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## THE IMPACT OF ACTS OF CORRUPTION ON THE ENJOYMENT OF THE RIGHT TO HEALTH

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### I. INTRODUCTION

1. The health sector is highly prone to corruption. In some countries, the health sector is considered to be the most corrupt sector of all. Health sector corruption deprives people of access to health care and leads to poor health outcomes. Corruption has for example been negatively associated with child and infant mortality, with the likelihood of an attended birth, with immunisation coverage and with low birth weight. As such, corruption potentially violates the 'right to the highest attainable standard of health' as set forth in a number of international human rights treaties. This report assesses how corruption impacts upon the right to health and how the right to health can be used as a tool to address health sector corruption.
2. This paper serves as a preliminary research paper for a large-scale research project carried out by the *International Council on Human Rights Policy* (ICHRP) on the more general relationship between corruption and human rights.
3. The consultant was asked to address the following questions:
  1. What acts of corruption violate the right to health?
  2. Where might use of human rights principles and methods improve the prevention, detection and punishment of corrupt practices that violate the right to health?
  3. Would the adoption of a human rights approach increase transparency and accountability in the health sector?
4. Whereas the first question focuses on the impact of corruption on the right to health, the other two questions are aimed at identifying how human rights principles and norms can be used as tools to combat corruption.
5. The character and extent of health sector corruption has been laid out clearly and extensively by existing research. In 2006, Transparency International (hereinafter *TI*) published an important report which itself also built on the extensive amount of already available research. Annex 1 of

the present report lists some of the main findings of this existing research and where necessary the present report will refer to these findings.

6. In this report a connection will first be made between the existing findings on health sector corruption and the framework of the right to health, as laid out in particular by the UN General Comment on the Right to Health (section 2). On the basis of these findings State obligations in relation to corruption in the health sector will be identified. Such obligations are also identified for non-state actors, including private hospitals, insurance companies and the pharmaceutical industry, as well as international organisations and health workers. Finally, an attempt is made to identify so-called violations of the right to health in relation to corruption.
7. Having made the connection between corruption and the right to health, an attempt is further made to analyse how human rights principles and norms can be used as tools to combat corruption. The question is also addressed whether and how the adoption of a human rights approach would increase transparency and accountability in the health sector (section 3).
8. As will be discussed in more detail below, the right to health is an inclusive right encompassing both health care services and underlying conditions for health. As this report has to be confined to 8,000 words, it adopts a selective approach and focuses on access to health care services rather than attempting to address all health-related issues. The author wishes to emphasise that just because the report does not address the underlying conditions, this does not mean that they are unimportant.
9. As requested, where necessary the report will pay attention to the vulnerability of women in relation to acts of corruption in the health sector.

## **II. CORRUPTION IN RELATION TO THE RIGHT TO HEALTH**

### **Human rights and corruption**

10. Human rights are rights that individuals enjoy in relation to their governments. A distinction is generally made between on the one hand civil and political rights, including the right to life, the right to a fair trial and the freedom of speech, and on the other hand economic, social and cultural rights, including the rights to housing, food, social security and health.
11. Human rights often imply the provision of a certain public service, for example legal assistance, schooling, health care services, and water services. As such, corruption in the provision of public services threatens the realisation of human rights. It is therefore of the utmost importance to address the issue of corruption from a human rights perspective.
12. Health sector corruption (see Annex 1 under B and E) potentially violates the right to the highest attainable standard of health. Before we can embark on an analysis of this violation, we need to define what the right to health means in relation to corruption.

### **Meaning and implications of the ‘right to health’ in relation to corruption**

13. The term ‘right to health’ is shorthand for the ‘right to the highest attainable standard of health’ as provided in Article 12 of the UN International Covenant on Economic, Social and Cultural Rights (ICESCR). As pointed out by the Special Rapporteur on the Right to Health, the right to health is a firmly established feature of binding international law (SR, § 15). Besides by Article 12 ICESCR, the right to health is recognised by provisions in a number of other international

human rights instruments, including Article 25 of the Universal Declaration on Human Rights (UDHR), Article 5(e) of the International Convention of All Forms of Racial Discrimination (CERD), Articles 11.1 and 12 of the Convention on the Elimination of All forms of Discrimination Against Women (CEDAW) and Article 24 of the Convention on the Rights of the child (CRC). At the regional level we come across the right to health in Article 11 of the (revised) European Social Charter (ESC), in Article 16 of the African Charter of Human and Peoples' Rights and in Article 10 of the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights. Furthermore, over 100 national constitutional provisions include a right to health (*JR*, §15). Finally, an increasing amount of case-law on the right to health is generated by national and international judicial bodies points to the increasing enforceability or justiciability of the right to health (*JR*, § 16).

14. An elaborate explanation of the right to health is provided by UN General Comment 14 on the right to health, which is an explanatory document on Article 12 ICESCR adopted by the Committee on Economic, Social and Cultural Rights, the Treaty-Monitoring body to the ICESCR. Although strictly speaking not legally binding, this document is the most authoritative document on the right to health. Therefore, this report closely follows the approach taken in the General Comment. The General Comment does not address the issue of corruption explicitly, but it does provide a suitable framework for addressing this issue in relation to the health sector.
15. As the General Comment explains, the right to health is closely related to and dependent upon the realisation of other human rights. With respect to corruption in the health sector, the following other human rights are of particular importance: the right to life, the principle of non-discrimination, the right to information, the right to participation, and the right to a remedy. While the right to health lies at the core of our analysis on corruption in the health sector, the other rights support and reinforce the right to health in this respect. In other words, the other rights contain values that to some extent overlap with the right to health. For example, serious acts of corruption in the health sector can lead to infringements of people's health (right to health), but can also result in a person's death (right to life). Furthermore, the right to information overlaps with the right to health in the sense that the right to health contains a right to health-related information. As to the principle of non-discrimination, it appears that the right to health includes a prohibition of discrimination in access to health services. And finally, in relation to the right to a remedy, the right to health reflects the notion that individuals whose health has been adversely affected by a health practitioner or other actor in the health sector should have adequate means of redress.
16. The right to health should also be read in conjunction with Article 2 (1) ICESCR, a general Article in the Covenant that underlines States parties' obligation to take 'steps' in relation to the substantive rights in the Covenant. Such steps need to be taken to 'the maximum of a State's available resources (...)'. Implicit in this obligation is the duty to use available resources effectively and in a transparent manner. Article 2(1) also stresses the need to adopt legislative measures to realise the substantive rights in the Covenant. As such, if we agree that corruption potentially violates human rights, it can be argued that States parties have an obligation to adopt anti-corruption legislation to ensure that the rights in the Covenant are realised in a transparent and efficient manner.
17. As mentioned above the right to health is an inclusive right which not only extends to timely and appropriate health care services, but also to the underlying determinants for health, such as access to safe and potable water and adequate sanitation, healthy occupational and environmental conditions, and access to health-related education and information. This implies that when we analyse corruption in relation to a right to health, it is not only the health care sector that should, in principle, be under scrutiny, but also for example water provision and the occupational and environmental health sectors. As mentioned above it goes beyond the scope of

this paper to discuss the underlying conditions inherent in the right to health. Yet the present author still wishes to suggest that the framework developed in this paper can equally be applied to, for example, corruption in the provision of water services.

### **General content of the right to health in relation to corruption: the ‘AAAQ’**

18. The General Comment on the Right to Health identifies a set of principles that apply at all levels of the health sector and that are also important in relation to the problem of corruption in the health sector: availability, accessibility, acceptability and quality of health facilities (the ‘AAAQ’, see GC, §12). In addition, the present author suggests the following additional principles for addressing health sector corruption: efficiency, accountability, (political) participation, and transparency. While this framework is especially relevant to *policy* analysis, the identification of obligations further on in this paper is more suited to *legal* analysis (SR, § 39).
19. **Availability** – health facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. Corruption may affect the availability of health goods and services. Money that is used to bribe regulators, health care providers or the pharmaceutical industry could have been spent on health facilities directly. Therefore, States need to ensure that the availability of health goods and facilities is not negatively affected by acts of corruption in the health sector.
20. **Accessibility** – health facilities, goods and services have to be accessible to all persons without discrimination. Accessibility has four overlapping dimensions:
  21. **Non-discrimination** – health facilities, goods and services must be within safe physical reach of all sections of society, especially vulnerable or marginalised groups. First of all, health sector corruption can generally mean that fewer dues are paid into the system, thereby reducing public expenditure on health (FIDH, 24). Research points out that in countries where corruption is endemic, the poorer sections of the population and those who live in rural areas suffer longer waiting periods at public health clinics and are also more frequently denied vaccines than rich and urban sections of the population (TI, 38). Health sector corruption can also lead to direct discrimination when health care providers and professionals treat patients differently according to their income and their contacts with the medical profession (FIDH, 24). Altogether therefore States need to ensure that individual patients or certain sections of the population are not disadvantaged by acts of corruption in the health sector.
  22. **Physical access** – health facilities, goods and services must be within safe physical reach of all sections of the population, especially vulnerable or marginalised groups, such as ethnic minorities and indigenous populations. Health sector corruption may lead to choices that are less favourable to the community, e.g. hospitals may be built in the cheaper areas of a city rather than in the vicinity of communities. Therefore, States need to ensure that decisions to build health centres and hospitals are not negatively affected by health sector corruption.
  23. **Economic access** (affordability) – health facilities, goods and services must be affordable to all, whether publicly or privately provided. Corruption can affect the affordability of health services in many ways. At a macro-economic level health services may become more expensive if the health sector is affected by corruption. Public officials can ask fees for drugs that have been provided free of charge by pharmaceutical companies or donor organisations. At the level of health care provision doctors can make health care services more expensive by demanding informal payments (under-the-table payments). Altogether States need to ensure that the affordability of health care services is not negatively affected by health sector corruption.

24. *Access to information* – patients and the public as a whole should have the right to seek, receive and impart information and ideas. As pointed out by Transparency International (TI, 5), health systems are vulnerable to corruption because they are characterised by ‘asymmetric information’; for example, health care providers are better informed than their patients on issues like diagnosis and treatment (See also Annex 1 under C). When seeking health services, patients should be in a position to make informed choices and select appropriate providers at appropriate prices and standards of quality (U4, 13). Patients should be informed of their rights, of the services available, and of prices and conditions of access (U4, 13). They should also be informed about the health services that they are entitled to free of charge (TI, 64) and about the eligibility criteria for certain medical programmes (TI, 110). Altogether States need to ensure that health information is available at all levels of the health sector and that the provision of such information is not negatively affected by health sector corruption.
25. **Acceptability** – health facilities must be respectful of medical ethics and they must be culturally appropriate. Among other things, health facilities must be designed to respect confidentiality and improve the health status of those concerned. Due to the above-mentioned ‘information asymmetry’ the health professional’s position is more powerful than that of the patient. States should put in place guarantees that ensure that health professionals do not abuse their position of power and thereby disrespect the ‘acceptability’ of the health service to the patient.
26. **Quality** – health facilities must be scientifically and medically appropriate and of good quality. Corruption can affect the quality of medicines, for example, when regulators are bribed to carry out less than rigorous checks, or when hospital administrators purchase cheaper, less effective drugs and embezzle the proceeds (TI, MR, xv). States should ensure that the quality of health services is guaranteed at all levels of the health sector and that the quality of health services is not negatively affected by health service corruption. In addition, the following conditions are important when it comes to addressing and preventing health sector corruption:
27. **Efficiency** – an efficient health care system is better able to guarantee the availability, accessibility, acceptability and quality of health services. It goes without saying that a health sector that is affected by corruption is less efficient. Measures must therefore be taken to prevent health sector corruption so as to enhance efficiency in the health sector.
28. **Accountability** – constraints must be placed on actors in the health sector, be they public or private actors, ranging from hospitals to health equipment providers. States should establish supervisory bodies which monitor the actions and decisions of actors in the health sector and where necessary impose sanctions upon them. In addition, they should provide mechanism of redress when people have been affected by health sector corruption. Such mechanisms can be either judicial or quasi-judicial (for example a health ombudsman or other independent complaint mechanism).
29. **(Political) participation** – the public must have a say in important decisions concerning the health sector, for example, the decision to privatise or decentralise (parts of) the health sector. States should ensure political participation in the decision-making on the organisation of the health sector. Political participation is not only realised through a democratic system of elections, but also by providing for public enquiries regarding planned health sector reform. When it comes to the health budget, the public and/or civil society can be actively included in all stages of the budget cycle for the health sector (U4, 23). Public budget hearings can be held at the local level to involve citizens in the way public services are delivered (U4, 23).
30. **Transparency** – transparency implies both access to information and political participation, as mentioned above. Therefore, in order to create transparency and to combat health sector

corruption States need to ensure that health information is provided where necessary and that the public has a say in important decisions regarding the health sector.

### **Vulnerable groups**

31. Pursuant to its Articles 2.2, 3 and 12, the ICESCR prohibits any discrimination in access to health services on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status. The General Comment on the Right to Health points out that inappropriate health resource allocation can lead to discrimination that may not be overt (*GC*, §18). As health sector corruption may enhance inappropriate health resource allocation, it can lead to discrimination indirectly.
32. The following population groups are particularly vulnerable when it comes to health sector corruption:
33. *The poor* – the poor are the most susceptible when officials hoard drugs or waste resources on the wrong kind of medicines (*TI*, 84). They also have the most difficulty affording the informal payments that are often required to receive the medical care they need.
34. *Persons with chronic diseases and disabled persons* – given their condition persons with chronic diseases and disabled persons often require more health services than others. This makes them particularly vulnerable to being excluded from health insurance, for example.
35. *Persons with HIV/AIDS* – HIV positive persons and persons with AIDS are likely to suffer due to health sector corruption as they are highly dependent on the availability and affordability of anti-retroviral drugs (ARVs). It is reported that particularly in low-income countries a lot of corruption surrounds the procurement and distribution of ARVs. Money available for ARVs is embezzled during all stages of the procurement and distribution chain, by government officials, doctors and others involved in this process (*TI*, 104). It is reported that where ARVs are provided free of charge, requests for ‘top-up payments’ are nevertheless common, as is trade in ARVs derived from patients or leaked out of the health system (*TI*, 105). There is also an extensive market in fake ARVs (*TI*, 106).
36. *People living in remote areas* – persons living in remote areas are vulnerable to health sector corruption. Building a health centre in a remote area may put a strain on the health care budget where it would be more lucrative to build health centres and hospitals in central areas.
37. *Women* – given their specific health needs in relation to their sexual and reproductive function women often require more health care services than men. As such they can be affected disproportionately by the effects of health sector corruption, for example when they do not have the money to afford informal payments exacted for assistance at the birth. Other factors need to be taken into account as well, for example the fact that women often face a disproportionate burden caring for sick family members, which reduces their participation in the paid labour force (*JR*, § 57(a)). As such they may lack the means to afford health care services, in particular when informal payments are required. The General Comment on the Right to Health stresses the need to develop and implement a comprehensive national strategy for promoting women’s health, including a policy to provide high quality affordable health care of which sexual and reproductive services also form a part (*GC*, § 21). Such strategies should not be affected by acts of corruption in the health sector. Another issue that should be mentioned is that women constitute a large proportion of health care personnel. As such they can also be

affected disproportionately when health sector corruption negatively affects the timely payment of proper wages.

### State obligations

38. On the basis of this framework a set of legal obligations can be identified that are incumbent upon States and possibly upon other actors in the health sector. As it is States that ratify human rights treaties, and not other actors in the health sector, States and their governments bear the primary responsibility for realising these obligations towards individuals.
39. **General obligation** – First of all, States, on the basis of the right to health, have a general legal obligation to adopt a national health strategy and plan of action. In countries where health sector corruption is endemic, national health policies and health financing strategies should include a policy to reduce the wasting of resources due to corruption (U4, 5). This policy should be coherently and consistently applied across all levels of the health sector.
40. Secondly States are under a general obligation to devote a sufficient percentage of their budget to health services. As mentioned above, this should be done to the ‘maximum of their available resources’. It should be noted that States do not always meet this requirement. It is reported that while most rich countries spend at least 5 % of GDP on health, many developing countries spend less than half this amount (U4, 3).
41. As to the (financial) organisation of the health sector, it should be pointed out that human rights law is neutral on the way in which States organise their health care systems. For example, the right to health may be satisfied through whatever mix of public and private sector services is appropriate in the national context. Yet States should take into account that certain choices may imply a higher risk of health sector corruption and should build in mechanisms to prevent this. As pointed out by the Special Rapporteur on the Right to Health, Paul Hunt, international human rights law requires that a chosen rule or policy delivers positive right to health outcomes, also for the disadvantaged (SR, § 12). Three trends are important:
42. *Health funding mechanisms* – when it comes to health funding mechanisms a distinction can be made between ‘integrated systems’, which finance the supply of services directly and ‘funder/provider systems’, where the funder and the provider are separate entities. It has been pointed out that a system of directly financing the supply of health services will be more vulnerable to corruption in procurement and abuses that undermine the quality of services. The second system, that relies on billing and health insurance, is generally more vulnerable to the diversion of funds (TI, 4). States should take into account such vulnerabilities when they take steps to reorganise their health funding mechanisms.
43. *Decentralisation* – there has been a widespread devolution of authority to local governments. As local governments attain more power over health care provision, it is important to ensure that local health authorities are not corrupt. As such the decentralisation of health care services should always include a strategy to prevent corruption at the local government level (HRW, 40-64).
44. *Privatisation* – under human rights law, States are free to privatise their health systems. However, they do have to ensure that health care privatisation does not lead to more corruption. The privatisation of public services implies a move away from direct government control. States should therefore establish the necessary mechanisms for monitoring the private health care sector (BT, 2006). Furthermore, health sector corruption has been linked to the lack of a clear-cut separation between public and private practice. Patients may find themselves paying for a

service twice, first in the public hospital and then in the private clinic where the same doctor is employed (*FIDH*, 24). States are to create mechanisms to prevent such practices.

45. *Payment of health professionals* – where earnings are low health professionals may take on second jobs and be more tempted to demand contributions from patients (*CGD*, 36). States should ensure access to decent wages to the ‘maximum of their available resources’. Secondly, research demonstrates that physicians whose earnings are based on salary rather than fee-for-service, bonus or capitation are less productive and show lower levels of care (*CGD*, 36, referring to an OECD study). Therefore States should be aware of the risks when deciding in favour of a salary-based system.

#### *Respect, protect, fulfil*

46. Furthermore, the General Comment distinguishes between so-called State obligations to ‘respect, protect and to fulfil’ the right to health. The obligation to respect the right to health is a negative obligation to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to protect requires States to take legislative and other measures that prevent third parties including private insurers, private health care providers, and suppliers from interfering with the guarantees under the right to health. Finally, the obligation to fulfil requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realisation of the right to health.
47. *State obligations to respect* – in relation to corruption, the obligation to respect implies that government regulators and public funders, providers and suppliers are to refrain from corrupt acts that lead to a denial of health services (See Annex 1 under B and E). Government authorities and their public officials should, among other things, refrain from:
  - bribery of other national or foreign (public) officials in relation to the health sector;
  - illicit enrichment, theft and embezzlement from the health budget;
  - misappropriation of funds from a health programme;
  - trading in influence in the health sector;
  - abusing their function in relation to the health sector;
  - diverting drugs that were destined for their country back into the international drug market (parallel importation) (*TI*, 92);
  - refrain from colluding with organisations that fake or sell counterfeit drugs (*TI*, 97).
48. *State obligations to protect* – in relation to the right to health, the ‘obligation to protect’ implies a State obligation to adopt legislation and to establish the necessary regulatory mechanisms to monitor the (partly) independent health sector. The ‘obligation to protect’ is a key obligation when it comes to the prevention and detection of health sector corruption. Health sector corruption takes place at all levels of the health sector and the State has an obligation to prevent and address corruption at each of these levels.
49. Generally, three types of State obligations can be identified when it comes to supervising the health sector in order to prevent and to combat corrupt acts. States are under a duty to:
  - *regulate*: the adoption of legislation to ensure that the actors in the health sector, whether public or private in character, refrain from health sector corruption;
  - *monitor*: the adoption of monitoring mechanisms aimed at supervising or regulating the behaviour of the actors in the health sector in such a way that health sector corruption may be detected;
  - *provide redress*: the creation of possibilities to complain about failure or malpractice by the actors in the health sector.

50. The following actors may be identified that are to be supervised by the State as part of its obligation to protect (see also Annex 1 under B and D and *LADB*, 3):

- a. State, regional and local governments and government regulators (health ministries, parliaments, specialised commissions):

Although strictly speaking part of the State itself, that same State is also required to adopt legislation and to take other measures to ensure that its own officials refrain from health sector corruption by, for example, disseminating performance data on state and local governments, providing information about the financial resources over which (local) governments have direct control, and submitting (local) governments to closer supervision (*HRW*, 5).

- b. Health insurers:

The State is required to take measures to ensure that public and private health insurers refrain from acts of corruption. More specifically, the State is required, as mentioned above, to regulate, to monitor and to provide redress. As noted, adverse selection practices by (private) health insurers lead to an uninsured population disproportionately made up of those most in need of care (*CGD*, 4). Government intervention is required to ensure that health insurers do not differentiate between customers on the basis of health status, age, financial capability or other factors related to the insured.

- c. Hospitals:

As will be discussed in more detail below, hospitals are especially vulnerable to corruption. Corruption in hospitals may vary from corruption in procurement to embezzlement and theft by medical personnel, and corruption in payment systems (*TI*, 50). States are under an obligation to adopt transparency and accountability measures to hold hospitals accountable administratively. States can adopt legislation to achieve this aim but they can also set up (citizen) health boards, procurement, pharmacy and therapeutic committees to enhance transparency within hospitals (*TI*, 52). For example, research has demonstrated that centralising hospital procurement is one way to reduce opportunities for corruption (*TI*, 52). Health Ministries may also decide to publish open waiting lists to curb the trend of patients paying bribes to reduce time spent on waiting lists (*TI*, 55).

- d. Medical professionals:

States are to take measures in order to reduce informal payments (fees, gifts and bribes) to the medical profession (*TI*, 67). This can be achieved by taking measures to create awareness among health system workers of their duty towards patients and by informing health system users of their rights (*TI*, 75). In addition, the State may try to reduce informal payments by tackling the shortages in the health sector, developing more appropriate and affordable benefits packages, formalising informal payments as co-payments, shifting to private health care or social insurance models, and by creating information and monitoring systems with penalties for infringement (*TI*, 69-73). In connection with this, States could consider prohibiting preferential treatment to well-connected individuals (*CGD*, 20). Furthermore, States should take measures to prevent absenteeism among health personnel (*CGD*, 16-20), create accountability for medical personnel and ensure proper wages so that health professionals are less inclined to take

on second jobs (*CGD*, 19). Finally, States should take measures to prohibit practices of selling public positions and requiring bribes for promotion (*CGD*, 20).

e. Pharmaceutical companies:

States have a general obligation to ensure that pharmaceutical systems are institutionally sound and transparent and that there are appropriate mechanisms to reduce the likelihood of corruption (*TI*, 77). More specifically they should adopt legislative and other measures to:

- prevent the distribution of counterfeit drugs, including drugs that have been relabelled and unregistered drugs (*TI*, 97);
- ensure that pharmacies, hospitals and health care providers are reimbursed for drugs in an appropriate and transparent way (*TI*, 84);
- reduce the likelihood of corruption in the drug selection process, for example by establishing drug selection committees which are composed of impartial persons with the appropriate technical skills, and who make use of the WHO criteria for selection (*TI*, 81);
- ensure that there is open, competitive procurement that prevents personal discretion in the selection of suppliers and provide for a strong supervisory mechanism (*TI*, 81);
- see to it that drugs are allocated, transported and stored appropriately;
- address inappropriate marketing practices by some pharmaceutical companies and avoid inappropriate prescribing by physicians (*TI*, 83);
- ensure that the manipulation of information on drug trials is prohibited and sanctioned.

f. Suppliers of medical equipment:

Similarly, States are under an obligation to regulate the behaviour of suppliers of medical equipment and should hold them accountable when they commit acts that can be classified as health sector corruption.

51. *State obligations to fulfil* – on the basis of the obligation to fulfil, States should formulate, implement and periodically review a coherent national policy to minimise the risk of corruption throughout the entire health system. While it is recognised that the resources available for preventing corruption may not be as plentiful in low-income countries as in high-income countries (*TI*, 57), States should adopt such policies ‘to the maximum of their available resources’.

### **Obligations of non-state actors**

52. The primary focus of this report is on the position of States in relation to health sector corruption. Yet it is increasingly being argued that other actors besides States have obligations under human rights law. There are several legal arguments to be found in international (human rights) law that support this assumption. For example, the preamble to the Universal Declaration of Human Rights recognises the human rights responsibilities of ‘all organs of society’. While it is important to identify these obligations, recognition of the human rights obligations of other actors besides States should never undermine the primary responsibility of States under international law. We can identify the following non-state actors in the health sector (Annex 1, D and *LADB*, 5):

a. Health insurers

Health insurers, in particular private health insurers, are sometimes inclined to adopt adverse selection practices that lead to an uninsured population made up of those most in need of care (CGD, 4). If we assume that both public and private health insurers bear a certain responsibility under the right to health we can identify the following obligations:

*Respect:*

Health insurers should refrain from:

- embezzlement, theft and illicit enrichment from the health insurance budget;
- adverse selection practices;
- refusing patients on the basis of their health status, age, and other factors;
- possibly, they should refrain from refusing patients on the basis of their financial capability.

*Protect:*

Health insurers should adopt internal regulations and other measures to prohibit and prevent, among other things:

- the illegal billing of health care providers and customers;
- the over-consumption of medical services by customers;
- the overproduction of care by physicians (CGD, 4).

*Fulfil:*

Health insurers are to adopt an anti-corruption strategy that addresses corruption in all departments and that includes the measures mentioned above.

b. Hospitals

As pointed out by TI (49) the hospital sector is quite vulnerable to corruption, in both developing and developed countries alike. Eventually corruption in the hospital's administration can leave patients without medicines which affects their enjoyment of the right to health. Assuming that hospitals bear a certain responsibility under the right to health, we can identify the following obligations of hospital authorities (TI, 50):

*Respect:*

Hospital authorities should refrain from, among other things:

- embezzlement, theft and illicit enrichment from the hospital budget;
- overpayment for goods and services;
- illegally billing insurance companies, governments or patients for uncovered services;
- performing unnecessary medical interventions in order to maximise fee revenue;
- selling public positions and requiring bribes for promotion.

*Protect:*

Hospital authorities are to adopt internal regulations and take other measures to prohibit and prevent, among other things:

- the diversion of budgets or user-fee revenue for personal advantage, stealing medicines or medical supplies or equipment;
- the acceptance of informal payments by their health personnel;
- preferential treatment to well-connected individuals;
- the use of hospital equipment for private business;
- physicians improperly referring public hospital patients to their private practice;
- absenteeism of medical personnel while being paid.

*Fulfil:*

Hospital authorities are to adopt an anti-corruption strategy that addresses corruption in all departments and that includes the measures mentioned above. It should be noted that approaches to prevention and control should not only require monitoring and control systems for detection and punishment, but may also require reforms to payment systems and reforms to strengthen professionalism (TI, 54). The creation of individual contracts with personnel and increased pay scales while sanctioning poor performance may also prevent corruption among hospital personnel (TI, 55). Furthermore, part of the strategy can be the adoption of an administrative system of procurement and inventory control (TI, 52). Such a system may provide for review committees to certify the need for new drugs or equipment, competitive bidding and other best-practice procurement procedures and inventory systems to safeguard supplies (TI, 59). It may also include the formalisation of user fees and the promotion of professionalism among staff (TI, 55).

c. The medical profession

Although the medical profession may not have direct legal obligations under human rights law, it can be argued that it has a moral responsibility to comply with human rights. In the first place, the profession's own professional codes commit it to abstain from unethical and unprofessional behaviour ('obligation to respect'). Furthermore, given the key position that the medical profession occupies in the health sector, its members are often the first to detect human rights violations and can therefore play an important role in detecting and preventing such violations ('obligation to protect'). Finally, also on the basis of its professional codes, the medical profession has committed itself to providing good quality health services ('obligation to fulfil').

In relation to corruption the medical profession can be said to have the following obligations:

*Respect:*

- to avoid conflicts of interests with their patients;
- to remain independent from the pharmaceutical industry in their clinical and educational activities (TI, 95);
- to refuse informal payments (TI, 63);
- to refrain from an overproduction of care when third parties cover costs (CGD, 4).

*Protect:*

- to protect patients from unethical behaviour by other health care providers or the pharmaceutical industry.

*Fulfil:*

- to provide good quality health care services and to provide independent advice;
- the medical profession as a whole could consider the adoption of strategies and codes to prevent corruption among its members.

d. Pharmaceutical industry

Pharmaceuticals are essential to health systems and they play an important role in enhancing the quality of life for many patients (TI, 77). As such, the pharmaceutical industry plays an important role in realising people's right to health. Arguably the pharmaceutical industry as a whole and individual pharmaceutical companies have the following human rights obligations:

*Respect:*

Pharmaceutical companies should refrain from:

- embezzlement, theft and illicit enrichment from their budgets;
- influencing health care providers to provide certain drugs;
- the excessive promotion of drugs;
- exerting pressure on the drug selection process to have their drugs selected.

*Fulfil:*

Pharmaceutical companies should adopt internal regulations and other measures to:

- provide for adequate registration procedures which regulate the labelling, marketing, usage, warning and prescription requirements for a drug (*TI*, 80);
- ensure that drugs are allocated, transported and stored appropriately;
- adopt, implement and enforce their own codes of conduct that detail best practice in the pharmaceutical industry (*TI*, 83, 93)

e. Suppliers of medical equipment

Similar to pharmaceutical companies, suppliers of medical equipment should refrain from influencing health care providers to purchase certain medical equipment. They should also refrain from excessive promotion of their equipment and from exerting pressure on the selection process to have their equipment selected. They should also provide for adequate registration procedures and they should implement their codes of conduct on best practices in the provision of medical equipments.

f. Donor organisations

Although (international) donor organisations may not have direct responsibilities under international human rights law they have an important role to play in minimising corruption. On many occasions donor organisations provide for vast funds to recipient countries. As reported, large amounts of the sums provided by donor agencies have not reached their goal but have disappeared into the pockets of public officials and health workers in poor nations (*TI*, 108-115). Donor organisations should be open and explicit about what they are giving and to whom (*TI*, 111). They can publish information about the dates and amounts of their disbursements. They can involve parties from government, civil society, the private sector, the UN and patient organisations in monitoring the submission of proposals and the use of funds (*TI*, 108-109). They should ensure that aid is used in line with good procurement guidelines. They can also try to enhance responsible behaviour within pharmaceutical companies (*TI*, 111).

g. Civil society

Although civil society, including NGOs, may not have direct obligations under human rights law, it can play a crucial role in combating corruption. Past examples demonstrate that civil society organisations can successfully raise awareness about corruption by means of campaigns and other activities (*TI*, 115, U4, 21). For example, they can get involved in budget analysis by carrying out budget surveys and thus putting pressure on governments to improve budget systems (*U4*, 23).

## International obligations

53. On the basis of, *inter alia*, Article 2(1) ICESCR States are obliged to provide ‘international co-operation and assistance’ in order to realise the rights provided for in the ICESCR, including the right to health. As such, developed States have a duty to assist developing nations, in particular when it comes to realising minimum essential levels of health facilities, goods and services (*GC*, § 39 and *MS*, 370-375). It is arguable that while providing such aid, developed States are under an obligation to ensure that this process is not affected by corruption. As such, we can define the following international obligations to respect, protect and fulfil:

### *International obligation to respect:*

- refrain from health sector corruption in the provision of health services to developing nations.

### *International obligations to protect:*

- ensure that pharmaceutical companies and health care providers refrain from health sector corruption while providing assistance to developing nations;
- ensure that receiving States, including their central and local governments, utilise and distribute the assistance received in a transparent and fair manner (*MS*, 376-377).

### *International obligation to fulfil:*

- assist developing nations to realise minimum levels of health facilities.

## Violations of the right to health in relation to corruption

54. On the basis of the above-defined obligations resulting from the right to health in relation to corruption, it is possible to identify potential violations in relation to such obligations (*MS*, 20-21). The following corrupt acts can be discerned as potential violations of the right to health:

### *States*

55. *Violations of the ‘obligation to respect’*: States may violate the obligation to respect the right to health if they or one of their agents (see also Annex 1 under E):
- misappropriate funds that have been allocated to the health sector;
  - accept bribes in exchange for, for example, a construction permit for a health facility;
  - embezzle or steal money from the health budget;
  - trade in influence in the health sector;
  - abuse their function in relation to the health sector;
  - collude with an organisation that fakes drugs or sells counterfeit drugs;
  - divert drugs that are destined for their country back into the international drug market.
56. *Violations of the ‘obligation to protect’*: States may violate the obligation to protect the right to health if they or their agents (structurally) fail to adopt legislation and other measures to:
- protect individuals from health sector corruption;
  - regulate and monitor the actors in the health sector;
  - provide redress for victims of health sector corruption.
57. *Violations of the ‘obligation to fulfil’*: States may violate the obligation to fulfil the right to health if they (structurally) fail to adopt a national strategy that tackles corruption throughout their entire health system.

### *Other actors*

58. Examples of violations to respect, protect and to fulfil by other actors in the health sector are:
59. *Violations of the 'obligation to respect'*: Actors in the health sector may violate the obligation to respect the right to health if they (structurally):
- accept informal payments;
  - select patients on the basis of their health status, age, and financial capability;
  - overproduce care when third parties cover the costs;
  - let themselves be influenced by the pharmaceutical industry or as a pharmaceutical company or producer of medical equipment influence health care providers to have their drugs or medical equipment selected.
60. *Violations of the 'obligation to protect'*: Health care providers and other actors in the health sector may violate the obligation to protect the right to health if they (structurally) fail to adopt regulations and to take other measures to offer protection against:
- illegal billing;
  - over-consumption of medical services;
  - overproduction of care by physicians when third parties cover the costs;
  - overpayment for goods and services;
  - unnecessary medical interventions in order to maximise fee revenue;
  - selling public positions and requiring bribes for promotion.
  - the diversion of budgets or user-fee revenue for personal advantage, or theft of medicines or medical supplies or equipment;
  - the acceptance of informal payments by their health personnel;
  - preferential treatment to well-connected individuals;
  - the use of hospital equipment for private business;
  - physicians improperly referring public hospital patients to their private practice;
  - absenteeism of medical personnel while being paid.
61. *Violations of the 'obligation to fulfil'*: Health care providers and other actors in the health sector may violate the obligation to fulfil the right to health if they (structurally) fail to adopt an anti-corruption strategy that addresses corruption across all departments of their hospital, health centre, pharmaceutical company or other health-related institution.

### **III. THE RIGHT TO HEALTH AS A TOOL TO COMBAT CORRUPTION**

62. Human rights are set forth in international treaties to which States become parties by ratifying these treaties. As such State parties are required to take into account these human rights norms in their laws and policies. In addition, they can be held accountable by national and international courts for possible violations of the human rights norms set forth in the treaty. It should be noted that how international human rights treaties are implemented at the national level is a matter for States to decide. On some occasions the treaty needs to be transformed into national law, yet it is not self-evident that without such transformation the international treaty is completely devoid of legal effect.
63. The right to health is one such right that is set forth in a few of the many international human rights treaties to which States become parties. As such many States have become bound by the right to health as laid down in one or more of these treaties, including the ICESCR, the Women's Convention, and the Children's Convention. Admittedly, the implications resulting from the right to health are not always clear, sound enforcement mechanisms are lacking and the right to health is not taken seriously by States. Yet there is an increasing understanding of the meaning

and implications of the right to health, not in the least because of the UN General Comment on the right to health and as a result of the important work done by the UN Special Rapporteur on the Right to Health. In addition there is an increasing body of case-law that demonstrates that the right to health can be justiciable both at the national and the international level. As such, we now have a workable and concrete tool available for holding States and possibly other actors accountable for violations of the right to health.

64. This paper and previous research have demonstrated that health sector corruption is a serious issue in the health sector and that it can adversely affect the availability, accessibility, acceptability and quality of health services. As such this paper has made clear that corruption seriously impacts upon the right to health. A set of State obligations and potential obligations of other actors have been identified in relation to preventing and addressing health sector corruption. On the basis of this set of obligations, a set of potential violations of the right to health in relation to corruption have been identified.
65. Having established that and how corruption impacts upon the right to health we now need to identify how we can employ human rights law as a tool to combat corruption:
66. *Policy tool* – Increasingly States are recommended to undertake ‘human rights impact assessments’ in order to identify the possible human rights consequences of, for example, health sector decentralisation and health care commercialisation bills and planned policies (BT, 2006). As part of such a ‘human rights impact assessment’ States are able to review whether the introduction of health sector reforms will increase health sector corruption (BT, 2006). For example, they can assess whether the transfer of responsibilities to local health boards will lead to more corruption which in turn may affect the ‘affordability’ of health care services. In addition to assessing new laws and policies States have an ongoing obligation to monitor and to address existing health sector corruption as outlined in this report.
67. Other actors in the health sector may similarly apply human rights in their regulation policies. For example, the pharmaceutical industry could implement a human rights approach in its existing codes of conduct. Doctors could embed an anti-corruption strategy in their existing professional codes or could adopt a new code that focuses on corruption as a violation of the right to health.
68. UN bodies may integrate a human rights approach in their existing anti-corruption strategies. When it comes to health sector corruption, they could apply the above-mentioned ‘AAAQ’ and define obligations to ‘respect, protect and fulfil’ the right to health in relation to corruption and with regard to the various actors in the health sector. The Committee on Economic, Social and Cultural Rights (CESCR) could adopt a General Comment that addresses the issue of corruption in relation to economic, social and cultural rights.
69. *Accountability* – the right to health provides a framework for holding States and possibly other actors accountable for acts of corruption that lead to violations of the right to health. Civil society groups can try to address such violations in their campaigns and other actions and they can use human rights as a framework for relaying their message. Individual victims of health sector corruption or interest groups could try to bring claims before national and international courts and quasi-judicial bodies.

## ANNEX 1. DEFINITIONS

### A. *Definition of corruption*

In line with the overall research project the definition of corruption as contained in the UN Convention against Corruption is applied here:

‘the bribery of national and foreign public officials, bribery in the private sector, embezzlement of property by a public official, trading in influence, abuse of functions, and illicit enrichment’ (project design ICHR)

This definition also extends to the private sector, which is important given that the health sector is partly privately owned.

### B. *Definition of corrupt acts*

Bacio Terracino (2006) identifies the following acts as corrupt acts:

- bribery of national public officials;
- bribery of foreign public officials;
- embezzlement by a public official;
- trading in influence;
- abuse of functions;
- illicit enrichment.

### C. *Health sector corruption: characteristics*

Extensive research on corruption in the health sector demonstrates that health sector corruption is a widespread phenomenon in all types of health care systems, both in rich and in poor nations. Transparency International (TI 2006, xvii) identifies three main characteristics of the health sector that make it so vulnerable to corruption:

- 1) the *imbalance of information* that prevails in the health system (health care providers possess more information on health, drugs and illness than their patients);
- 2) health markets are very *uncertain*; and
- 3) health systems are highly *complex*.

### D. *Actors in the health sector*

The complexity of the health sector is partly due to the large amount of actors involved in the health sector and the complexity of their multiple forms of interaction (TI, 6). Transparency International identifies five main categories of actors:

- a) government regulators (health ministries, parliaments, specialised commissions);
- b) funders (social security institutions, government office, private insurers);
- c) providers (hospitals, doctors, pharmacists);
- d) consumers (patients);
- e) suppliers (producers of medical equipment and pharmaceutical companies).

### E. *Forms of corruption in the health sector*

In its report, Transparency International identifies the following forms of corruption in the health sector:

- embezzlement and theft from the health budget or user-free revenue;
- corruption in procurement;
- corruption in payment systems;
- corruption in the pharmaceutical supply chain;
- corruption at the point of health service delivery.

## **ANNEX 2. SELECTED BIOGRAPHY**

*CGD*: Center for Global Development (Maureen Lewis), *Governance and Corruption in Public Health Care Systems*, January 2006.

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*MS*: Magdalena Sepúlveda, *The Nature of the Obligations under the International Covenant on Economic, Social and Cultural Rights*, Intersentia, 2003.

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*GC*: UN Committee on Economic, Social and Cultural Rights (CESCR), *The right to the highest attainable standard of health*, UN General Comment No. 14 (2000), UN Doc. E/C12/200/4, 11 August 2000.

### **Relevant internet sites**

Transparency International: [www.transparency.org](http://www.transparency.org)

Office of the United Nations High Commissioner for Human Rights (UN human rights website): [www.unhchr.ch](http://www.unhchr.ch)

Right to Health Unit, Human Rights Centre, Essex University, [www2.essex.ac.uk/human\\_rights\\_centre/rth](http://www2.essex.ac.uk/human_rights_centre/rth) (including the webpage of the UN Special Rapporteur on the Right to Health, Paul Hunt).

Health and Human Rights at the University of Aberdeen School Of Law, [www.abdn.ac.uk/law/hhr.shtml](http://www.abdn.ac.uk/law/hhr.shtml).