EXECUTIVE SUMMARY
Study on Corruption in the Healthcare Sector

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

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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: Lorijn 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.

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.

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1. Purpose, motivation and problem statement

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 citizens of the European Union spend more than 1 trillion euro a year on healthcare. However, the healthcare sector is one of the areas that is particularly vulnerable to corruption. The forms of abuse may differ depending on how funds are mobilised, managed and paid. A healthcare system that is financed and controlled privately or by the state may give some indication of possible specific corrupt practices. In addition to this, 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 overall impact of corruption in healthcare on society and on individuals is (much) larger than the monetary value of the sums involved. Corruption in healthcare may, among other, lead to a provision of services or procurement of equipment and drugs at above market prices. It may lead to low quality in the provision of healthcare services. It may threaten the goal of universal health coverage and increase inequality in health status between socioeconomic groups. Corruption in healthcare may lead to a non-optimal allocation of health budgets. It may also lead to market distortions and distrust in provisions of services by the government.

The objectives of the study are: (i) to enable a better understanding of the extent, nature and impact of corrupt practices in the healthcare sector across the EU; and (ii) to assess the capacity of the MSs to prevent and control corruption within the healthcare system and the effectiveness of these measures in practice.

2. Methodology, procedure and approach

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 professional's 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.

Out of a total of 86 corruption cases identified through this study, 24 cases are related to medical devices, 33 to pharmaceuticals and 17 cases are related to informal payments in medical service delivery. 9 cases fall outside the scope of our study. It is important to note that not all cases are proven (by court decision) corruption cases. In many cases there is only a suspicion of corruption or malpractice.

3. Results and findings

On the basis of our 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.

The latter two typologies fall outside the scope of this study. In the figure on the next page a simplified model of the major financial relations and corruption typologies between actors in the healthcare system is presented.

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. A general acceptance, or at least tolerance, of corruption is considered one of the main drivers behind widespread corruption in healthcare.

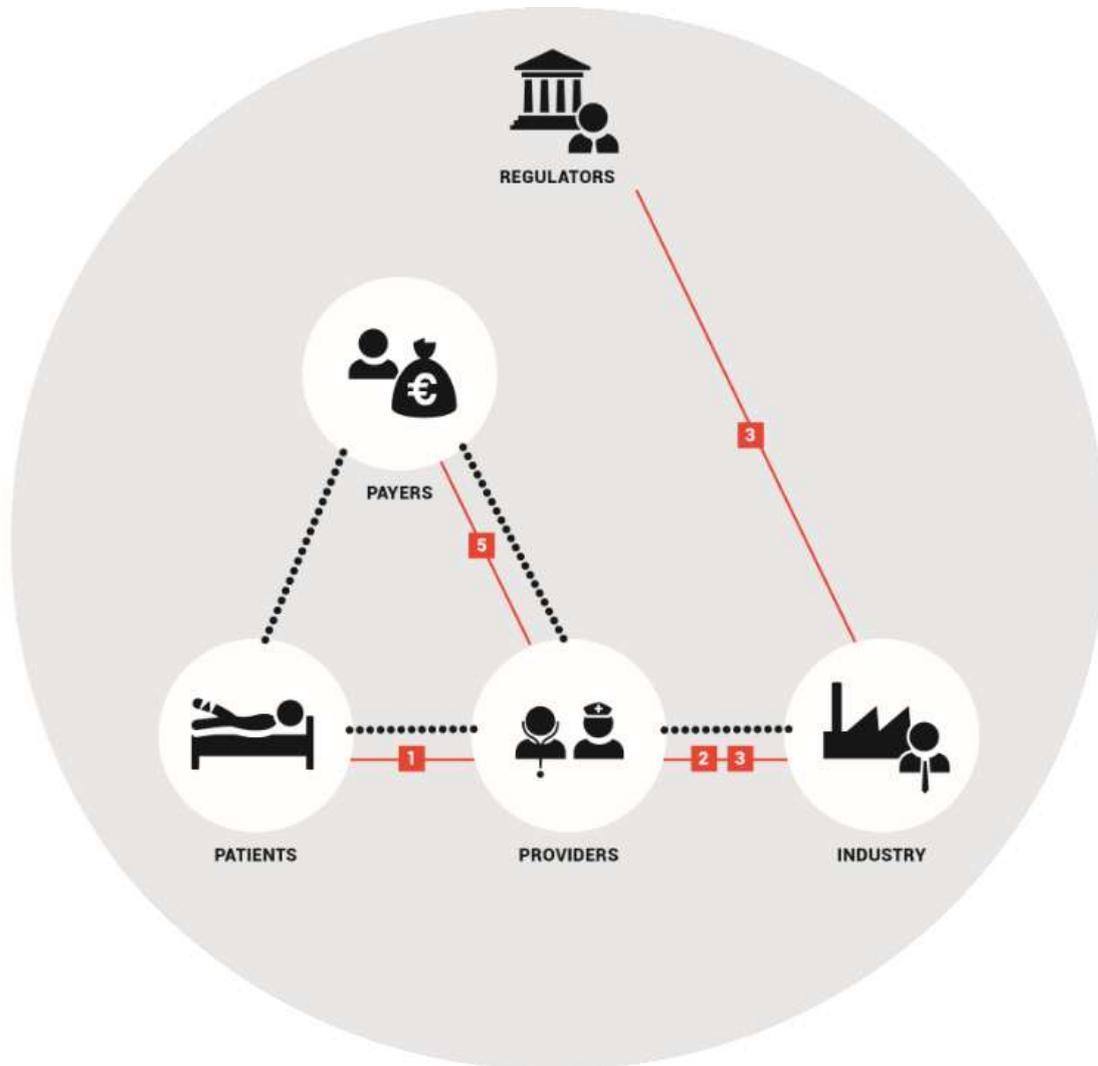### *Bribery in medical service delivery*

Bribery in medical service delivery occurs most frequently, and is considered systemic, in (former) transition economies of Central and Eastern Europe. There is, however, a trend that this practice is slowly decreasing and is sometimes restricted to specific types of healthcare (such as obstetrics, gynaecology, and orthopaedics).

Bribery is also widespread in southern European MSs, such as Greece and Italy. 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.

The majority of the 17 cases of bribery in EU MSs are related to preferential treatment – particular to bypassing waiting lists. The recent organ transplant scandal in Germany illustrates that shortages can motivate patients and physicians to circumvent the rules.

A related type of corruptive behaviour by healthcare providers versus patients observed in the MSs, including Finland, Austria and Croatia, considers misuse of dual practices. Healthcare providers can charge higher fees by referring patients to their own private practice (sometimes even by utilising publicly funded healthcare facilities).

Figure 1. Corruption in healthcare actors and typologies

Source: Ecorys / Medamo Data Visualisation

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.

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). Improper marketing occurs, with variable frequency and to different extent, in all EU MSs.

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).

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.

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.

4. Conclusions, implications and recommendations

Clear and effectively enforced general anti-corruption legislation, 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.

Good practices are 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.

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.

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.

Some EU MSs have successfully set up **control mechanisms within the health system** 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.

The introduction of **transparent waiting lists** has had a positive effect on healthcare bribery in some MS (for example Austria and Croatia). 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 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. In Slovakia the campaign by doctors themselves to refuse accepting bribes, is considered as a positive step in the complex problem of corruption.

Awareness raising campaigns and fraud and corruptions **reporting hotlines** are another good example of mobilisation of 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.

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).

The importance of active – independent – **media involvement** and pressure form '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.

Finally it must be noted that 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.

EU level recommendations

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, 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 this already in place for their members. Self-regulation should also be organised at a national level. 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 recommentations

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. 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 initiating 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.