jsp&mid=WC0b01ac0580036d63)
- <http://www.nbog.eu/4.html>
- [http://ec.europa.eu/health/medical-devices/links/contact\\_points\\_en.htm](http://ec.europa.eu/health/medical-devices/links/contact_points_en.htm)
- <http://ec.europa.eu/enterprise/newapproach/nando/index.cfm?fuseaction=country.main>

Please note that this list is non-exhaustive.

## **Box 3. Identification of cases**

Contacting a local (corruption) expert is the best way to start with the study as he/she can direct you towards the right sources and people;

Contact organisations in your country that are targeting corruption (dealing with corruption-related aspects, including conflicts of interest, revolving doors, incompatibilities, etcetera). Several countries have organisations that focus on the identification of corruption and sometimes have a database of suspicious or corrupt projects/cases;

Investigative journalists as well as academics may have good regional expertise;

Legal databases such as from the European Court of Human Rights, InfoCuria and national databases such as [www.legifrance.fr](http://www.legifrance.fr) (France) and <http://zoeken.rechtspraak.nl/ResultPage.aspx> (Netherlands) may contain relevant information.

## **Box 4. Instructions**

Please use 1 Interview report per interviewee. Maximum 3 pages per report;

Please use 1 Case report per case. Maximum 2 pages per case;

Please prepare one Good and one Negative Policies and Practices report. The reports should be based on interviews, desk research and an analysis of cases.

## Interview Report

### Study on Corruption in the Healthcare Sector

**Client: European Commission, Directorate-General Home Affairs**

<i>Country</i>	
<i>Interview with</i>	
<i>Organisation and function</i>	
<i>Contact details</i>	
<i>Interviewed by</i>	
<i>Date and location</i>	

### Questionnaire

If possible specify each answer for:

- Informal (under-the-table) payments in medical service delivery;
- Certification and procurement of medical equipment;
- Authorisation and procurement of pharmaceuticals.

1. What is the general perception of corruption in the healthcare system?

Please indicate in the table below whether corruption is a serious issue with regard to the three specific risk areas.

Please indicate on a scale of 1 to 5 to what extent corruption is a serious issue in your country with regard to..... (1 = no problem, 5 = very serious problem)						
	1	2	3	4	5	Don't Know
Informal payments in medical service delivery						
Certification and procurement of medical equipment						
Authorisation and procurement of pharmaceuticals						

2. What are the prevailing types of healthcare corruption in the country? (see checklist A)

3. What are the causes and/or risks of corruption in general, and specifically for the healthcare sector in the country? (see checklist B)

4. Are you aware of specific policies and practices to prevent and control corruption in the country (government, healthcare sector, private sector)?

- What are (i) successful policies and practices and (ii) unsuccessful policies and practices? Why?

5. Suggestions for:

- Relevant experts (government, healthcare sector, lobby organisations, academic, journalists.)
- Relevant literature (policy reports, academic studies, other reports, media coverage)
- Statistics and publicly available data and databases
- Cases (court cases, cases in the media)

## Case Report

### Study on Corruption in the Healthcare Sector

**Client: European Commission, Directorate-General Home Affairs**

Country	
Healthcare area	<input type="checkbox"/> Informal (under-the-table) payments in medical service delivery <input type="checkbox"/> Certification and procurement of medical equipment <input type="checkbox"/> Authorisation and procurement of pharmaceuticals
Information source(s)	
Status of the case	<input type="checkbox"/> Proven (court case) <input type="checkbox"/> Suspicion of corruption (under investigation, media)

### Factual description of the case

*Please describe the case as detailed and factual as possible. Elements to be included (if possible) are: facts, main actors, estimated prejudice, type of corruption, activities, detection, and judicial follow-up.*

### Contextual interpretation

*Please give a brief interpretation of the case (is this an example of systematic corruption or an exception, does this case indicate systemic corruption risk, what are the impacts etc.)*

**Please attach relevant literature and other source material as much if possible.**

## Good Policies and Practices Report

**Study on Corruption in the Healthcare Sector**

**Client: European Commission Directorate-General Home Affairs**

*EU Member State*

Please provide an overview of current and suggested policies and practices in controlling corruption in healthcare as brought forward by the interviewees and/or emerged from desk research and case research.

**Please attach relevant literature and other source material as much if possible.**

## Negative Policies and Practices Report

### **Study on Corruption in the Healthcare Sector**

**Client: European Commission Directorate-General Home Affairs**

*EU Member State*

Please provide an overview of negative or failed policies and practices in controlling corruption in healthcare as brought forward by the interviewees and/or emerged from desk research and case research.

**Please attach relevant literature and other source material as much if possible.**

## Checklist A Corruption definitions

Corruption is much broader than paying or receiving bribes, transferring kickbacks or diverting (healthcare) funds. You are asked to adopt a broad perspective on corruption:

- For this study we are interested in more 'direct' forms of corruption, but also in more indirect forms of corruption such as conflict of interest, trading in influence, revolving door policies and regulatory capture. In addition, with relation to corruption in procurement of medical supplies and pharmaceuticals, various forms of collusion (such as bid-rigging- price fixing or market division) may be relevant;
- We are interested in so-called 'petty corruption' (paying and receiving small sums of informal payments by individual clients) to large single corruption cases (for example in procurement of medical equipment) up to state capture types of corruption in healthcare;
- Another relevant angle is to analyse to which extent corruption is systematised within a society or economic (sub) sector. It is important to assess to what extent corruption should be considered as deviant behaviour (isolated corruption cases) or to what extent various forms of corruption are considered as normal practise (systematic corruption).

### Paying and receiving bribes

Bribery is the act of offering someone money, services or other valuables, in order to persuade him or her to do something in return. Active bribery refers to the offence committed by the person who promises or gives the bribe. Passive bribery is the offence committed by the official who receives the bribe.

### Paying and receiving kickbacks

A kickback is a form of negotiated bribery in which a commission is paid to the bribe-taker as a quid pro quo for services rendered. Generally speaking, the remuneration (money, goods, or services handed over) is negotiated ahead of time. The kickback varies from other kinds of bribes in that there is implied collusion between the two parties (rather than one party extorting the bribe from the other). The purpose of the kickback is usually to encourage the other party to cooperate in the illegal scheme.

### Embezzlement (diversion of assets)

Embezzlement is the outright theft of public funds. Embezzlement can be defined as the misappropriation of property or funds legally entrusted to someone in their formal position as an agent or guardian.

### Conflict of interest

According to the OECD a conflict of interest involves a 'conflict between the public duty and private interests of a public official, in which the public official has private-capacity interests which could improperly influence the performance of their official duties and responsibilities'. A conflict of interest occurs when an individual or organisation is involved in multiple interests, one of which could *possibly* corrupt the motivation for an act in the other. The presence of a conflict of interest is independent from the execution of impropriety. Therefore, a conflict of interest can be discovered and

voluntarily defused before any corruption occurs. A widely used definition is: 'A conflict of interest is a set of circumstances that creates a risk that professional judgment or actions regarding a primary interest will be unduly influenced by a secondary interest.'

### **Collusion in public procurement**

Collusion is a horizontal relationship between bidders that restricts competition and harms the public purchaser. Collusion can take many forms such as bid-rigging, price fixing or market division. A conflict of interest occurs when an individual or organisation is involved in multiple interests, one of which could *possibly* corrupt the motivation for an act in the other. The presence of a conflict of interest is independent from the execution of impropriety. Therefore, a conflict of interest can be discovered and voluntarily defused before any corruption occurs.

### **Trading in influence**

Trading in influence occurs when a person misuses his influence over the decision-making process for a third party (person, institution or government) in return for his loyalty, money or any other material or immaterial undue advantage.

### **Revolving door policies**

In politics, the 'revolving door' is the movement of personnel between roles as legislators and regulators and the industries affected by the legislation and regulation. In some cases the roles are performed in sequence but in certain circumstances may be performed at the same time. Political analysts claim that an unhealthy relationship can develop between the private sector and government, based on the granting of reciprocated privileges to the detriment of the nation and can lead to regulatory capture.

### **Regulatory (state) capture**

In all areas of regulation that regulators become 'captured' by the industry they regulate, meaning that they take on the objectives of management in the firms they regulate. They may thereby lose sight of the ultimate objectives of regulation. Regulatory capture is particularly serious in industries such as banking where there is a conflict of interest between the firms' objectives (to maximise profits) and the objectives of the regulation (to provide consumer protection and maintain systemic stability).

### **Clientelism / favouritism / nepotism**

Clientelism is an informal relationship between people of different social and economic status: a 'patron' (boss, big man) and his 'clients' (dependents, followers, protégés). The relationship includes a mutual but unequal exchange of favours, which can be corrupt. Favouritism refers to the normal human inclination to prefer acquaintances, friends and family over strangers. When public (and private sector) officials demonstrate favouritism to unfairly distribute positions and resources, they are guilty of cronyism or nepotism, depending on their relationship with the person who benefits. Nepotism is usually used to indicate a form of favouritism that involves family relationships.

## **Checklist B: Risk indicators**

The list below can be used as a **checklist** to identify factors that can affect the potential of corruption in general, and specifically the healthcare sector in your country. Please note that not all factors may be relevant.

### **1. Transparency & Information**

There is limited access to information (e.g. consumer/patients rights, service delivery standards, official price schedules, procurement information) for all stakeholders

There is an imbalance in the availability of information between stakeholders.

### **2. Control and audit mechanisms**

The country has a weak control and audit systems (internal and external), e.g. through bodies such as Supreme Audit Institutes, inspectors, notified bodies and ombudsmen.

The country has inefficient or weak appeal mechanisms in place

### **3. Civil society & participation**

Limited or no involvement of consumers/community groups in the design and delivery of public services.

There is limited or no engagement civil society in the oversight of policy and services

### **4. Beliefs, attitudes, social value system**

There is a 'high' tolerance towards (forms of) corruption in the country.

In general, there is low awareness of corruption (and its forms).

There is no clear definition of corruption.

Social structure of the country accepts nepotism/favouritism, e.g. among family members.

### **5. Policy, legal and regulatory framework**

- There are no or weak special measures to prevent and detect corruption;
- The government has no or a weak anti-corruption program in place;
- Codes of Conduct/Codes of Ethics are non-existent or weak;
- Inconsistent legislation, both within and between countries (loopholes).

### **6. Human resource management**

- The salaries of healthcare providers are low and/or irregular;
- Healthcare providers are not paid fee-for-service (salary based);
- The number of public providers is relatively high.



## **7. Economic factors**

- There is scarcity of resources (healthcare professionals, drugs, medical devices) – public spending on healthcare is relatively low;
- Out of pocket payments are relatively high (i.e. patients pay for healthcare consumed);
- The healthcare system is tax-based.

## **8. Procurement and authorisation of medical supplies**

- There is a high level of decentralisation;
- There are most often a small number of providers participating in the procurement process;
- Drugs are actively promoted to physicians;
- Purchasing method (restricted tenders, quotation-based methods, direct ordering);
- There are only a few providers of medical supplies (market power).



