



# Updated Study on Corruption in the Healthcare Sector

Final Report

Written by Ecorys Nederland B.V.,  
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# **Updated Study on Corruption in the Healthcare Sector**

Final Report

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## **ABSTRACT**

In 2012, Ecorys conducted an initial study on corruption in the healthcare sector (SCH1).<sup>1</sup> The purpose of the current study on corruption in the healthcare sector was two-fold: (i) to analyse and report on relevant developments since the publication of SCH1 and (ii) to provide an in-depth analysis of selected issues: privileged access to medical services, improper marketing and potential risks involving double practice.

The study covered all EU-28 Member States, with specific attention focused on: Greece, Croatia, Hungary, Lithuania, Poland, and Romania. The analysis is based on desk research, an online survey sent to stakeholders across the EU, thematic interviews with various organisations in the field of (EU) healthcare, and fact-finding missions, providing more detailed analysis and examples with regard to the six selected countries.

The study concluded that:

- Bribery in medical service delivery remains one of the main challenges, especially in many Eastern and Southern European Member States.
- Corruption related to granting privileged access to healthcare or potential risks involving double practice are not isolated to Member States with a high perception of corruption (in healthcare).
- Transparent procedures are key in addressing corruption in procurement processes.
- Attempts to address improper marketing increase at both EU and national level.

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<sup>1</sup> SCH = study on corruption in healthcare

## SYNTHESE

En 2012, Ecorys a mené sa première étude sur la corruption dans le secteur de la santé (SCH1).<sup>2</sup> L'étude actuelle sur la corruption dans le secteur de la santé visait 2 objectifs : (I) Analyser et faire état de l'évolution de la situation dans ce domaine depuis la publication de l'étude SCH1 (ii) ainsi que fournir une analyse poussée de certains problèmes, comme l'accès privilégié aux services médicaux, la vente abusive et les risques potentiels associés à une pratique double.

L'étude a porté sur les 28 pays membres de l'UE, avec une attention toute particulière aux pays suivants : la Grèce, la Croatie, la Hongrie, la Lituanie, la Pologne et la Roumanie. L'analyse s'est basée sur une recherche documentaire, une étude en ligne envoyée aux acteurs européens, des entrevues thématiques avec de nombreuses organisations dans le secteur de la santé (UE) et des missions d'enquête, qui fournissent plus d'informations et des exemples sur les six pays en question.

Les conclusions de l'étude ont été les suivantes :

- La corruption dans la prestation de services médicaux demeure l'un des principaux enjeux, notamment au sein de nombreux pays membres de l'Europe du Sud et de l'Est.
- Les États membres, qui ont une vision très claire de la corruption (dans le secteur de la santé), sont également concernés par l'octroi d'un accès privilégié aux services médicaux ou par les risques potentiels associés à la pratique double qui sont liés à la corruption.
- Les procédures transparentes sont des facteurs clés pour lutter contre la corruption lors des processus d'approvisionnement
- Des tentatives de lutte contre la vente abusive sont de plus en plus nombreuses à la fois à l'échelle nationale et européenne

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<sup>2</sup> SCH = étude sur la corruption dans le secteur de la santé



## Executive Summary

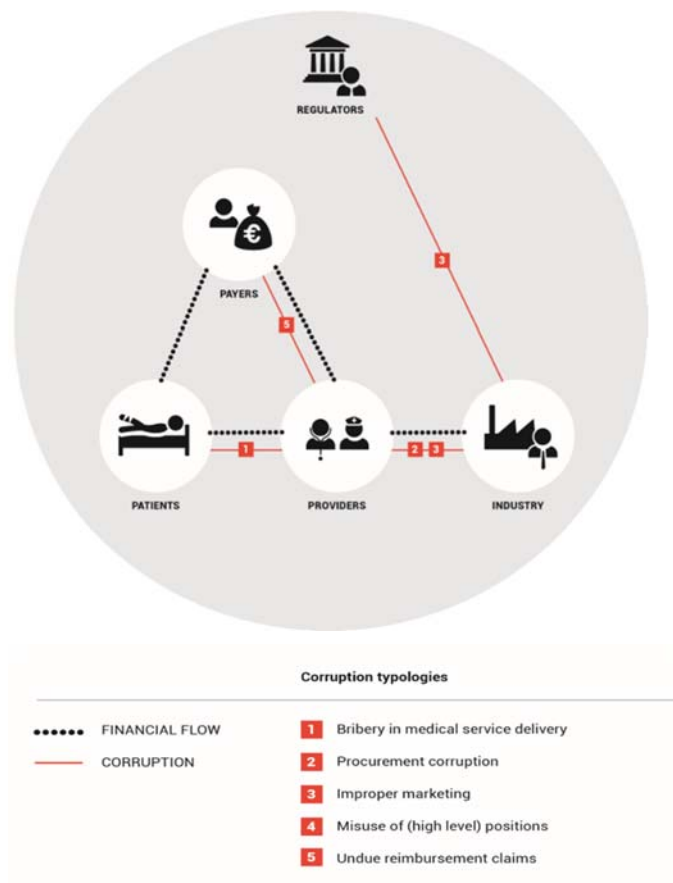
### Introduction

The health sector is one of the areas that is particularly vulnerable to corruption, but relatively little is known about this subject. In this context, the Commission (Directorate-General Migration and Home Affairs – DG Home) commissioned Ecorys to conduct an initial study on corruption in the healthcare sector (henceforth: SCH1) in 2012. The objectives of the SCH1 were to develop 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 Member States to prevent and control corruption within the healthcare system and the effectiveness of such measures in practice.

The study identified six typologies of corruption (see Figure 0.1):

- 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 (not included in figure 0.1).

**Figure 0.1 Corruption in the healthcare sector typologies**



Source: Ecorys, 2013.

In 2016, the Commission requested an update (henceforth: SCH2) of the initial study. The purpose of the update study on corruption in the healthcare sector (SCH2) is two-fold: (i) to analyse and report on relevant developments since the publication of SCH1 and (ii) to

provide an in-depth analysis of selected issues: privileged access to medical services, improper marketing, and potential risks involving double practice.

The study covers all EU-28 Member States, with specific attention focused on six countries: Greece, Croatia, Hungary, Lithuania, Poland, and Romania. The analysis is based on desk research, an online survey sent to stakeholders across the EU, thematic interviews with various organisations and associations in the field of (EU) healthcare, and fact-finding missions, providing more detailed analysis and examples with regard to the six selected countries.

### **Corruption in general and corruption in healthcare are correlated**

The Special Eurobarometer 397 (published in February 2014) shows that corruption in healthcare is not an isolated phenomenon. In general, perceived corruption in healthcare is correlated with general levels of perceived corruption. Greece, Lithuania, Romania, Slovakia, and Cyprus are among the countries with both the highest levels of perceived general corruption and specific healthcare corruption, while at the other side of the continuum the Scandinavian countries score well on both indicators.

### **Main corruption typologies highlighted**

#### **Bribery in medical services delivery remains a challenge**

Bribery in medical service delivery remains one of the main challenges, especially in many Eastern and Southern European Member States. Countries where patients have the most frequent experiences of paying for privileged treatment are: Slovakia (41%), Slovenia (38%) and Germany, Spain, France and Sweden (all 29%), while the EU average stands at 19%. In-depth analysis of the Special Eurobarometer 397 on corruption in healthcare perceptions reveals that the perceptions of corruption in healthcare are not influenced by experiences in actually giving fees, i.e. an extra payment or a valuable gift to a nurse or a physician, or a donation to the hospital.

Stakeholders mentioned that the root causes of this type of corruption, for most countries, include a general acceptance of bribery; low wages for health professionals, including physicians; ineffective managerial structures; and ineffective control mechanisms. Prosecution of physicians for bribery in medical service delivery has, over the last few years, become more common. Also, it appears that the younger generation – both physicians and patients – tend to no longer accept bribery in medical service delivery as common practice.

There are, however, differences between Member States in terms of their efforts as well as their successes, in fighting this type of corruption since the publication of the SCH1. For example, much progress was made in Poland as the result of a combination of awareness raising campaigns, active prosecution of physicians, and media coverage of these cases. In Greece, on the other hand, the situation has worsened due to the economic downturn.

#### **Privileged access and double practice is hidden across all EU Member States**

Compared to bribery in medical service delivery, corruption related to granting privileged access to healthcare or potential risks involving double practice occur much more randomly. Analysis of the Special Eurobarometer 397 shows that the problem of double practice is not isolated to Member States with a high perception of corruption (in healthcare); there is no clear correlation of experiences with double practice with general perceptions of corruption in the healthcare sector. In some countries misuse of double practice goes hand in hand with privileged access. Also, it was observed that in many of the countries, double practice is not illegal, and sometimes even considered a good thing as it may reduce informal payments and/or decrease waiting lists in the public sector.

### Transparent procedures are key in addressing corruption in procurement processes

One of the proposed solutions to mitigate the risks for this type of corruption is the centralisation of procurement processes. An important precondition for this measure to be effective is transparency in the central procurement body. We found that stakeholders differ in their views on whether or not centralising procurement will reduce corruption risk.

Several Member States have implemented other measures to reduce the risk of corruption in the procurement of medical devices and pharmaceuticals, such as: the online publication of procurement data, collaboration (between Member States) to enable larger procurements and to reduce the bargaining power of the industry, creation of anti-corruption bureaus/directorates, and the development of a price observatory for medical supplies indicating the maximum prices that can be charged to hospitals.

### Attempts to address improper marketing increases at both EU and national level

Relationships between physicians and the industry are necessary and beneficial, in the context of product development and monitoring the appropriate use of medicines in practice. However, these relationships also create risks for improper and corrupt practices, such as influencing prescribing behaviour.

In some countries policies allowing physicians to prescribe only active substances instead of branded medications have had some effect. However, physicians may still find ways to prescribe branded products, and industry can shift their influencing efforts from physicians to the officials responsible for determining the reimbursement list.

In order to prevent improper marketing, several (self-)regulation initiatives have been introduced, both at the EU and at national level. The trade associations EFPIA (pharmaceuticals) and MedTech Europe (medical devices), have both introduced a new code since the publication of the SCH1 in October 2013. In addition to the transposition of the EFPIA and MedTech Europe Code, there are also other initiatives at the national level to prevent improper marketing. In many countries, the national associations have introduced a code of conduct or ethics, or transparency enhancing initiatives.

### Revisiting the general conclusions of SCH1

In the initial study on Corruption in the Healthcare Sector (SCH1), 13 general conclusions were drawn. In the current study, stakeholders were asked, during the survey, fact-finding missions and interviews, whether they believe these conclusions are still relevant. The consulted stakeholders added the following nuances to the conclusions on the phenomena of corruption in healthcare, and avenues to combat it:

#### Conclusion 1: Convictions of (high-profile) corruption cases have a deterrent and norm-setting effect.

The majority of the stakeholders confirmed that this conclusion is still valid. However, in some countries hardly any cases are brought to court and this weakens the norm-setting effect. In addition, stakeholders mentioned that a norm-setting effect is only effective when it is followed up by sustained political action.

#### Conclusion 2: Centralisation of procurement is a method to lower the risks of corruption.

The majority of the stakeholders consulted agreed (either fully or to some extent) that central procurement is a good method of lowering the risks for corruption. Agreement with this conclusion is stronger in Eastern and North West Europe than in the Mediterranean countries. It was noted that it may also be important to have public registries in place and

to introduce transparency increasing measures, otherwise centralised procurement may actually face more risks (also see "conclusion 3").

**Conclusion 3: Central procurement systems can become vulnerable as targets for lobbyists and more politically inspired types of corruption.**

The majority of the stakeholders agreed with this statement, though it was noted that decentralised systems may also be prone to lobbying and politically inspired corruption. As with conclusion 2, for conclusion 3 we observed regional differences in the stakeholder responses in the survey: the outcomes indicate that the risks of lobbying and political inspired types of corruption are perceived to be higher in the Mediterranean and Eastern Europe area compared to North West Europe.

**Conclusion 4: Bribery in medical service delivery cannot be contested with only targeted policies against the phenomenon as such, but need to be supplemented with a variety of accompanying (structural) measures.**

In regions where bribery in medical service delivery is still common, the majority of the stakeholders agreed that both targeted policies and structural measures are required to fight this problem. Interviewees indicated a wide variety of requisite accompanying measures, including: strengthening the judicial system, changes in the healthcare system, and changes in attitudes towards corrupt practices. In North West Europe, where this form of corruption is less common, only a minority of the stakeholders expressed the need for more structural changes alongside targeted policies.

**Conclusion 5: Raising salaries does not have a significant preventive effect on reducing bribery in medical service delivery.**

Low salaries are indeed a problem, according to the majority of the stakeholders. However, the majority of respondents in all regions agree that raising salaries cannot be a standalone measure. For example, it was mentioned that active prosecution and public awareness of the unethical aspects are also needed.

**Conclusion 6: There is more than one root cause of corruption in healthcare.**

Survey results showed that the most frequently mentioned root causes are: a general acceptance of corruption, ineffective managerial structures, inappropriate financing mechanisms, and unequal allocation of resources. Respondents also mentioned insufficient healthcare capacity and insufficient funding for independent medical research as causes for corruption.

**Conclusion 7: The introduction of transparent waiting lists has a positive effect on reducing healthcare bribery.**

Most stakeholders agreed that introducing transparent waiting lists would have a positive effect on healthcare bribery. However, recent attempts to reduce such lists has not been successful in all countries, for example, due to the fact that the lists were not frequently updated, which led to outdated information to patients.

**Conclusion 8: Prescription of generics instead of branded pharmaceutical products has a positive effect on reducing healthcare bribery.**

The majority of respondents indicated that they are of the opinion that the prescription of generics instead of branded pharmaceutical has, at least to some extent, a positive effect on reducing healthcare bribery. Particularly in Eastern Europe, where several countries have introduced this type of policy, the majority of people agree to the statement. However, our research has shown that in practice, this measure has had a minimal impact to date, or only reduces bribery to some extent.

**Conclusion 9: Self-regulation between the industry and healthcare providers is needed to fight corruption in healthcare.**

The vast majority of stakeholders agreed that self-regulation is an instrument to fight corruption. Looking at the different regions, it is clear that stakeholders in Eastern European countries appear to be the most sceptical, and only expect self-regulation to be effective to 'some extent'. Many stakeholders noted that self-regulation is important, but insufficient on its own, and that it would be beneficial if initiatives between the industry and the healthcare provider were embedded in legislation, for example, to strengthen enforcement mechanisms.

**Conclusion 10: Self-regulation among players (such as within the pharmaceutical industry or among physicians) is needed to fight corruption in healthcare.**

The majority of the stakeholders agreed that self-regulation among players is important. Compared to 'conclusion 9' there is relatively little geographical variation in the responses of stakeholders. As with self-regulation between the industry and healthcare providers (conclusion 9), stakeholders note that it is not sufficient by itself, and that incentives for cooperation are important for self-regulation to be effective.

**Conclusion 11: Awareness raising campaigns and fraud and corruption reporting hotlines are an effective instrument to fight corruption in healthcare.**

Most stakeholders agreed that awareness campaigns and reporting hotlines are effective instruments in the fight against corruption. Nevertheless, some interviewees stressed that many patients do not report to such hotlines, and therefore many cases may remain unknown. Also, reporting hotlines alone cannot be effective in reducing corruption; they need to be combined with other measures as well as legislation.

**Conclusion 12: The government should play a (more) active role in creating transparency in the relations between the industry and healthcare providers.**

According to the vast majority of the stakeholders, the government should play a (more) active role in creating transparency in the relations between industry and healthcare providers. The respondents in North West Europe are the most positive about the role the government could play in this. In our research, we encountered incidental scepticism regarding the role of the government when governments do not show sufficient willingness to fight corruption in general.

**Conclusion 13: Active – independent – media involvement and pressure from 'civil society' watchdogs are essential to fight corruption in healthcare.**

Media involvement and civil pressure are generally considered as essential to fight corruption, also by the stakeholders involved in this study: the vast majority agreed with the statement at least to some extent. Though it is considered an important tool in the fight against corruption, our research shows that there is a difference between countries regarding the countervailing power of these 'watchdogs'.

## RESUME ANALYTIQUE

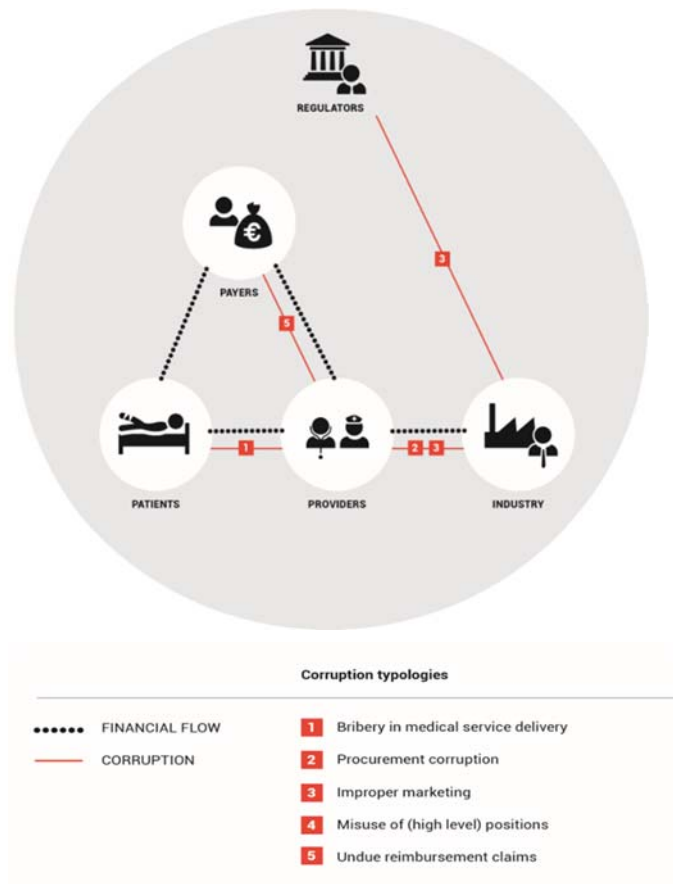
### Présentation

La santé est l'un des secteurs qui est particulièrement vulnérable à la corruption, mais sur lequel on en sait relativement peu. Dans ce contexte, la Commission (Direction générale pour les migrations et les affaires intérieures – DG Affaires intérieures) a chargé Ecorys de mener une première enquête sur la corruption dans le secteur de la santé (désormais : SCH1) en 2012. L'étude SCH1 visait à comprendre mieux l'impact, le caractère et l'étendue des pratiques de corruption dans le secteur de la santé au sein de l'UE, et d'évaluer la capacité des États membres à empêcher et contrôler la corruption au sein de leur système de santé ainsi que l'efficacité de ces mesures dans la pratique.

L'étude a permis d'identifier six types de corruption (se référer au Schéma 0.1) :

- corruption dans la prestation de services médicaux ;
- corruption dans l'approvisionnement ;
- mauvaises relations commerciales ;
- recours abusif aux fonctions de (haut) niveau ;
- demandes de remboursement indu ;
- fraude et détournement de médicaments et de dispositifs médicaux.

Schéma 0.1 Types de corruption dans le secteur de la santé



Source : Ecorys, 2013.

En 2016, la Commission a demandé une mise à jour de la première étude (désormais : SCH2). L'étude sur la corruption dans le secteur de la santé mise à jour (SCH2) visait 2

objectifs : (I) Analyser et faire état de l'évolution de la situation dans ce domaine depuis la publication de l'étude SCH1 (ii) et fournir une analyse poussée de certains problèmes, comme l'accès privilégié aux services médicaux, la vente abusive et les risques potentiels associés à une pratique double.

L'étude porte sur les 28 pays membres de l'UE, avec une attention toute particulière aux 6 pays suivants : la Grèce, la Croatie, la Hongrie, la Lituanie, la Pologne et la Roumanie. L'analyse s'est basée sur une recherche documentaire, une étude en ligne envoyée aux acteurs européens, des entrevues thématiques avec de nombreuses organisations et associations dans le secteur de la santé (UE) et des missions d'enquête, qui fournissent plus d'informations et des exemples sur les six pays en question.

### **La corruption de manière générale et la corruption dans le secteur de la santé sont liées**

L'Eurobaromètre spécial 397 (publié en février 2014) indique que la corruption dans le secteur de la santé n'est pas un phénomène isolé. D'une façon générale, la corruption perçue dans le secteur de la santé est liée à la corruption perçue à l'échelle globale. La Grèce, la Lituanie, la Roumanie, la Slovaquie et Chypre font partie des pays qui disposent à la fois des niveaux les plus élevés de corruption perçue à l'échelle globale, et notamment dans le secteur de la santé, alors qu'à l'autre extrémité, les pays scandinaves obtiennent de bons résultats concernant ces 2 indicateurs.

### **Principaux types de corruption mis en avant**

#### [La corruption dans la prestation de services médicaux demeure un enjeu](#)

La corruption dans la prestation de services médicaux demeure l'un des principaux enjeux, notamment au sein de nombreux pays membres de l'Europe du Sud et de l'Est. Les pays dont les patients ont le plus l'habitude de payer pour obtenir des soins privilégiés sont : la Slovaquie (41 %), la Slovénie (38 %) et l'Allemagne, l'Espagne, la France et la Suède (29 % au total), alors que la moyenne européenne s'élève à 19 %. L'analyse poussée de l'Eurobaromètre spécial 397 en matière de corruption perçue dans le secteur de la santé révèle que la pratique d'honoraires accordés actuellement, comme un remboursement supplémentaire ou un cadeau de valeur à une infirmière ou à un médecin, ou bien un don à l'hôpital, n'influe pas sur les perceptions de la corruption dans le secteur de la santé.

Les acteurs ont indiqué que les causes pour la plupart des pays viennent de la reconnaissance de la corruption d'une manière générale, des faibles revenus des professionnels de la santé, y compris les médecins; ainsi que de l'inefficacité des structures de gestion et des mécanismes de contrôle. Poursuivre en justice des médecins pour corruption dans la prestation de services médicaux est devenu, au cours des dernières années, de plus en plus courant. Par ailleurs, la nouvelle génération, à la fois les médecins et les patients, semble ne plus reconnaître que la corruption dans la prestation de services médicaux est une pratique courante.

Néanmoins, depuis la publication de l'étude SCH1, les États membres semblent fournir des efforts de degré différent et progresser de manière distincte en termes de lutte contre ce type de corruption. Ainsi, de nombreuses avancées ont été réalisées en Pologne suite à la combinaison de campagnes de sensibilisation, de poursuites engagées contre des médecins et de couverture médiatique de ces procès. De l'autre côté, en Grèce, la situation a empiré en raison de la récession économique.

### L'accès privilégié et la pratique double sont dissimulés parmi l'ensemble des États membres de l'UE

Comparée à la corruption dans la prestation de services médicaux, la corruption liée à l'octroi d'un accès privilégié aux soins de santé ou les risques potentiels associés à une pratique double surviennent davantage de manière aléatoire. L'analyse de l'Eurobaromètre spécial 397 indique que le problème de la pratique double ne concerne pas seulement les États membres à la perception élevée en matière de corruption (dans le secteur de la santé). La pratique double et les perceptions globales en matière de corruption dans le secteur de la santé ne sont, de toute évidence, aucunement liées. Dans certains pays, le recours abusif à la pratique double va de pair avec l'accès privilégié. On a également fait valoir que dans de nombreux pays, la pratique double n'est pas un acte illégal, et qu'elle est même parfois considérée comme une bonne chose, car elle peut réduire les paiements informels et/ou les listes d'attente dans le secteur public.

### Les procédures transparentes sont des facteurs clés dans la lutte contre la corruption lors des processus d'approvisionnement

L'une des solutions proposées pour diminuer les risques de ce type de corruption est la centralisation des processus d'approvisionnement. La transparence du système centralisé des approvisionnements fait partie des conditions préalables importantes pour que cette mesure soit efficace. Nous avons constaté que les opinions des acteurs divergent quant au fait de savoir si centraliser ou pas les achats réduirait le risque de corruption.

Certains États membres ont mis en place d'autres mesures afin de diminuer le risque de corruption au cours de l'achat de dispositifs médicaux et produits pharmaceutiques, telles que : la publication en ligne de données relatives aux achats, la collaboration (entre les États membres) afin de permettre des volumes d'approvisionnement plus importants et de réduire la possibilité de négocier dans le secteur, la création de bureaux/directions chargés de lutter contre la corruption ainsi que d'un observatoire des prix des fournitures médicales qui indiquerait les prix maximums qui peuvent être facturés aux hôpitaux.

### Des tentatives de lutte contre la vente abusive sont de plus en plus nombreuses à la fois à l'échelle nationale et européenne

Les relations entre les médecins et l'industrie sont nécessaires et bénéfiques dans le cadre d'un développement de produits et d'un contrôle de l'utilisation appropriée de médicaments dans la pratique. Cependant, ces relations génèrent également des risques de pratiques abusives et actes de corruption, comme influencer le comportement du prescripteur.

Dans certains pays, les politiques permettant les médecins de ne prescrire que des substances actives à la place de médicaments de marque ont en quelque sorte contribué à lutter contre la corruption. Cependant, les médecins peuvent toujours trouver des moyens pour prescrire des produits de marque. Par ailleurs, au lieu de s'efforcer à influencer les médecins, le secteur peut influencer les représentants chargés d'établir la liste des remboursements.

Afin d'empêcher la vente abusive, plusieurs mesures d'(auto)réglementation ont été présentées. À l'échelle européenne et nationale. Les associations professionnelles EFPIA (produits pharmaceutiques) et MedTech Europe (dispositifs médicaux) ont lancé toutes les 2 un nouveau code depuis la publication de l'étude SCH1 en octobre 2013. Outre la transposition du code de l'EFPIA et de la MedTech, d'autres mesures sur le plan national permettent également d'empêcher la vente abusive. Dans de nombreux pays, les associations nationales ont lancé un code de conduite, d'éthique ou de transparence encourageant la prise d'initiatives.



## Conclusions générales de SCH1

Dans la première étude sur la Corruption dans le secteur de la santé (SCH1), 13 conclusions générales ont été tirées. Dans l'étude actuelle, il a été demandé aux acteurs, au cours de l'étude, des missions d'enquête et des entrevues, s'ils estiment que ces conclusions demeurent pertinentes. Les acteurs interrogés ont ajouté les nuances suivantes aux conclusions à propos du phénomène de corruption dans le secteur de la santé proprement dit et aux possibilités pour lutter contre :

**Conclusion 1 : Les condamnations pour affaires de corruption (médiatiques) ont un impact dissuasif et normatif.**

La majorité des acteurs a confirmé que cette conclusion est toujours d'actualité. Cependant, dans certains pays, rares sont les affaires qui sont portées devant les tribunaux, ce qui tend à réduire l'effet normatif. En outre, les acteurs ont indiqué qu'un effet normatif n'est efficace que s'il est suivi par l'appui d'actions politiques.

**Conclusion 2 : La centralisation des achats est un moyen de diminuer les risques de corruption.**

La majorité des acteurs interrogés se sont entendus (soit totalement soit dans une certaine mesure) sur le fait que l'approvisionnement centralisé est un bon moyen de réduire les risques de corruption. L'Europe du Nord-Ouest et de l'Est est plus d'accord avec cette conclusion que les pays méditerranéens.

Il convenait de noter qu'il est peut-être également important de disposer de registres publics et de mettre en place des mesures dans le but d'obtenir plus de transparence, car sinon il est possible que l'approvisionnement centralisé soit effectivement confronté à plus de risques (se référer également à la « conclusion 3. »)

**Conclusion 3 : Les systèmes d'approvisionnement centralisés peuvent devenir une cible vulnérable pour les lobbyistes et les politiques qui encouragent ces types de corruption.**

La majorité des acteurs se sont entendus sur cette déclaration, bien qu'il a été convenu que les systèmes décentralisés peuvent également faire l'objet d'une corruption encouragée par des lobbyistes et politiques. Comme avec la conclusion 2, pour la conclusion 3 nous avons noté des différences au niveau des régions dans les réponses des acteurs de l'étude. Les résultats indiquent notamment que les risques de types de corruption encouragés par des lobbyistes et des politiques sont perçus comme étant plus élevés en Europe de l'Est que dans les pays méditerranéens par rapport à l'Europe du Nord-Ouest.

**Conclusion 4 : Des politiques ciblées ne suffisent pas à lutter contre le phénomène de corruption dans la prestation de services médicaux à proprement parler. D'autres mesures d'accompagnement (structurelles) doivent également être prises.**

Dans les régions où la corruption dans la prestation de services médicaux demeure une pratique courante, la majorité des acteurs se sont entendus sur le fait que des politiques ciblées ainsi que des mesures structurelles doivent être mises en place pour lutter contre ce problème. Les acteurs interrogés ont indiqué que les mesures d'accompagnement qui doivent être prises sont multiples. Il s'agit du renforcement du système judiciaire, des modifications du système de la santé et des changements de comportement vis-à-vis des pratiques en matière de corruption. En Europe du Nord-Ouest, là où cette forme de corruption est moins courante, seule une minorité des acteurs a exprimé le besoin de plus amples changements structurels à l'image des politiques ciblées.

**Conclusion 5 : L'augmentation des salaires n'a pas d'effet préventif important sur la réduction de la corruption dans la prestation de services médicaux.**

La majorité des acteurs estime que les bas salaires représentent bel et bien un problème. Néanmoins, la majorité des acteurs interrogés dans toutes les régions sont d'accord sur le fait qu'augmenter les salaires ne peut pas faire l'objet d'une mesure isolée. Ainsi, il a été indiqué que les poursuites engagées et la sensibilisation des citoyens quant aux aspects contraires à l'éthique sont également nécessaires.

**Conclusion 6 : Les causes principales de corruption dans le secteur de la santé sont multiples.**

Les résultats de l'étude ont révélé que les origines des causes qui sont mentionnées le plus souvent sont : une reconnaissance de la corruption en général, l'inefficacité des structures de gestion, des mécanismes de financement inappropriés et une distribution inégale des ressources. Les acteurs interrogés ont également indiqué que les moyens insuffisants dans le secteur de la santé et le manque de financement pour la recherche médicale indépendante sont à l'origine de la corruption.

**Conclusion 7 : La mise en place de listes d'attente transparentes joue un rôle clé dans la diminution de la corruption dans le secteur de la santé.**

La plupart des acteurs se sont entendus sur le fait que mettre en place des listes d'attente transparentes contribuerait réellement à la diminution de la corruption dans le secteur de la santé. Néanmoins, les dernières tentatives de réduire ces listes n'a pas porté ses fruits dans tous les pays, par exemple du fait que les listes n'ont pas été souvent mises à jour, d'où des informations désuètes pour les patients.

**Conclusion 8 : La prescription de génériques à la place de produits pharmaceutiques de marque a permis de diminuer la corruption dans le secteur de la santé.**

La majorité des acteurs interrogés ont indiqué qu'ils estiment que la prescription de génériques à la place de produits pharmaceutiques de marque contribue, du moins dans une certaine mesure, à réduire la corruption dans le secteur de la santé. Notamment en Europe de l'Est, où plusieurs pays ont mis en place ce type de politique, et où la majorité des citoyens sont d'accord avec cette déclaration. Cependant, notre étude a révélé que dans la pratique, cette mesure a eu très peu d'incidence jusqu'à présent ou ne diminue la corruption que jusqu'à un certain point.

**Conclusion 9 : L'autoréglementation entre l'industrie et les prestataires de santé est nécessaire pour lutter contre la corruption dans le secteur de la santé.**

La grande majorité des acteurs se sont accordés sur le fait que l'autoréglementation est un moyen de lutter contre la corruption. Si l'on examine les différentes régions, on remarque que les acteurs des pays de l'Europe de l'Est semblent être plus sceptiques et ne s'attendent à ce que l'autoréglementation ne soit efficace que jusqu'à « un certain point. » De nombreux acteurs ont remarqué que l'autoréglementation est une mesure importante, mais pas suffisante. Par ailleurs, elle serait plus bénéfique si les mesures prises entre l'industrie et les prestataires de santé étaient inscrites dans la législation, par exemple pour renforcer les mécanismes de contrôle.

**Conclusion 10 : L'autoréglementation parmi les acteurs (tels qu'au sein de l'industrie pharmaceutique ou parmi les médecins) est requise pour lutter contre la corruption dans le secteur de la santé.**

La majorité des acteurs se sont entendus sur le fait que l'autoréglementation parmi eux est une mesure importante. Par rapport à la « conclusion 9 », la réponse des acteurs varie relativement peu selon les régions. Comme avec l'autoréglementation entre l'industrie et

les prestataires de santé (conclusion 9), les acteurs remarquent que seule elle n'est pas suffisante, et que les incitations à la coopération constituent un élément important pour que l'autoréglementation devienne efficace.

**Conclusion 11 : Les campagnes de sensibilisation, l'assistance téléphonique pour signaler des actes de fraude ou de corruption sont des moyens efficaces pour lutter contre la corruption dans le secteur de la santé.**

La plupart des acteurs se sont accordés sur le fait que les campagnes de sensibilisation et l'assistance téléphonique pour faire un signalement sont des moyens efficaces dans la lutte contre la corruption. Néanmoins, certains acteurs interrogés ont souligné que de nombreux patients n'ont pas recours à cette assistance téléphonique. Par conséquent, de nombreuses affaires pourront ne pas être connues. En outre, recourir à l'assistance téléphonique ne peut pas être le seul moyen efficace pour diminuer la corruption ; cette action doit être combinée à d'autres mesures et lois pour lutter contre la corruption.

**Conclusion 12 : Le gouvernement devra prendre (davantage) de mesures pour rendre les relations transparentes entre l'industrie et les prestataires de santé.**

Selon, la grande majorité des acteurs, le gouvernement devra prendre (davantage) de mesures pour rendre les relations transparentes entre l'industrie et les prestataires de santé. Les acteurs interrogés en Europe du Nord-Ouest sont ceux qui sont les plus favorables quant à une contribution du gouvernement dans cette lutte. Dans notre étude, nous nous sommes retrouvés face à un scepticisme lié au rôle du gouvernement lorsque les gouvernements n'affichent pas une volonté suffisante pour lutter contre la corruption d'une manière générale.

**Conclusion 13 : L'importance de la participation des médias de manière isolée et active ainsi que la pression des organismes de surveillance de la « société civile » est indispensable pour lutter contre la corruption dans le secteur de la santé.**

En général, la participation des médias et la pression de la société civile sont considérées comme essentielles pour lutter contre la corruption, également par les acteurs qui ont participé à cette étude. La grande majorité d'entre eux s'est entendue sur la déclaration, du moins dans une certaine mesure. Bien qu'elle soit considérée comme un outil important dans la lutte contre la corruption, notre étude montre que le contre-poids de ces « organismes de surveillance » varie selon les pays.



## 1. INTRODUCTION

### 1.1. Background of the study

The fight against corruption is one of the key priorities for the European Commission. In 2011, an anti-corruption package was adopted to reinforce European Union (EU) policy against corruption. In 2014, the first EU Anti-Corruption report was published, analysing the efforts of Member States against corruption.<sup>3</sup>

The health sector is one of the areas that is particularly vulnerable to corruption, but relatively little is known about this subject. In this context, the Commission (Directorate-General Migration and Home Affairs – DG Home) commissioned Ecorys to conduct an initial study on corruption in the healthcare sector (henceforth: SCH1) in 2012. The objectives of the SCH1 were to develop 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 Member States to prevent and control corruption within the healthcare system and the effectiveness of such measures in practice. We focused on medical service delivery, procurement and certification of medical devices, and procurement and authorisation of pharmaceuticals.

In the SCH1 we identified six typologies of corruption in the selected healthcare areas on the basis of desk research and more than 100 interviews, as well as an analysis of 86 cases of corruption (see Figure 1.1):

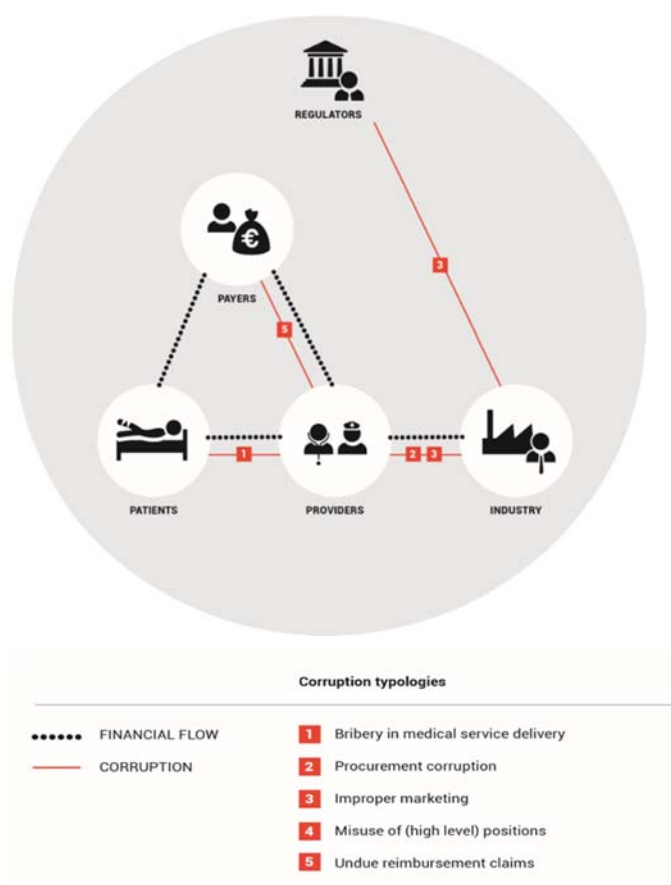
- bribery in medical service delivery;
- procurement corruption;
- improper marketing relations;
- misuse of (high) level positions;
- undue reimbursement claims;
- fraud and embezzlement of medicines and medical devices (not included in Figure 1.1).

The latter two typologies were outside the scope of the study.

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<sup>3</sup> COM(2014) 38 final - EU anti-corruption report.

Figure 1.1 Corruption in the healthcare sector typologies



Source: Ecorys, 2013.

Furthermore, we identified three categories of policies and practices to prevent and control corruption:

- generic anti-corruption policies and practices, e.g. procurement policies and forceful anti-bribery legislation;
- generic healthcare policies and practices, e.g. healthcare supervision and reforms to address structural healthcare system weaknesses; and
- corruption-in-health policies, e.g. health specific anti-corruption strategies and self-regulation.

We concluded that corruption in the healthcare sector occurs in all EU Member States, and that both the nature and the prevalence of corruption typologies differ across the EU. In addition, we found no single policy to successfully fight corruption in healthcare. Policies and practices that work in one country do not necessarily work in another. Necessary preconditions for successfully targeting corruption in health care policies included:

- a general rejection of corruption by society;
- clear and effectively enforced general anti-corruption legislation;
- independent and effective judicial follow up on corruption cases; and
- sound general procurement systems.

## 1.2. Scope and objectives of the study

In 2016, the Commission requested an update (henceforth: SCH2) of the initial study.

The purpose of this updated study on corruption in the healthcare sector is two-fold:

- To analyse and report on relevant developments since the publication of the initial study on corruption in the healthcare sector (SCH1) (October 2013);
- To provide an in-depth analysis of selected issues, including:

- Privileged access to medical services (including not only informal payments but also the use of privileged information and information peddling);
- Improper marketing by pharmaceutical companies and medical device producers (at national and/or EU level, including for market authorisation and reimbursement approval);
- Potential risks involving double practice in public and private clinics.

The study covers all EU-28 Member States with specific attention (fact-finding missions with more detailed analysis and examples) focused on six countries: Greece, Croatia, Hungary, Lithuania, Poland, and Romania. These are countries where the EU Anti-Corruption Report highlights healthcare as an issue.

In this study, we have - as in the initial study - :

- Focused on practical aspects and kept the theoretical part to a minimum;
- Not limited the scope to issues that are comparable across the EU; and
- Focused on the specifics of each Member State and on illustrative case studies.

This resulted in:

- An analysis of the extent, nature and impact of corrupt practices in the healthcare sector across the EU;
- An analysis of the capacity of the Member States to prevent and control healthcare corruption; and
- Policy recommendations for further action, which could be beneficial at Member State and EU level.

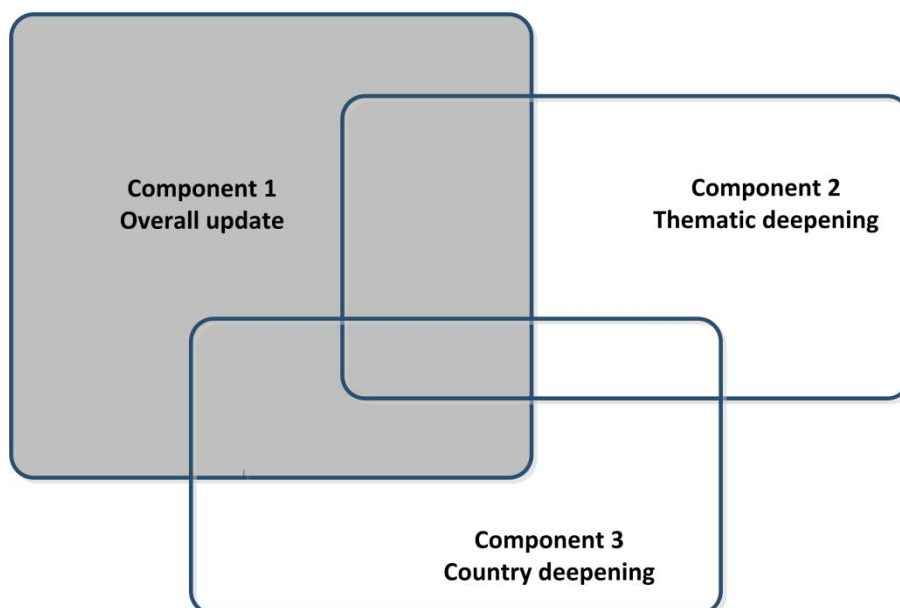
### 1.3. General approach

This study covers three – interlinked – components:

1. An update of the initial study;
2. Analysis of selected thematic issues;
3. Country studies.

As presented in the Figure below, the three components are partially overlapping and therefore certain methods (e.g. survey and interviews) were used to collect data for multiple components.

**Figure 1.2 Overlap of the three research components**



### **Component 1. Update of the initial study since October 2013**

Component 1 concerns an update of the initial study, covering all EU-28 Member States. We sent a survey to relevant stakeholders in all EU-28 Member States, and conducted interviews with stakeholders at the EU level. The stakeholders were asked if the findings and conclusions of the 2013 report are still relevant and what has changed (for example in terms of occurrence/extent/legal initiatives/policy changes) since its publication in October 2013.

### **Component 2. Thematic analysis**

We conducted desk research per thematic issue:

- Privileged access to medical services (including informal payments and the use of privileged information and information peddling);
- Improper marketing by pharmaceutical companies and medical device producers (at national and/or EU level, including for market authorisation and reimbursement approval);
- Potential risks involving double practice in public and private clinics.

Furthermore, we collected data through the survey sent to stakeholders in all EU-28 Member States and through the interviews with stakeholders at the EU level (see component 1).

### **Component 3. Country studies**

We conducted fact-finding missions in all selected countries (Greece, Croatia, Hungary, Lithuania, Poland, and Romania), which included interviews with relevant stakeholders in each country. In Chapter 2, we present our methodological approach in more detail.

#### **1.4. Outline of the Final Report**

The report includes our methodology used (Chapter 2). Thereafter, we present the findings and conclusions of the study as follows:

- Chapter 3 provides the results of the fact-finding missions to Greece, Croatia, Lithuania, Hungary, Poland and Romania (i.e. country reports);
- Chapter 4 provides an update of the SCH1 study and an in-depth analysis of the selected thematic issues;
- Chapter 5 presents our conclusions and recommendations;
- The report is supported by the following Annexes:
  - The interview guide;
  - Overview of stakeholders invited for the survey;
  - The survey design; and
  - Corruption indicators (Special Eurobarometer 397).



## 2. METHODOLOGICAL APPROACH

As stated in Chapter 1, we used several data collection tools, including desk research, online survey, interviews, and fact-finding missions. In the sections below, we provide more information on these tools.

### 2.1. Survey

The purpose of the EU-28 Member States survey was two-fold:

1. To update the results of the initial study; and
2. To collect information on the thematic issues.

The survey design and circulation was organised as follows:

First, we [compiled the list of survey invitees](#). Based on the initial study and desk research we gathered contact details from all relevant stakeholder categories (i.e. patients, payers, providers, industry and regulators), in all EU-28 Member States.

The next step was to [draft the survey](#).

After [agreement by DG Home](#), the survey was [piloted by the EHFCN](#). The final version was programmed [in Check Market](#) (see Annex III). The survey was then circulated to 300 invitees on 8 December 2016. A first reminder was sent out on 20 December 2016 and second reminder was sent out on 16 January 2017. The survey was closed at the end of January 2017.

#### 2.1.1. Survey invitees

The geographic spread of the 300 invitees is presented in Table 2.1, while the number of invitees per stakeholder category is presented in Table 2.2.

**Table 2.1 Overview number of surveys sent per Member State**

Country	Number of surveys sent	Country	Number of surveys sent
Austria	11	Latvia	5
Belgium	20	Lithuania	7
Bulgaria	14	Luxembourg	8
Croatia	3	Malta	8
Cyprus	5	Netherlands	16
Czech Republic	11	Portugal	9
Denmark	12	Romania	12
Estonia	7	Slovakia	9
Finland	13	Slovenia	8
France	20	Spain	7
Germany	35	Sweden	12
Hungary	1	UK	20
Ireland	11	EU level	3
Italy	13		
<b>Grand total</b>			<b>300</b>

**Table 2.2 Number of invitees by stakeholder category**

Stakeholder category	Number of survey invitees
Patients	46
Payers	53
Providers	74
Industry	56
Regulators	58
Other	13
<b>Grand total</b>	<b>300</b>

For more detailed lists of survey invitees per country, please see Annex II.

### 2.1.2. Response rate

Out of 300 invitees, 44 responses were received, distributed geographically as presented in the Table below. This translates into a response rate of 14.7%, which is fairly common for online surveys.

**Table 2.3 Overview number of survey responses per Member State**

Country	Number of survey responses	Country	Number of survey responses
Austria	4	Latvia	2
Belgium	2	Lithuania	3
Bulgaria	2	Luxembourg	0
Croatia	1	Malta	0
Cyprus	0	Netherlands	2
Czech Republic	1	Portugal	7
Denmark	2	Romania	5
Estonia	2	Slovakia	1
Finland	2	Slovenia	1
France	1	Spain	1
Germany	2	Sweden	0
Hungary	0	UK	3
Ireland	0	EU level	-
Italy	1		
<b>Grand total</b>			<b>44</b>

### 2.2. Thematic interviews

As part of the study, we conducted thematic interviews with various organisations and associations in the field of (EU) healthcare. The aim of these interviews was two-fold:

- Discuss developments per thematic area since the initial study (extent, cases as well as good practices); and
- Identify current challenges with regard to the thematic areas:
  1. Informal payments in medical service delivery;
  2. Certification and procurement of medical devices;
  3. Authorisation and procurement of pharmaceuticals;
  4. Privileged access to medical services (including not only informal payments but also the use of privileged information and information peddling);
  5. Improper marketing by pharmaceutical companies and medical device producers (at national and/or EU level, including for market authorisation and reimbursement approval);

6. Potential risks involving double practice in public and private clinics.

Interviewees were approached in relation to specific themes as represented in the Figure below.

**Figure 2.1 Relevant stakeholder categories per thematic area**



Table 2.4 lists the organisations that we approached for interviews in relation to the thematic areas.

**Table 2.4 Overview of organisations and persons invited for an interview**

Stakeholder category	Organisation	Thematic area
Patients	European Patient Forum (EPF)	1, 4 and 6
Payers	International Association of Mutual Benefit Societies (AIM)	1, 5 and 6
Providers	European Hospital and Healthcare Federation (HOPE)	1, 2, 4, 5 and 6
	Standing Committee of European Doctors (CPME)	
	European Union of General Practitioners / Family Physicians (UEMO)	
Industry	MedTech Europe	2 and 5
	European Federation of Pharmaceutical Industries and Associations (EFPIA)	3 and 5
Regulators	Directorate-General Health and Food Safety (DG SANTE)	3 and 5
	Directorate-General for Internal Market, Industry, Entrepreneurship and SMEs (DG Growth)	2 and 5
	DG Home	All areas
	European Medicines Agency (EMA)	3 and 5
Other	Eurojust	All areas
	Transparency International	All areas
	European Association of Notified Bodies for Medical Device (Team NB)	2
	EU research project: Assessment of patient payment policies and projection of their efficiency, equity and quality effects (ASSPRO) <sup>4</sup>	1

Reminders were sent within approximately two weeks after the initial request for an interview. Out of this group, representatives from the following organisations agreed to an interview:

- AIM;
- ASSPRO;

<sup>4</sup> See [https://ec.europa.eu/research/social-sciences/pdf/project\\_synopses/ssh\\_projects\\_7-13.pdf](https://ec.europa.eu/research/social-sciences/pdf/project_synopses/ssh_projects_7-13.pdf), p.430.

- DG Growth;
- DG SANTE;
- EMA;
- EPF;
- HOPE;
- MedTech Europe;
- Transparency International.

Several of the organisations approached did not respond to the request for interview (e.g. EFPIA and Team NB), while others indicated that they were not willing to contribute to the study (e.g. CPME).

Prior to the interview, the interviewees received an interview guide (Annex I), including background information about the study and a topic list. The topics for the interviews included:

- Updates and comments to the general conclusions of the initial study on Corruption in the Healthcare Sector;
- Developments in the relevant thematic areas since 2013;
- Current challenges with regard to the thematic areas relevant for the stakeholder group;
- Examples of good practices since 2013;
- Cases since 2013.

### **2.3. Fact finding missions**

The aim of the fact-finding missions in each selected country was to deepen the knowledge on the specific themes highlighted in the EU Anti-Corruption Report.

Before each fact-finding mission, relevant interviewees were identified (representing different stakeholder groups) through desk research/our initial contacts, and approached for an interview in the country. Prior to the missions, we sent them the interview guide. The topics for the interviews included:

- Updates to and comments on the general conclusions of the initial study on Corruption in the Healthcare Sector;
- Developments in the relevant thematic areas since 2013;
- Current challenges with regard to the thematic areas relevant for that stakeholder group;
- Examples of good practices since 2013;
- Cases since 2013;
- Country and/or stakeholder specific questions based on the results of desk research.

Based on each country visit, we delivered a brief mission report. These are detailed in Chapter 3. In order to compare the results of the different missions, we used a common template in order to analyse the collected data in a standardised way.

Per mission, about five interviews were conducted face-to-face, with follow-up by Skype or phone interviews where necessary. The interviewees included representatives of:

- Transparency International national chapter or local partner;
- National anti-corruption bureau or agency;
- Ministry of Health;
- National EHFCN contact point (if available);
- Contacts interviewed for the initial study (SCH1);
- EU medical devices contact points, vigilance contact points, clinical Investigation contact points, and other contact points;
- Experts from academia, the media, NGOs, or for example, the EU Group of experts on corruption;
- Other stakeholders (Government regulator, Healthcare provider, Medical devices supplier, Pharmaceutical supplier, Payers of healthcare).

#### 2.4. Desk research

We carried out desk research throughout the study: in the early stages to review European developments in order to prepare the EU-level interviews and fact finding missions, and later to follow-up on specific issues mentioned during the (thematic and fact-finding) interviews.

The desk research involved, amongst others, the following key publications: the special Eurobarometer on Corruption (Eurobarometer 2014/397), reports on Corruption in Healthcare from Transparency International (e.g. on lobbying), EC report on Health Care and Long-term Care Systems & Fiscal Sustainability (2016)<sup>5</sup>, as well as Healthcare in Transition reports and OECD publications (e.g. 'Health at a Glance Europe 2016'). In each of the country studies (Chapter 3) we refer to the Euro Health Consumer Index, as it ranks health systems according to their performance on several relevant indicators, including patient rights and information, accessibility, outcomes, range and reach of services. However, please be aware that some scholars have recently cautioned against this kind of ranking of health systems<sup>6</sup>, and that the information provided is thus for illustrative purposes only.

We also reviewed websites, news items, and broader developments related to the six areas for thematic deepening, at the European level and also specifically for the countries of the fact-finding missions:

1. Informal payments in medical service delivery;
2. Certification and procurement of medical devices;
3. Authorisation and procurement of pharmaceuticals;
4. Privileged access to medical services (including not only informal payments but also the use of privileged information and information peddling);
5. Improper marketing by pharmaceutical companies and medical device producers (at national and/or EU level, including for market authorisation and reimbursement approval);
6. Potential risks involving double practice in public and private clinics.

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<sup>5</sup> Commission services (Directorate-General for Economic and Financial Affairs), Economic Policy Committee (Ageing Working Group). Joint Report on Health Care and Long-Term Care Systems & Fiscal Sustainability. Brussels: 7 October 2016. Available at: [https://ec.europa.eu/info/publications/economy-finance/joint-report-health-care-and-long-term-care-systems-fiscal-sustainability-0\\_en](https://ec.europa.eu/info/publications/economy-finance/joint-report-health-care-and-long-term-care-systems-fiscal-sustainability-0_en).

<sup>6</sup> What, if anything, does the EuroHealth Consumer Index actually tell us? Blog by Cylus, Nolte, Figueras and McKee, BMJ, February 9, 2016. Available at: <http://blogs.bmj.com/bmj/2016/02/09/what-if-anything-does-the-eurohealth-consumer-index-actually-tell-us/>.



### **3. COUNTRY STUDIES**

#### **Introduction**

We conducted fact-finding missions in Croatia, Lithuania and Romania during December 2016 and in Hungary, Poland and Greece during January-February 2017. Fact-finding missions were organised for three days on average, and combined whenever feasible.

The country reports are all structured in the same way and cover the following topics:

- Overview of the organisations interviewed;
- General description of the healthcare system;
- Risks and obstacles;
- Types of healthcare corruption;
- Recent cases;
- Challenges and conclusions.

### 3.1. Greece

#### Overview/summary

The fact-finding mission to Athens, Greece took place between 6 and 9 February 2017. During this mission, six interviews were held. An overview of the interviews conducted is presented below.

**Table 3.1 Overview of Interviews conducted**

Date	Organisation	Stakeholder category
7-2-1017	EKPIZO	Patients (Consumer organisation)
7-2-2017-	-	Academic
7-2-2017	SEIV	Providers
8-2-2017	Panteion University	Academic
8-2-2017	-	Civil society
9-2017	YPEDYFKA	Payer / Regulator

Note: please mark in red the information for which the interviewee has not given explicit consent for publication.

#### 3.1.1. General description of the healthcare system

In Greece, there is a mixed healthcare system: an NHS type system (which is called ESY in Greece) coexists with a social health insurance system.

Statutory financing is based on taxes and social insurance contributions (which 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.

After the economic downturn in Greece in 2010, many reforms were adopted in the healthcare sector as well as in other sectors. Probably the most significant reform was Law 3918/2011, which introduced a major restructuring of the system. One of the main changes was the clustering of all major social insurance funds into one fund, i.e. EOPYY, which acts as the sole buyer of healthcare services, medical devices, 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. Another value added by the establishment of EOPYY is that there is now only one regulation governing contracts, with the result that the same rules apply to all patients.

The regulation of healthcare services is quite centralised in Greece. The Ministry of Health is responsible for national healthcare policy (including priority setting for both health policy and public health), the regulation and management of EOPYY (the sole payer), the regulation of the private sector, and overall management of the healthcare system.

With the establishment of EOPYY, there was the shift from multiple control bodies to one control body for social insurance. YPEDYFKA (which was already established in 2003) is responsible for the control, auditing and monitoring of claims filed with EOPYY. Although it is part of the social health insurance fund, YPEDYFKA is highly independent and authorised to independently conduct investigations. As all claims and complaints are now received centrally, there is a better overview of what is happening.

#### YPEDYFKA in 2016

In 2016, YPEDYFKA conducted 298 inspections and 250 evaluations that resulted in a penalty, which can be either a fine or a temporary suspension of a healthcare professional. Of all the cases investigated in 2016, 27 involved pharmaceutical companies, and 181 physicians were investigated. The offences that were detected cover a wide range of fraudulent or corrupt activities such as incorrect/undue charges, collaboration between physicians and pharmaceutical companies, and prolongation of hospitalisation. The vast majority of cases (94% in 2016) were detected on the basis of complaints made by patients. YPEDYFKA has to investigate all the complaints they receive, but are faced with serious resource constraints; they only have 30 people available to look into complaints, conduct controls and impose penalties. As a result, YPEDYFKA hardly has any time for preventive proactive inspections – all available time is dedicated to following up on complaints.



## Healthcare delivery

In Greece, primary healthcare is provided by both public (ESY) 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, but reforms have recently been announced that will change this.

Secondary and tertiary care is provided in two different settings: public hospitals and private clinics (which play an important role in the provision). People can choose any public hospital for receiving treatment – there are no restrictions in terms of choice.

**Table 3.2 Indicators of the healthcare system in Greece**

<b>Indicators of the healthcare system</b>			
<b>Financing of the healthcare system (1)</b>			
	2012	2015 (or nearest year)	EU average
Total health expenditure as % of GDP	8.9%	8.2%	10%
Public expenditure as % of total health spending	66.7%	60.6%	77.8%
Private insurance as % of total health spending	3%	3% (2013)	2.2%
Private-out-of-pocket as % of total health spending	28.8%	30.7% (2013)	13.9%
<b>Organisation of the healthcare system (2)</b>			
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		
<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	3		

Sources: (1) OECD 'Health expenditure indicators' DOI: 10.1787/data-00349-en, OECD: DOI:10.1787/health\_glance-2015-graph156-en, Eurostat healthcare expenditure by financing agent (2) Joint Report on Health systems (2010), HEIDI WIKI and EuroHealth Consumer Index 2012; (3) EuroHealth Consumer Index 2012.

**Table 3.3 Corruption in healthcare perception in Greece**

<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>			
	2011*	2014**	EU average**
(% of respondents agree - Eurobarometer)	75%	81%	33%

Sources: \* Special Eurobarometer 374, table QC4 (fieldwork September 2011); \*\* Special Eurobarometer 397, 2014 (fieldwork February - March 2013), Annex IV.

**Table 3.4 Corruption Perception Index (CPI), Greece**

Corruption Perception Index	
	2016
Score	44*
Rank	69***

Source: www.transparency.org; \* CPI score is based on a scale ranging from 0 to 100, a score of 0 indicates a country is perceived as very corrupt and a score of 100 indicates a country is perceived as very clean; \*\* the 2012 CPI ranked 174 countries, where a lower rank indicates a cleaner country; \*\*\* the 2016 CPI ranked 176 countries, where a lower rank indicates a cleaner country.

### 3.1.2. Risks and obstacles

Within the Greek healthcare system many risks and obstacles exist, which all increase the opportunities for corrupt and/or fraudulent behaviour.

#### *Underfunding and no clear and predictable budget allocation between hospitals*

Underfunding of the Greek healthcare sector is a large problem, which is also considered one of the main causes of corruption. Between 2010 and 2014, the public funding on healthcare decreased from 70% to 60%. In contrast, the private funding increased from 30% to 40% and private payments increased from 27% to 35%.<sup>[5]</sup> The share of healthcare expenditure in household consumption rose from 5.3% in 2010 to 5.9% in 2014, while in the same period total household consumption fell by 24% as a result of the crisis. The increase in private expenditure was mainly the results of changes in the reimbursement rule for pharmaceuticals; the OOP<sup>7</sup> contribution has increased, and at the same time, the number of medicines on the reimbursement list has declined. It is estimated that patients' part in pharmaceutical expenditure increased from approximately 12% to 31% between 2010 and 2014. This is particularly problematic for the chronically ill and pensioners.

In addition to underfunding, the resources available are not allocated efficiently. There is one general budget for the healthcare sector, but this budget is not divided between hospitals or between specific departments within a hospital, e.g. cardiology. According to multiple interviewees, it is not transparent how the money is spent and the system does not provide any incentives to spend the money efficiently. For example, a physician does not have a budget available to cover for equipment or devices required – he is free to choose how much he spends on these items and the costs will be covered by the hospital. As a result, efficient spending does not have priority for the physician; he / she will be refunded anyway.

Closely linked to the underfunded system, are the low salaries of physicians. Although salaries have always been low, they have decreased further during the crisis. Since the crisis, salaries have been cut by 30%. On average, a physician earns 1,200 – 1,500 Euros per month. The salaries do not depend on the medical discipline or the physician's productivity. As a result of the low salaries, physicians seek different ways to increase their income. Examples mentioned by the interviewees include:

- Asking patients for additional payments (under the table payments);
- Declaring more hours than that they have actually worked;
- Asking for money / gifts / sponsorships from providers.

#### *Overcapacity of physicians*

Another big problem in Greece is the large number of physicians. This is also highlighted in the recent publication on Health Care and Long-term Care Systems & Fiscal Sustainability (2016)<sup>8</sup>: in 2013, there were 629 physicians per 100,000 inhabitants in

<sup>[5]</sup> See press release Hellenic Statistical Authority (31 March 2016).

<sup>7</sup> OOP = out of pocket.

<sup>8</sup> Joint Report on Health Care and Long-Term Care Systems & Fiscal Sustainability Volume 2 Country Documents, Institutional paper 037, October 2016.

Greece, while the EU average was 344 per 100,000 inhabitants in that same year. There are more physicians – particularly medical specialists - than the system needs and, as a result, the competition among physicians is high. Although some physicians have moved abroad, the number of available physicians is still high, especially compared to other countries. As a result of the overcapacity, salaries (public physicians) and earnings (private physicians) are under pressure and decreasing. In order to increase their income, physicians are more willing to accept informal payments, declare more hours than actually worked, or ask providers for money, gifts or sponsorships. In addition, specifically within the private sector, there are also cases of avoiding tax payments in order to increase earnings.

### ***Lack of a functioning primary care system***

A major problem in the Greek healthcare system is the lack of a well-functioning primary healthcare system. Currently this is almost non-existent, especially in the larger cities. In rural areas there is a form of primary care. In the larger cities, patients go straight to a hospital outpatient or emergency department to receive care. For example, emergency care is used to obtain access to a hospital bed, even when the patient is not in acute need of medical assistance. One interviewee noted that effectively the bed goes to the highest bidder, or to the patient with the best hospital connections, not the patient in most acute need of care.

In the past, several attempts have been made by the Greek government to re-introduce the primary healthcare system. However, so far these attempts have failed. In the attempts, no links were created between primary care and hospitals, and primary care is therefore a standalone system. In April 2017, the Ministry of Health announced new reforms for the primary healthcare system, which will introduce primary healthcare services at both the first and second level, as well as a gatekeeping system. At the first level, services will be provided by Local Health Units (ToMY) and private practices that are contracted by EOPYY. At the second level, health centres will provide services<sup>9</sup>.

### ***Unqualified hospital managers***

The interviewees indicated that they have a strong impression that hospital managers are often not the most capable or suitable persons for running a hospital. The political affiliation of the hospital manager appears to be more important than his / her managerial skills or knowledge about the healthcare system. This leads to inefficient hospital management, a lack of budgetary control and wrong decision-making. The joint report on Health Care and Long-term Care Systems & Fiscal Sustainability (2016)<sup>10</sup> notes that progress has been made in this area, however *“the system has not fully succeeded in isolating political interventions from decision making”*.

### ***Unstable political climate***

It is important to keep in mind that political cycles are very important in shaping (long-term) policies to fight corruption. As several of the main risk factors for corruption in healthcare in Greece are fundamental issues in the healthcare system (as described in this Chapter), long terms plans and structural reforms to the system are essential in the fight against this problem. This has, for the last few years however, been complicated by political instability and frequent shifts in power. When the political climate is stable, changes to the system can be made. However, when the political climate is unstable, as it has been in Greece

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<sup>9</sup> Online Health Systems in Transition (HiT) profile of Greece – updated on 01/06/2017. <http://www.hspm.org/countries/greece09062014/livinghit.aspx?Section=5.1%20Physical%20resources&Type=Section>.

<sup>10</sup> Joint Report on Health Care and Long-Term Care Systems & Fiscal Sustainability Volume 2 Country Documents, Institutional paper 037, October 2016.

in recent years, it is likely that not much structural reform will or can happen. In addition, the fact that the Minister of Health in Greece has changed quite frequently has also led to political instability; during the last 7 years, 6 different people have been Minister of Health. The frequent changes of power imply that policies are mainly focused on the short term; not many long-term plans are developed, as they are politically not feasible.

### ***The disciplinary board***

When physicians are caught asking for bribes they face a hearing with the disciplinary board. This board predominantly consists of other physicians. Interviewees estimated that, in approximately 90% of cases, this disciplinary board drops the charges against the physicians and lets them go without punishment. There are, however, no official numbers available to support this claim. Physicians are also allowed to return to the same position they were working in before being caught. Some stakeholders pointed out that the signals given by the board are counterproductive as they indicate that a physician can get away with requesting a bribe. In addition, it discourages patients from reporting such incidents, and sometimes even makes them fear for their own or someone else's health.

### ***Lack of reporting and control***

It is difficult to detect corruption in the Greek healthcare system, as patients are naturally unwilling to report bribes or other forms of corruption. People tend to not talk about this problem as they are usually in a state of dependency. If people are willing to talk, they can file a complaint/report (either in person or anonymously) via several phone numbers that have been established for the purpose. There are some whistleblowing systems in place in Greece, but the available systems are rather vague and complicated. Since 2013, no new whistleblowing systems have been developed. This is partly because Greece has 'complicated' whistleblowing laws. For example, the 'double-edged-sword' laws (saying that the corruptor and corrupted are both criminally liable) discourages people to report. In addition, it appears that the institutions behind these phone numbers generally fail to take adequate action.

Officially, an anti-corruption bureau has been established which is also tasked with fighting corruption in the healthcare system. One stakeholder however mentioned that, to date, not much progress has been made.

In addition, the Greek legal system is very complicated, especially in terms of the Penal Code. Based on the Penal Code, physicians could be prosecuted for taking bribes, however this is rarely done. It should also be noted that it takes a considerable time before a final verdict in a criminal case is obtained. It can easily take 10 – 15 years before the case comes to a final conclusion. This lack of capacity within the judicial system creates big risks; it sends out a signal that there is a very real chance that corrupt behaviour will go unpunished. It is important to note that this is not a problem of capability; the judicial system is considered one of the least corrupted powers in Greece as it manages to maintain a certain degree of independence.

Finally, there is no political willingness to actively prosecute corruption. In a recent case, evidence was collected showing that 225 Greek physicians were involved. All these physicians appeared on the pay-roll of the company; however, prosecution of the case has progressed very slowly. Early in 2016, it was announced that a court case was being prepared, but to date (August 2017), only three doctors (all orthopaedic surgeons) have been convicted of bribery and embezzlement of 2 million EUR. Although all received a prison sentence, none of them went to prison as the sentences were on probation. The three doctors maintain they are innocent.<sup>11</sup>

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<sup>11</sup> <https://www.vice.com/gr/article/wn9b8m/giatroi-apo-thn-8essalonikh-katadikasthkan-gia-to-skandalo-depuy>.

### ***Cultural aspect***

A final, but not to be overlooked, risk for (petty) corruption is the cultural aspect. Physicians, and other public officials, requesting a bribe for (privileged) access or better quality treatment is considered accepted practice. This can create insecurities among patients about what will happen if they refuse to pay. Moreover, people sometimes also consider it normal to make informal payments as a way of thanking the physician.

#### **3.1.3. Types of healthcare corruption**

In Greece, many forms of corruption exist. The main forms reported during the fact-finding mission were:

- Informal payments;
- Double practice;
- Improper marketing;
- Corruption in procurement;
- Clientelism;
- Overcharging by technical services;
- Induced demand.

It should be noted that the latter three types of corruption / fraud are not the focus of this study; however, these types were mentioned multiple times during the interviews.

#### ***Informal payments***

Informal payment is still seen as the most prevailing type of corruption in Greece. The perception is that the problem of under-the-table payments has increased over the years. This is partly due to the declining salaries of physicians. In addition, the use of public hospitals has increased, as people no longer have the money to pay for private hospitals. It is this combination of increased demand and decreased salaries that has resulted in an increase in physicians asking for informal payments for better quality and/or quicker access to healthcare services. This is aggravated by the fact that there are still no transparent waiting lists in Greece. One speciality where typically a lot of money is paid under the table is surgery. The exact amount of the payment depends on the level of complexity of the surgery as well as the organ/part of the body that is operated on (the highest payments are made for heart or brain surgery).

Although informal payments have increased, they also have become less visible. Often the physician will not ask explicitly for a payment, but will use other means of making clear that a payment is required. Some of the interviewees mentioned that that the physicians will create insecurity for the patient in order to force him / her to pay.

##### ***Insecurity on who is going to perform surgery***

When someone needs surgery, a physician might tell the patient that not he but his assistant will perform the surgery as his own schedule is fully booked. The patient will become insecure because he/she wants the surgeon himself to operate. The patient will start offering bribes to get access to this higher quality of care. Creating such insecurity is an important cultural aspect.

Informal payments are not only made to physicians; they can also be made to other personnel, e.g. nurses often receive a gratuity for small favours offered. Nurses also receive payment for securing hospital beds.

##### ***Bribery for hospital beds***

Stakeholders mentioned that heads of departments typically have the 'right' to reserve approximately 3-4 beds for themselves, to allocate to patients as they wish. Other physicians typically have 1 or 2 beds. This is an 'unwritten law' in hospitals and facilitates the preferential treatment of patients based on informal relations or payments. In addition, there is an interconnection between staff, such as nurses and physicians, which

makes the problem even worse. For example, people may pay a nurse or have a nurse in their family, who can then ask the physician to reserve a bed for them/provide more immediate treatment.

It is also important to note that bribery, or corruption in general, is not only a problem in the public sector. There is also a black economy within the private sector. In the private sector, a patient is often offered a discount when he/she agrees not to receive a receipt for payment of the treatment. In such cases, the physician is able to generate non-taxable income.

### ***Double practice***

The problem of double practice is a relatively new problem in Greece. Until some years ago physicians in hospitals used to be employed fully as civil servants. As a consequence, they were not allowed to work in the private sector as well. Currently, some physicians have other types of contracts, which allow them to work, under conditions, in both the public and private sector. Moreover, some public physicians (still being civil servants) are also illegally active in the private sector.

Corruption in the context of double practice works as follows: the patient will visit the private clinic, where he/she will pay the physician under-the-table in order to get to the top of the waiting list when applying in the public hospital. Once on top of the list, the patient will be treated in the public facility. Hence, informal payments are made for preferential access through another route.

### ***Improper marketing***

Despite the fact that direct sponsorship is allowed under Greek law, the larger medical device manufacturers and distributors aim to prohibit direct sponsorship. However, as was pointed out by the medical technology association in Greece (SEIV), only the members of the association, who will adopt the new MedTech Code (expected in second half 2017), will be bound by the prohibition. Many smaller companies are still allowed to offer direct sponsorship, something that is willingly accepted by physicians, for whom little educational budget is available. Although direct sponsorship is legally allowed, several larger companies do perceive it as unethical behaviour, which should be stopped.

### ***Corruption in procurement of medical devices***

In Greece, multiple cases of corruption within public procurement processes for medical devices and pharmaceuticals have occurred. In order to combat this problem, the Greek government established a central procurement body that is solely responsible for procurement. However, this body is not functioning well, with the result that hardly any big tenders are procured. As hospitals still need their supplies, they tend to buy devices and products themselves, tendering them in smaller quantities, so that the procurement rules do not apply. This, in turn, provides risks and opportunities for corruption.

### ***Clientelism***

Hospital managers are often not the most capable manager or physician, but are political appointees. The political affiliation of the hospital manager is more important than work experience and knowledge of the sector. As a result, hospital management becomes ineffective, budget control is lacking and wrong decisions are taken.

### ***Overcharging by technical services***

Although not directly linked to the types of corruption elaborated on in this study, the problem of overcharging of certain hospital related services was mentioned during the interviews. All hospitals have internal technical services and these technical services are typically overcharging hospitals for the work/repairs they are doing.

**Overpricing of technical services during the crisis (2012)**

An anecdote shared related to a hospital where the technical service division charged 15,000 Euros for a simple maintenance job, while a quotation from an outside company (requested on an own initiative by a cardiologist in the hospital) was only 1,500 Euros. This means the technical services were overpricing by factor 10.

***Induced demand***

Another form of corruption mentioned that does not fall under the scope of this study, but was mentioned during the field mission, was the case of induced demand. Often physicians seem to prescribe fake prescriptions. Such prescription can take different forms:

1. Overcharging of medicine prices;
2. Prescribing medicines that are not actually needed;
3. Prescribing medicines that are not delivered to the patients.

This latter category can also be an indication for parallel export.

Another type of induced demand relates to the hospitalisation of patients. In some cases, the patient did not have an overnight stay in the hospital and consequently, the costs of hospital admittance are falsely claimed. In other cases, the patient was admitted to the hospital, however more nights are claimed than that the patient actually stayed. While undue charges and prescriptions are thus a big problem in Greece, none of the interviewees mentioned the use of fake patients, i.e. all undue charges were made for patients actually treated.

An important cause of induced demand is the information asymmetry between patients and healthcare providers. Induced demand is also caused by broadly defined contracts that leave room for interpretation. At the time of the fact-finding mission, new contracts are under negotiation and were expected to be in force as of Q2 2017.

**3.1.4. Recent cases**

During the fact-finding mission several cases were mentioned. These cases received media attention and were debated in Greek society. It should be noted that little to no investigation and/or prosecution in those cases was undertaken.

**Pharmaceutical company: suspicion of bribery of physicians and public officials<sup>12</sup>**

In January 2017, it was reported that the Greek Authorities had raided the office of a pharmaceutical company in Athens, Greece. The company stands accused of bribing physicians and public officials in order to increase their market share on the Greek pharmaceutical market.

The investigation is based on reports received through hotlines. Media reports indicate that at least 4,000 public and private physicians are involved in the scandal. The company exerted pressure on the physicians to buy innovative and expensive anti-cancer drugs. The company's executive in Greece attempted suicide on New Year's night, which fuelled further suspicions.

Officials indicate that the scandal is not only related to Greece, but that physicians in other countries are also involved.

**Medical service provider: suspicion of bribery of hospital staff**

In this case hospital employees, who were part of the procurement decision process, were bribed by a company specialising in medical equipment to favour tender processes and the purchase of medical equipment to the benefit of the accused. The investigation revealed that the company paid a wide array of medical staff, from nurses and midwives, operating theatre chiefs, through to physicians, professors, and hospital directors.

The proceedings included cases that took place between 2001 - 2006 and were conducted in multiple countries. The bribes were disguised as fictitious services provided by the physicians for employees of the company (for example, training, symposiums, and overpaid consultations) in exchange for money. In

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<sup>12</sup> <http://mobile.reuters.com/article/idUSKBN14O156>.

exchange for the bribes, the physicians were encouraging other physicians to become interested in purchasing the company's equipment and they tried to qualify the highest number of patients for procedures, which influenced the sale of the specific medical equipment. Apart from these activities, the company sponsored physicians' trips to symposiums and training events.

In several countries, e.g. Poland and the US, the involved people have already been brought before court. In Greece, the investigation is still pending, although investigative authorities found evidence that shows that 225 Greek physicians were involved. All these physicians appeared on the pay-roll of the company; however, none of the physicians has been punished to date. Early in 2016, it was announced that a court case was under preparation, but only eight physicians seem to have been brought to court. Shortly after this announcement, it was communicated that the court case was postponed indefinitely. Proceedings resumed on May 8th 2016, however, only three doctors (all orthopaedic surgeons) were convicted of bribery and embezzlement of 2 million EUR. Of the three, two received sentences of 11 years each and the third doctor received a sentence of 14 years. However, they are all free as the sentences were on probation, with the first two doctors free on a bail of 10 000 EUR each and the third with 15 000 EUR bail. They maintain they are innocent.<sup>13</sup>

#### **Corruption with reimbursement of healing dressing (2016)**

A big scandal recently uncovered by YPEDYFKA (investigative unit of EOPYY – the sole payer in Greece) related to the reimbursement of healing dressings used for ulcers. The e-prescription system (introduced to control medical expenditure on medicines) helped YPEDYFKA to uncover this type of corruption. Based on the data included in the system, it became clear that many more healing dressings were prescribed and against higher prices than were included in the price list (which sets the maximum price for different medicines).

In order to receive reimbursement from EOPYY, it was required to upload a photo of the specific ulcer into the e-prescription system. Based on a photo comparison, YPEDYFKA established that some photos were used multiple times, even by different physicians. Hence, the claims for reimbursement were based on fake medical services. After thorough investigation, it turned out that around 1,000 physicians were involved in the scheme.

This case received much media coverage. The physicians involved received a fine, which most of them have already paid. It was easy for YPEDYFKA to collect the fines, as EOPYY owned the physicians money (i.e. the reimbursements). The fines were subtracted from that amount. EOPYY has also decided to decrease the reimbursement for the healing dressings as a result of this scandal.

### **3.1.5. Recent policy developments<sup>14</sup>**

Recently, different policies have been adopted. Some of the policies have been adopted by the central government, other by individual bodies (e.g. EOPYY) and some by the industry. The level of success differ widely.

#### **Policies by public authorities**

##### ***The anti-corruption strategy***

In 2013, the Ministry of Health published its anti-corruption plan, which specifically focuses on the healthcare sector. This plan had to be written as part of the structural reforms needed to help Greece out of its economic depression. All measures included in the plan aim to fight corruption in the Greek healthcare system. However, it is unclear if the plan was actually implemented. Many of the stakeholders doubt the effectiveness of the plan and indicate that it is just another document that seems to have ended up in the drawer.

##### ***Prescription of active substances / generics***

The Greek government adopted an initiative in which physicians are no longer allowed to prescribe a specific brand of medication. The attempts to increase generics have not been very successful; penetration of generics is still relatively low in Greece (approximately 20%). The policy that physicians can only prescribe the active substance rather than a branded pharmaceutical shows some promise in promoting generics. However, to date, no

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<sup>13</sup> <https://www.vice.com/gr/article/wn9b8m/giatroi-apo-thn-8essalonikh-katadikasthkan-gia-to-skandalo-depuy>.

<sup>14</sup> At the time of the fact-finding mission, i.e. early February 2017.



results have been obtained, and it is therefore difficult to indicate whether or not this new policy is successful.

### ***Price observatory for medical devices***

The government introduced a price list – the Price Observatory – which presents the maximum prices for different types of equipment/devices. These maximum prices are based on the lowest price that was paid for such a device/piece of equipment in Greece in previous years. This observatory also records the prices from other EU Member States, and devices cannot be sold in Greece for prices higher than paid for the same devices in other EU countries. Whether or not this observatory list is successful is debated among the stakeholders interviewed. Some see a clear value added by the list as it helps to combat corruption, while others think the list, in its current form, takes away all possibilities for competition and forces companies into a deadlock situation. Also, the list does not allow for price differences based on geographical differences. For example, delivering equipment in Athens is cheaper than on one of the smaller islands (as a result of higher transport cost).

### ***E-prescription system***

The e-prescription system is seen as a good practice by many stakeholders. A first attempt to introduce such a system was launched in 2003. At that time, the system was filled with scanned prescriptions, which were included in one overall database. Between 2003 and 2010, not much happened and the system was not very active. In 2010, a new format for e-prescriptions was launched and this system has been actively rolled out since 2012. The introduction has been gradual, starting with medicines (which now have 100% coverage), and followed by other healthcare services. These days it covers all kinds of healthcare services (e.g. hearing aids, glasses, lab tests and hospitalisation). Currently more than 26,000 medical service providers are included.

### ***Online patient health records***

A few years ago, EOPYY introduced the so-called patient health records, which are available online. For each patient, a record is made which provides insights into the care received, in terms of both services and medicines. The patient can check the status of this record and when the patient detects an irregularity, he/she can report this to YPEDYFKA, who can then begin an investigation. In this way, the patient records help to reduce fake prescriptions as the patient can check whether or not the records are actually true. It is unclear at the moment to what extent the system is used by patients. There is, however, the expectation that patients have the incentive to use the system as they are becoming increasingly suspicious, mainly as a result of the crisis.

### ***Price list for medicines and hospital supplies***

The price list for medication is quite new and easy accessible. However, it is not known whether elderly patients are able to check this list, as it is only published online. It is also not known whether patients check this list before going to the physician. Nevertheless, it is noted that patient awareness of costs and prices has increased during the last couple of years. In addition, patients are becoming more critical and suspicious towards physicians, especially regarding what they prescribe. This has also led to an increase in complaints from patients.

EOPYY has also introduced its own price list. This price list is meant for hospitals and indicates to them what the regular prices are, for certain supplies. The enforcement of this list will be done by SEYP, who are responsible for the control and monitoring of hospital expenditures.

### ***Disease register***

EOPYY recently introduced registries for certain diseases. In each registry, it is laid down who is suffering from a particular disease, what medication is prescribed and how far advanced the disease is. An example of such a registry is the registry for hepatitis. The registry can help to check how money is spent also how much money is spent. It will enable authorities to assess whether the money is being correctly spent and make prognoses for future costs, which is very useful for negotiations. It is the intention of EOPYY to expand this system and include more diseases into it.

### ***Change in reimbursement rules***

Another new policy introduced by EOPYY relates to the new rules on reimbursement. EOPYY will reimburse the physician directly instead of reimbursing the patient (which is the current practice). The patient no longer has to pay in advance for the part that is reimbursed by EOPYY.

### **Industry related initiatives**

#### ***Adoption of the MedTech Code of Ethical Business Practice***

The Medical technology association has already translated the newly adopted MedTech Code of Ethical Business Practice. In June, a General Assembly will be held in which the association's members will be asked to adopt the Greek translation. It seems that the companies are willing to do so and it is likely that from June onwards the Code can be implemented among the members. The Code needs to be implemented by 2020 at the latest. It is likely that larger companies will also apply the Code to their distributors, irrespective of whether they are members of SEIV. As a result, the impact of the Code could reach further than members only.

A new aspect in the MedTech code is the phasing out of direct sponsorship. This is an aspect that is difficult to regulate, and currently there is much debate among members and other equipment producers / distributors on this topic. Physicians are keen on accepting direct sponsorships, especially as educational funds in Greece are very limited.

#### **3.1.6. Challenges and conclusions**

In Greece, petty corruption remains a big challenge. The problem has only increased in recent years as a result of the combination of higher demand for public healthcare and the decline in wages for physicians. Although it is a major challenge for the Greek healthcare system and society in general, it does not appear to be a priority in anti-corruption plans for the healthcare sector as there have not been many policies or initiatives to tackle (the root causes of) this problem; the problem does not seem to get the attention it needs and deserves.

One of the main problems in the Greek healthcare system is that is underfunded. Given the current economic climate and the required budget cuts, it is also one of the most difficult problems to solve. However, efficient allocation of the resources that are available would already be an important step in the right direction. The challenge for Greece is thus to strive for efficiency in allocation of the scarce resources available. The joint report on Health Care and Long-term Care Systems & Fiscal Sustainability (2016)<sup>15</sup> also acknowledges this as an important challenge for Greece. Stakeholders agree that the implementation of a functioning primary healthcare system can have an important role in this respect. By establishing such a system and giving it a gatekeeping function, self-referrals to the hospitals and admission via emergency rooms can be reduced. The recently

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<sup>15</sup> Joint Report on Health Care and Long-Term Care Systems & Fiscal Sustainability Volume 2 Country Documents, Institutional paper 037, October 2016.

announced reform of the primary healthcare system in Greece, including the introduction of a gatekeeping system, is a promising development.

Only after establishing the proper infrastructure, with qualified people in managing positions, can the focus shift to changing mentality and behaviour. As long as the healthcare system is not functioning properly and people have no trust in the system – which is currently the case – policies aimed at changing mentality will not reach their potential. For such policies, it will also be important that people are educated on, for example, how to deal with information asymmetries. This would require action from civil society organisations, which are currently not active in Greece in the field of anti-corruption in healthcare.

Another major challenge for Greece is the functioning of the judicial system. The system is currently facing major capacity constraints. As a result, cases are only prosecuted after 10 to 15 years (if at all), which sends the message that people and companies can get away with corrupt practices.

Some stakeholders believe that decent plans are sometimes developed, and relevant studies are conducted, but that there is subsequent lack of implementation. The main reasons for this are the lack of resources and, maybe even more importantly, the lack of political will to fight corruption and the unstable political climate. Because of this unstable climate, all actors in the healthcare sector are operating in a risky environment and frequent changes within the Ministry, policies and legislations make it difficult to keep up and plan ahead.

Hence, preconditions for the implementation of successful policies to fight corruption in healthcare in Greece include: implement and support recent (announced) changes to fundamental elements of the healthcare system (including the set-up of a primary healthcare system, which is currently ongoing), reforms in the judicial system, active involvement of civil society, and – very important – political stability.

Looking from a broader perspective, there have been some promising developments. For example, the anti-corruption Secretariat General at the Ministry of Justice. Although it does not deal with petty corruption – only high-level corruption – it is a good practice in itself. Moreover, the SEYYP, the Inspectorate of Health and Welfare in Greece, has been investigating cases of corruption and produces reports with their findings and recommendations. Another example of a promising development is the translation of the MedTech Europe code into Greek and the aim to implement it by mid-2017. Though there are some concerns with regard to the implementation, the fact that efforts are made to ban direct sponsorship, thereby reducing the risks for improper marketing, is an important step. Another example concerns the role and functioning of YPEDFYFKA. They have been successful in investigating a large number of cases and punishing physicians and companies for fraudulent behaviour and misconduct. A final example concerns a development, which took place after the fact-finding mission in February 2017, namely the development of an electronic anti-corruption platform to monitor informal payments. The platform is being developed by the Ministry of Health, and aims to facilitate reporting and subsequent investigation of the reports by the authorities<sup>16</sup>.

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<sup>16</sup> <http://greece.greekreporter.com/2017/04/14/greek-health-ministry-announces-e-platform-to-address-countrys-health-care-corruption/>.



## 3.2. Croatia

### 3.2.1. Overview/summary

The fact-finding missions to Zagreb, Croatia, took place from 12 – 14 December 2016. Five interviews with stakeholders from different categories were undertaken in person. An overview can be found below.

**Table 3.5 Overview of Interviews conducted in Croatia**

Date	Organisation	Stakeholder category
12/12/2016	Croatian Medical Chamber	Providers
12/12/2016	Coalition of Associations in Healthcare	Patients
13/12/2016	Ministry of Justice, Anti-Corruption Sector	Regulator
13/12/2016	Innovative Pharmaceutical Initiative	Industry
14/12/2016	Croatian Ombudsman	NGO
12/01/2017	Ministry of Health	Regulator

Furthermore, we have received answers in writing from USKOK (national anti-corruption agency) and from HALMED (regulatory agency for medicines).

### 3.2.2. General description of the healthcare system<sup>17</sup>

In 2015, Croatia ranked 16th out of 35 European countries in terms of healthcare performance in the Euro Health Consumer Index.<sup>18</sup>

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 has been delegated to municipalities and local authorities. Ownership of the hospitals is shared between the central government and local authorities.<sup>19</sup>

There is a mandatory health insurance system, and the sole insurer is the Croatian Health Insurance Fund (CHIF or HZZO in Croatian). It is a quasi-public body and is overseen by a director and board of directors who are appointed by the Croatian government, following the Minister of Health's recommendation. It is the main purchaser of health services, sets performance standards, sets prices for covered services, and handles payments for sick leave compensation, maternity benefits, and other allowances. Complementary voluntary health insurance (which involves user charges) is also provided mainly through the CHIF.

In 2013, the CHIF was funded by a combination of health insurance contributions of employers and employees (76%) and financing from the State budget (15%). Complementary financial resources are out-of-pocket payments and private health insurance. In line with the decentralisation of healthcare services, local governments increasingly contribute to the public expenditures in healthcare.

The provision of public health services is done through a network of one national institute and 21 county institutes. Although citizens are required to register with a general practitioner (GP) or paediatrician, patients often seek healthcare services directly at hospitals. At the same time, GPs do function as gatekeepers, as prescriptions can only be acquired via GPs, and payments for hospital services from the health fund are only made after feedback on treatment has been sent to the GP. There have been no attempts so far to establish integrated care pathways. Since 2013, GPs have been given financial incentives by CHIF to create group practices.

<sup>17</sup> Main source for this section is the WHO/European Observatory 'Health Systems in Transition' report on Croatia (2014).

<sup>18</sup> See <http://www.healthpowerhouse.com/en/news/euro-health-consumer-index-2015/>.

<sup>19</sup> See <http://www.hspm.org/countries/croatia30062014/countrypage.aspx>.

Pharmaceuticals are procured by the CHIF for all of Croatia. They calculate prices on the basis of three reference countries, lowered by 5%. There is reference pricing: a product below the baseline falls under category A, and above the baseline into category B. Category B involves co-payment by patients. In addition, there is a list of expensive drugs. In 2013, the essential medicines list had 3455 drugs that are fully paid for by CHIF. The additional list has 760 drugs, for which an additional payment is required. High cost medicines and orphan drugs are available through hospitals.<sup>20</sup>

There is a risk sharing mechanism in place with the pharmaceutical industry for expensive drugs. Costs of consumption of drugs in total health costs are high (20%). The main payer is the CHIF, while private insurance companies offer some additional services, such as partial reimbursement of hospital costs.<sup>21</sup>

### **Regulatory oversight**

The Agency for Medicinal Products and Medical Devices (HALMED) provides services pertaining to medicinal products, medical devices and homeopathic medicinal products, in accordance with the primary and secondary legislation of the Republic of Croatia. Its tasks include market authorisation and quality control of medicinal products, the regulation of medical devices, and monitoring of adverse reactions. It determines which drugs are reimbursed,<sup>22</sup> and has various committees whose memberships can be seen on the website.<sup>23</sup> Information about procedures and lists of approved drugs can also be viewed here, increasing transparency of the organisation's operations.

The key players in public procurement generally are the Directorate of the Public Procurement in the Ministry of Economy, Entrepreneurship and Crafts, the Ministry of Finance for concessions, the Agency for Investments and Competitiveness for PPPs, and the State Commission for the Supervision of Public Procurement Procedures. Information related to public procurement in the healthcare sector is made publicly available on HALMED's website, including the procurement plan, ongoing public procurement procedures, the registry of public procurement contracts and framework agreements.

**Table 3.6 Indicators of the healthcare system in Croatia**

<b>Indicators of the healthcare system</b>			
<b>Financing of the healthcare system (1)</b>			
	2012	2015 (or nearest year)	EU average
Total health expenditure as % of GDP	7.8%	7.8% (2014)	10%
Public expenditure as % of total health spending	81.61%	81.87% (2014)	77.8%
Private insurance as % of total health spending	-	1.4% (2014)	2.2%
Private-out-of-pocket as % of total health spending	-	11.21% (2014)	13.9%
<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)</b>			

<sup>20</sup> See [http://www.ispor.org/CeeNetwork/documents/Health\\_care\\_system\\_reimbursement\\_policy\\_croatia.pdf](http://www.ispor.org/CeeNetwork/documents/Health_care_system_reimbursement_policy_croatia.pdf).

<sup>21</sup> Ibid.

<sup>22</sup> See

<http://www.hspm.org/countries/croatia30062014/livinghit.aspx?Section=2.8%20Regulation&Type=Section>.

<sup>23</sup> See <http://www.halmed.hr/en/O-HALMED-u/>.

Indicators of the healthcare system		
Family doctor same day access	3	
Major surgery < 90 days	1	
Cancer therapy < 21 days	3	
CT scan < 7 days	1	

Sources: (1) WHO/European Observatory 'Health Systems in Transition' report on Croatia (2014), OECD Health at a Glance Europe (2016), (2) World Bank healthcare statistics, Eurostat healthcare statistics, European Commission (2016), Joint Report on Healthcare and Long-Term Care Systems and Fiscal Sustainability.

### 3.2.3. Risks and obstacles

A broader issue with regard to corruption in healthcare relates to the politicisation of Croatian public institutions – not only in healthcare, but also in the media. An artefact of the old communist era is that when the political colour of the government changes, the leadership in the healthcare sector (and other public institutes) also changes. The governing party replaces, for example, hospital directors and the director of the CHIF. This type of behaviour (political appointees) is regarded as 'normal' behaviour by society.

In addition, the system is such that personal interests can play a big role. For example, an association can be founded with just three citizens, so if there are conflicts within an organisation, this is sometimes solved by establishing another organisation. This leads to inefficiency and ultimately runs the risk of having personal interests prevail over public interests. Furthermore, as Croatia is a small country, there are only about 10-15 people that are key experts in their field and these are, because of their expertise and status, subject to less strict scrutiny by the general public.

On the healthcare system in general, there are concerns that the quality of healthcare provided is not equal among all healthcare providers, and that there is too much focus on healthcare in the capital Zagreb (and urban areas) to the detriment of healthcare in other regions of the country, especially the Croatian islands. There is no national accreditation programme of hospitals, there is no systematic data available on the quality of healthcare services, and there is no clear performance indicator system in place.

Structural challenges for Croatian healthcare are further related in the National Health Care Strategy 2012-2020<sup>24</sup> and concern:

- the strengthening of the connections and continuity throughout the healthcare system (organisation of care);
- standardising and improving the quality of healthcare;
- increasing efficiency and effectiveness of the healthcare system;
- making health care more available and improving health indicators.

The risks of corruption are – to some extent – inversely related to the performance on meeting these challenges.

**Table 3.7 Corruption in healthcare perception in Croatia**

Corruption in healthcare perceptions			
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?			
	2011*	2014**	EU average**
(% of respondents agree - Eurobarometer)	-	56%	33%

Sources: \* in 2011 Croatia was not part of EU(27); \*\* Special Eurobarometer 397, 2014 (fieldwork February - March 2013), Annex IV.

<sup>24</sup> See

<https://zdravlje.gov.hr/UserDocsImages/dokumenti/Programi,%20projekti%20i%20strategije/National%20Health%20Care%20Strategy%202012-2020.pdf>.

**Table 3.8 Corruption Perception Index (CPI), Croatia**

Corruption Perception Index	
	2016
Score	49*
Rank	55***

Source: [www.transparency.org](http://www.transparency.org); \* CPI score is based on a scale ranging from 0 to 100, a score of 0 indicates the country is perceived as very corrupt and a score of 100 indicates a country is perceived as very clean; \*\* the 2012 CPI ranked 174 countries, where a lower rank indicates a cleaner country; \*\*\* the 2016 CPI ranked 176 countries, where a lower rank indicates a cleaner country.

### 3.2.4. Types of healthcare corruption

In 2013, 94% of Croatians indicated that corruption is widespread in their country.<sup>25</sup> Paradoxically, this may be because of the success of Croatia's Bureau of Suppression of Corruption and Organised Crime (USKOK) in prosecuting high-level officials, cases that feature prominently in the media. In addition to complementing USKOK's achievements, Croatia was complimented by the European Commission for its creation of an electronic database for public procurement, increasing transparency. In 2015, Croatia ranked 50th on the TI Corruption Perceptions Index rank listing of 168 countries.<sup>26</sup>

There is a difference between the perception of corruption and corruption in practice. The media play an important part in increasing the perception of corruption – i.e., some cases are given lots of emphasis in the media, even if it is an old case. This is not to say that there is no corruption, however due to underreporting of corruption and the focus of attention on certain cases in the media, public views on corruption in healthcare are not necessarily aligned with the scope and affected areas.

#### *Double practice*

In Croatia, it is not possible for physicians to hold a private practice in public hospitals, but physicians can work in both public and private hospitals (double practice). In the old system, the Minister of Health needed to approve a licence for a physician willing to work in private practice. A new rulebook with regard to double practice was adopted last year. In the new (current) system, a physician needs approval from the hospital director where he/she works in order to work in a private practice as well. In addition, the physician must prove that the work at the public hospital is at least at the level of the national average, or else a physician cannot even apply for a private practice license. Finally, the private practice needs to sign a contract with the public hospital, specifying the exact number of hours and services to be performed by the physician. A private practice that employs public sector physicians cannot have a contract with the CHIF; these costs can only be paid out of pocket by a patient.

Double practice is considered a problem, because the physicians working in private clinics do not have enough energy to perform their work properly at the public hospitals. People prefer private hospitals because they are quicker and more efficient. This may be problematic with regard to equal access. Stakeholders, however, support the combination of public and private healthcare, and some even argued that having private practice could lower waiting lists in public hospitals.

From 2002-2004 there was a strong media campaign against double practice. At that time, the accusations may have had some merit: two physicians that tried to avoid working in the public hospital were caught in 2002. Today, changes have been made, for example through the implementation of the DRG (payment) system, and the CHIF maintains a

<sup>25</sup> See Special Eurobarometer 397, [http://ec.europa.eu/public\\_opinion/archives/ebs/ebs\\_397\\_en.pdf](http://ec.europa.eu/public_opinion/archives/ebs/ebs_397_en.pdf).

<sup>26</sup> See Transparency International Report here [http://www.transparency.hr/upload\\_data/site\\_files/corruption-perceptions-index-2015-report.pdf](http://www.transparency.hr/upload_data/site_files/corruption-perceptions-index-2015-report.pdf).



register where it is easy to check whether a double practice physician performed the procedures to be reimbursed by the CHIF.

### ***Informal payments***

In Croatia, three factors play a role with regard to the issue of bribery for medical services. Firstly, there is a historical heritage of communism, where it was common to express gratitude to physicians. Secondly, Croatia was always a part of a bigger country unit (Austro-Hungary, Yugoslavia), so there was a general predisposition to avoid taxes (they are now working to change this attitude.) Thirdly, Croatia is part of the Mediterranean cultural circle. If you go to a friend's place, it is the norm that you bring a box of chocolates, or a bottle of wine.

Interviewees stressed the fact that it is important to make a distinction between a gift and a bribe. For a long time it has been common to bring a bottle of spirits or some coffee when visiting a physician, which is perceived as a small gift just to show appreciation. Bribery takes place at the level of politicians, and involves much bigger gifts, according to several interviewees. However, this practice may lead to problems as it is blurring the lines between (more or less 'acceptable') gifts and straightforward bribes. The cultural habits are, however, different from country to country.

Gifts to physicians are becoming less common. The culture is changing, also because attention is paid to the risk of corruption during medical education. In addition, it is now regulated through the Conflict of Interest Act. This cultural change has taken place in society over the last 15 years.<sup>27</sup>

### **3.2.5. Recent cases**

#### **Case 'X affair' – bribery between a pharmaceutical company and physicians**

USKOK provided the following facts and figures about the 'X affair' (2013). In the X affair, 364 physicians and a pharmaceutical company were indicted for having committed several criminal offences – associating to commit criminal offences, taking and giving bribe, abuse of power and authority, and instigating the abuse of power and authority. The 1st accused person was the Management Board president of a pharmaceutical company, the 2nd accused person was the executive director of corporate affairs and director of controlling of the company sales, whereas the 3rd accused, 4th accused and 5th accused were regional directors of certain sectors. They were indicted for the criminal offence of bribing a large number of physicians and pharmacists between 2009 and October 2012 to achieve the highest possible sales rates for certain drugs. They established and managed a continuous connection of larger number of physicians and pharmacists in the Republic of Croatia who received bribe from the pharmaceutical company.

Bribes were provided in the form of value tickets, money, paid travel arrangements on behalf of the pharmaceutical company, as well as other gifts in the value of five to ten per cent of the value of prescribed drugs.

Final convicting judgments have been rendered for 313 persons (of which 297 are physicians and 16 are 'other' persons - veterinarians, pharmacists etc.). Most persons pled guilty to avoid lengthy procedures. It concerned mostly low-level cases.

These prosecuted persons have also been taken up by the independent disciplinary Court of Honour of the Medical Chamber. This Court can proclaim a physician to be unworthy to practise. Two penalties are possible: lose your license with probation, or lose your license without probation. Some 277 trials were completed during the last six months. There were 267 penalties of physicians losing their license with probation. Only three physicians lost their license without probation, and 6 physicians have been cleared.

Between 2014 and 2015 there was only one other formal case, and this concerned a disciplinary affair. In the Court of Honour there are two types of procedures: one to determine whether one can still practise medicine, the other concerns a disciplinary

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<sup>27</sup> The turning point was when, 15 years ago, some 10 doctors were discovered to provide false disability testimonials in return for money.

procedure. The first is mandatory, the other is not. The one case referred to above was also about a bribe, and was reported by another physician, who referred him to the disciplinary procedure.

Furthermore, from the interviews it became clear that there has also been a hospital which changed the medicines for a chronic patient group without a clear reason (such as quality or cost). This was done because the hospital director had made an agreement with a pharmaceutical company to prescribe a specific type of drug. However, this never became a big case in the media.

### **3.2.6. Recent policy developments**

#### ***Healthcare***

Whereas reforms between 2006 and 2013 focused on financial stabilisation of the healthcare system, reforms between 2014 and 2016 focused on preserving financial stability and increasing efficiency in the sector.

An important change is that Croatia has had a unified public procurement in place since 2013. Before 2012, some hospitals paid up to four times as much for identical products. Access to the same level of service and quality of products was not guaranteed, even though there is one national health insurance scheme.<sup>28</sup> Nowadays, one specific hospital acquires a certain product/service for all of Croatia. The government appointed 9 state-owned hospitals and the Croatian Health Insurance Fund (CHIF or HZZO) as central authorities, responsible for the procurement of a range of products. Joint procurements were widely challenged by manufacturers through legal means, but this has generally been unsuccessful. The estimated savings from the concluded joint tenders up to February 2014 were EUR 59 million or about 27%, compared to prices paid before the introduction of joint procurement.<sup>29</sup>

A more fundamental change occurred as of 1 January 2017, when the Parliament adopted a new procurement law, which replaces 'lowest cost' with 'economic price', which also takes into account actual quality as the main evaluation criterion. As part of the "economic price" criterion, the relative consideration of price or cost cannot be higher than 90%. In the negotiated procedure without prior publication, framework agreements, the awarding of Social and other specific services, and procurement for defence and security, that percentage can be higher than 90%. The recommendations from health technology assessments are included in the procurement.

In 2014, Croatia applied for a World Bank loan to introduce a number of reforms to its healthcare sector. Under the identified priority of 'preserving financial stability of healthcare', it lists reducing corruption and informal payments.<sup>30</sup> The latest World Bank progress report states that Croatia's reforms are beginning to yield results.<sup>31</sup> At the same time, the overall risk rating remains 'moderate'. Better measurement of progress and communication of the reforms (to key stakeholders) would contribute to strengthening reform momentum.

In 2015, the CHIF was separated from the State Treasury to improve health protection and reduce waiting lists.<sup>32</sup> This boosted the public healthcare budget by 2.2bn Croatian kuna

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<sup>28</sup> See <http://www.lse.ac.uk/LSEHealthAndSocialCare/pdf/EuroHealthVol20No2.pdf>, in particular Table 1 (on p.30).

<sup>29</sup> Ibid., p.32.

<sup>30</sup> See <http://documents.worldbank.org/curated/en/2014/04/19416051/croatia-improving-quality-efficiency-health-services-project> and Article19(vii) in underlying document.

<sup>31</sup> See [http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/ECA/2015/10/24/090224b08316908b/1\\_0/Rend ered/PDF/Croatia000Heal0Report000Sequence005.pdf](http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/ECA/2015/10/24/090224b08316908b/1_0/Rend ered/PDF/Croatia000Heal0Report000Sequence005.pdf).

<sup>32</sup> See <https://about.hr/news/croatia/healthcare-system-gets-hrk-22-billion-more-2015-4259>.

(approximately EUR 91 million).<sup>33</sup> A new financing scheme for hospitals has been introduced, aimed at achieving savings and to promote functional integration of hospitals that have unsustainable financial positions.<sup>34</sup> However, implementation of the reforms has not proceeded apace.<sup>35</sup>

A process to draft a new healthcare law was started about two years ago, and would have changed, amongst other things, the position of hospitals. However, due to frequent changes in government over the past few years (and resulting changes in preferences for what the new healthcare law should address), the process has stalled, and no new law has been introduced (or even drafted) yet.

### ***Anti-corruption***<sup>36</sup>

Croatia has a dedicated anti-corruption unit involved in prosecuting cases, that is called USKOK,<sup>37</sup> operates under the State Attorney's office, and a dedicated sector under the Ministry of Justice,<sup>38</sup> which is responsible for developing anti-corruption policies and coordinating anti-corruption initiatives between various governmental actors and other stakeholders. The Sector (Ministry of Justice) has about 3.5 FTE and has been operating for the last three years.

In 2015, an anti-corruption strategy was adopted by the Croatian Parliament, and yearly action plans to implement it have been developed. The anti-corruption strategy includes a chapter about health, which proposes transparency improvements in terms of gifts to physicians, enforcement of the legal framework, strict surveillance of public procurements, and waiting lists, and also includes measures to increase the trust between physicians and patients, shorten waiting lists, improve efficiency in the healthcare sector and improve the satisfaction of patients and employees.

None of the health actions have been fully implemented, and only a few have been partially implemented. The action plan for 2017-2018 needs to be adopted, and consultations between the Ministry of Health and the anti-corruption sector of the Ministry of Justice have already taken place. Although the proposed measures in the area of health are quite good, the proposed actions to implement these measures are not very satisfactory to the sector.

As the responsible policy-unit, the anti-corruption sector of the Ministry of Justice asks the relevant (government) stakeholders (e.g. Ministry of Health) to carry out an analysis of risks and problems regarding their own sector; and these serve as inputs for the action plans.<sup>39</sup> The different corruption themes from the 2013 Study on Corruption in Healthcare overlap to a large extent with the ones in the Croatian anti-corruption strategy.

The Ministry of Justice collects quarterly monitoring reports from the various stakeholders, who need to report progress with regard to the measures in their action plans. These monitoring reports go to the Council for Anti-Corruption, a monitoring body that includes USKOK, NGOs, and representatives from the Agency for Access to Information and the Agency for Conflicts of Interest. Afterwards, there reports are then presented to the

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<sup>33</sup> Exchange rate on 1 July 2015.

<sup>34</sup> See

[http://ec.europa.eu/economy\\_finance/economic\\_governance/documents/201503\\_hr\\_imbalances\\_epc\\_report\\_en.pdf](http://ec.europa.eu/economy_finance/economic_governance/documents/201503_hr_imbalances_epc_report_en.pdf).

<sup>35</sup> See

[http://ec.europa.eu/economy\\_finance/economic\\_governance/documents/20160118\\_hr\\_imbalances\\_epc\\_report\\_en.pdf](http://ec.europa.eu/economy_finance/economic_governance/documents/20160118_hr_imbalances_epc_report_en.pdf).

<sup>36</sup> An overview of Croatia's anti-corruption regulatory framework can be found here: <http://rai-see.org/croatia-anti-corruption-institutional-framework/>.

<sup>37</sup> See section above and <http://www.dorh.hr/Default.aspx?sec=19>.

<sup>38</sup> As part of the Directorate European Affairs, International and Judicial Cooperation.

<sup>39</sup> The Croatian Medical Chamber was involved as a sub-stakeholder from the Ministry of Health.

government. There is also a Parliamentary monitoring body, which receives the reports from the government.

The action plan for 2015-2016 was adopted in June/July 2015. In the healthcare sector, not many actions were implemented, due to the frequent changes in leadership/government over the past two years. Political stability should partially address this issue, as will ongoing consultations with the Ministry of Justice. At the same time, it seems a strengthening of the Ministry of Health through hiring a policy officer to function as an anti-corruption expert in healthcare would seem desirable, since, at present, evaluating healthcare from an anti-corruption perspective is not yet ingrained within the Ministry.

The government has also recently codified the distinction between a gift and a bribe in the Conflict of Interest Act, which specifies that all gifts worth more than 500 Croatian kuna count as bribery.

Furthermore, the CHIF has a register of which companies pay for example for the education of which physicians. Sponsoring by industry is still allowed, but it is regulated. The personal information in these registries is not by default open to the public, only if the physician consents to it. General information on how many physicians are sponsored and the total amount paid is, however, public.

### **3.2.7. Challenges and conclusions**

There have been no indications of systemic corruption since the 2013 case. Combating corruption is taken seriously by the government, which has adopted regulations to lower the risks for corruption and an anti-corruption strategy; as well as by the providers of healthcare and by the industry itself, which both pay attention to the issue, attempt to increase transparency, and have ethical agreements amongst themselves (self-regulation) and with the CHIF to combat corruption.

At the same time, it is notable that there have not been any complaints to the Ombudsman regarding corruption in healthcare even though the perception of corruption among citizens is relatively high in Croatia. It seems that there is underreporting of corruption cases, and/or a mismatch between which kind of corruption reaches the public sphere (a few high-profile cases) and what is going on in terms of actual corruption (more lower level 'petty' corruption).

An important issue regarding the regulatory framework for tackling corruption is that Croatia currently does not have whistle blower protection.

A challenge is that the Ministries with whom the dedicated anti-corruption sector of the Ministry of Justice collaborates to develop the anti-corruption strategy and action plans often have no dedicated anti-corruption policy officers. Anti-corruption is not necessarily the first priority for the Ministries, as there are other, more pressing issues to deal with (in light also of the changes in the government over the last two years).

Remuneration in hospitals remains a concern, also, in light of discrepancies between urban and rural hospitals, and staff wages, the framework for incentivising should be looked into. This is important for fiscal sustainability, but can have a knock-on effect on combatting corruption.

Corruption is highlighted as a point of attention in the Croatian Health Care Strategy, and it is important that ownership of this strategy – and the relevance of combatting corruption – is increased among all stakeholders. The two latter challenges were also reported in the recent publication on Health Care and Long-term Care Systems & Fiscal Sustainability (2016).

### 3.3. Lithuania

#### 3.3.1. Overview/summary

The fact-finding mission field mission to Vilnius, Lithuania took place from 12 – 14 December 2016. Five face-to-face interviews with members from different stakeholder categories were undertaken. An overview can be found in Table 3.9.

**Table 3.9 Overview of Interviewees in Lithuania**

Date	Organisation	Stakeholder category
12/12/2016	IFPA – Innovative Pharmaceutical Industry Association	Industry
13/12/2016	National Health Insurance Fund (VLK)	Payer
13/12/2016	Transparency international	Other
14/12/2016	-	Research
14/12/2016	Ministry of Health	Regulator

Note: please mark in red the information for which the interviewee has not given explicit consent for publication.

#### 3.3.2. General description of the healthcare system

Lithuania has a mixed system of compulsory statutory health insurance, providing universal coverage. The National Health Insurance Fund (VLK), 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 VLK 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 is 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 VLK. In 2012 a new hospital financing system using DRGs was introduced.

Private healthcare institutions provide mostly outpatient services. They can be contracted by the VLK 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.

**Table 3.10 Indicators of the healthcare system in Lithuania**

<b>Indicators of the healthcare system</b>			
<b>Financing of the healthcare system (1)</b>			
	2012	2015 (or nearest year)	EU average
Total health expenditure as % of GDP	6.7%	6.6% (2014)	10%
Public expenditure as % of total health spending	65.2%	67.9% (2014)	77.8%
Private insurance as % of total health spending	0.8%	2.1% (2014)	2.2%
Private-out-of-pocket as % of total health spending	31.8%	31.3% (2014)	13.9%
<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)</b>			
Family doctor same day access	2		
Major surgery < 90 days	2		
Cancer therapy < 21 days	3		
CT scan < 7 days	2		

Sources: (1) The World Bank 'health expenditure', WHO/European Observatory 'Health Systems in Transition' report on Lithuania (2016), OECD Health at a Glance Europe (2016), Eurostat healthcare expenditure by financing agent, (2) World Bank healthcare statistics, Eurostat healthcare statistics and underlying data for indicators, European Commission (2016), Joint Report on Health Care and Long-Term Care Systems and Fiscal Sustainability.

**Table 3.11 Corruption in healthcare perceptions in Lithuania**

<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>			
	2011*	2014**	EU average**
(% of respondents agree - Eurobarometer)	64%	74%	33%

Sources: \* Special Eurobarometer 374, table QC4 (fieldwork September 2011); \*\* Special Eurobarometer 397, 2014 (fieldwork February - March 2013); own research (fieldwork February/March 2013). No new information was found in the Eurobarometer of 2013.

**Table 3.12 Consumer Perception Index (CPI), Lithuania**

<b>Corruption Perception Index</b>	
	2016
<b>Score</b>	59*
<b>Rank</b>	38***

Source: [www.transparency.org](http://www.transparency.org); \* CPI score is based on a scale ranging from 0 to 100, a score of 0 indicates the country is perceived as very corrupt and a score of 100 indicates a country is perceived as very clean; \*\* the 2012 CPI ranked 174 countries, where a lower rank indicates a cleaner country; \*\*\* the 2016 CPI ranked 176 countries, where a lower rank indicates a cleaner country.

### 3.3.3. Perception of corruption

In 2016, the Lithuania Corruption Map was published. This Corruption Map is the result of a survey amongst three target groups: residents (n=1,002), business leaders (n=503), and civil servants (n=502)<sup>40</sup>, which was initiated by the Special Investigation Service and

<sup>40</sup> There is no overlap between the target groups, i.e. each individual can only belong to one of the three target groups for this survey.

conducted by an independent research centre<sup>41</sup>. The survey revealed that 56% of Lithuanian residents consider corruption in general to be a serious problem, and that 42% think the problems have grown in the last 5 years. Important to note here is that while people perceived an increase, the percentage of people reporting has decreased substantially over the years: where it was 77% in 2011, it was 53% in 2014, and reduced to 42% in 2016. Hence, it seems that overall progress has been made, but that there is still room for improvement.

Looking specifically at the healthcare sector, the Lithuania Corruption Map 2016 indicates that 51% of the residents consider healthcare institutions to be the most corrupt institutions in the country. In addition, hospitals and clinics appear to be the institutions with the highest bribes extortion and giving indices. Nevertheless, these indices have improved since 2014: for town/district hospitals from 0.53 to 0.36, for republican hospitals from 0.43 to 0.40, and for clinics from 0.32 to 0.16.

#### **3.3.4. Risks and obstacles**

The healthcare sector in Lithuania is very informal. Many people consider it common practice to pay small bribes to physicians in the form of either gifts or money. These informal payments ('petty corruption') are considered both a necessity for gaining access to the best treatment, as well as a way of showing gratitude towards a healthcare professional. Petty corruption is generally accepted by society, but, as pointed out by multiple stakeholders, this mentality is slowly changing. The new generation of patients is publicly stating that they are not willing to pay bribes, and young physicians are very active in the field of anti-corruption.

Not only informal payments, but also informal relations can play an important role in gaining access to treatment or finding a physician. This holds for all types of healthcare; from family doctor to tertiary hospital services. The importance of informal relations creates risks for unequal, and privileged, access to healthcare.

Informal relations also play an important role in the appointment of managers of healthcare institutions. Over the last years, ownership of an increasing numbers of hospitals has moved to the Ministry of Health and the municipalities. The managers, who are appointed by the owner, typically have political affiliations and are appointed based on their informal relations (political appointees) rather than their managerial skills. As a result, many of these managers have a perpetual conflict of interest and the managerial structure of many institutions is not effective (enough).

Another risk in the healthcare system is the information and knowledge asymmetry between different actors, such as between different parties within procurement, but also between patients and providers (e.g. with regard to medical treatments, but also with regard to reimbursement for specific services). When one actor takes advantage of the information/knowledge mismatch with another actor, this can lead to corrupt practices.

Finally, inefficient resource allocation is also a risk in the Lithuanian healthcare sector. Stakeholders differ in their opinion as to whether or not the total healthcare budget is sufficient, but all agree that it is allocated in an inefficient manner. This can lead to waste or create incentives for corrupt practices. For example, it is common knowledge that the wages for physicians in Lithuania are low, which creates the risk of physicians asking for bribes, having multiple practices (sometimes up to 7 or 8), or leaving the country. Several stakeholders mentioned that another illustration of inefficient allocation of funds is that there is hardly any money (made) available for evaluating anti-corruption initiatives, which is key in identifying effective practices. Two stakeholders also mentioned the current

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<sup>41</sup> Lithuanian Map of Corruption, 2016: <http://www.stt.lt/lt/menu/tyrimai-ir-analizes/?print=1>.

reimbursement system in this context, because this system is based on diseases and social groups, rather than on therapeutic value.

### **3.3.5. Types of healthcare corruption**

The main corruption problems in the Lithuanian healthcare sector concern:

- Informal payments ('petty corruption'); and
- Corruption in public procurement, both for medicines and for medical devices ('big corruption').

Which of these two problems is the biggest depends on how you define big; most money is being lost to corrupt practices in public procurement, but informal payments are more widespread, and accepted as common practice by a large part of society.

In addition to petty corruption and corruption in public procurement, improper marketing, privileged access (through informal relations), and double practice – which in itself is not illegal in Lithuania - are observed.

#### ***Informal payments***

In Lithuania the problem of informal payments is widespread (not only in healthcare) and generally accepted by society. However, there has been a downward trend in the number of people that report having made informal payments: from 1 in 3 Lithuanians in 2010, to 1 in 4 in 2013, to 1 in 6 at the end of 2015<sup>42</sup>. This decreasing trend is confirmed by the results presented in the Lithuania Corruption Map 2016<sup>43</sup>. People in Lithuania are generally aware that informal payments constitute corruption and are open about making such payments. As a result of this, the size of the problem can be estimated rather accurately and a lot of information is publicly available.

All interviewees mentioned that among young people, there seems to be a resistance to petty corruption – they openly question why they should pay for healthcare services that are reimbursed by the National Health Insurance Fund. Younger physicians also publicly state that they do not take bribes. Hence, the change in generation seems to create a change in the thinking about informal payments.

According to several stakeholders, the main causes for informal payments in the Lithuanian healthcare system are:

- Insufficient knowledge of patients with regard to healthcare services and their reimbursement;
- Low wages for physicians;
- The mind-set that people think that they need to show their gratitude to physicians through informal payments.

The main impact of informal payments is that it creates a lack of trust in the public health insurance system; when people pay taxes for the health insurance and need to pay extra to ensure they receive proper healthcare, they lose trust in the system.

#### ***Corruption in public procurement***

In Lithuania, there is a central procurement system in place. In this system, the Public Procurement Office (PPO) and the Central Procurement Organisation (CPO) are responsible for ensuring rational use of procurement using public funds and administrative resources. VLK uses CPO catalogues for the procurement of medicines that are either really expensive

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<sup>42</sup> Numbers are based on results of surveys conducted by the Ministry of Health (for 2010 and 2013) and the Lithuanian Corruption Map that was developed by the Special Investigation Service (for 2015). (source: interviews during fact-finding missions).

<sup>43</sup> Lithuanian Map of Corruption, 2016: <http://www.stt.lt/lt/menu/tyrimai-ir-analizes/?print=1>.



or only used by a small group of patients, or else are on the market with few competitors. Other medicines and medical equipment are typically bought by individual hospitals.

The Ministry of Health tries to introduce the concept of 'consolidated purchases' by encouraging big and small healthcare institutions to work together, and emphasising that this consolidated purchasing will enable them to achieve lower prices. Currently, the number of purchases of medical devices through the central procurement system is lower than for pharmaceuticals. Overall, there has been an increase in the use of the central system.

One stakeholder mentioned that for public procurement the main risk for corruption seems to be the mismatch between the levels of knowledge as well as the levels of influence of the different players.

The latest research on public procurement in the healthcare sector in Lithuania stems from 2008 – no systematic research on this topic has been conducted since, which makes it difficult to estimate the current extent of the problem. Based on a 2015 report from Transparency International it is, however, possible to say something about perceptions, as this study reveals that 41% of businesspeople in Lithuania perceive procurement in the healthcare sector not to be transparent<sup>44</sup>.

Recently, public procurement data is open to the public, so everyone is now able to look up the cash flow.

### ***Double practice***

In Lithuania it is not illegal, and actually very common for physicians to have multiple positions in the public and private sector.

In 2015 the Ministry of Health sought to estimate the size of the problem with double practices. This was done based on the 2014 Law on Private Interest, according to which all physicians had to declare their interests in 2015 to the supreme commission on ethics. When looking at the data and comparing it with data from the tax authority it became apparent that a large number of physicians had not declared all their interests<sup>45</sup>. This made it impossible to make an accurate estimation of the size of the problem, but confirmed that double or multiple practices should be further investigated. In addition to the size of the problem, it is also very difficult to estimate the influence that these double/multiple practice activities have on the healthcare system.

One stakeholder mentioned that there were the suggestions for addressing the issue of double practice by not allowing physicians in the private sector to also work for public institutions. However, analysis showed that this would lead to a significant decrease of physicians in the public sector, which is undesirable. The Ministry is now in the process of working out other measures, in terms of reform of the healthcare system that could address the problem of double/multiple practices. The basis of the solution seems to be to offer good wages, so that physicians no longer have to think about other practices.

### ***Improper marketing***

On 9 December 2016, the new Minister of Health talked in his speech about the issue of illegal lobbying practices (referred to in the study as 'improper marketing'). This is an area which, up to now, has not been properly managed in Lithuania – there is no legislation in

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<sup>44</sup> Lithuanian business survey on lobbying - Attitudes towards Lobbying Activities, 2015.

[http://www.transparency.lt/wp-content/uploads/2015/10/verslininku\\_poziuris\\_i\\_lobistine\\_veikla1.pdf](http://www.transparency.lt/wp-content/uploads/2015/10/verslininku_poziuris_i_lobistine_veikla1.pdf).

<sup>45</sup> At the time of fact finding mission no action was taken against the physicians that had not declared all their interest, no information was available on compliance in 2016.

place with regard to lobbying. Lobbying is not necessarily a bad thing, but as there is a lack of relevant legislation in this area, there are risks for corrupt behaviour. The Ministry of Health is aware that there is still a lot of work to be done in this area.

### 3.3.6. Recent cases

During the fact-finding mission different stakeholders mentioned recent cases, covering 2012 to 2016. Information on eight cases is presented below.

#### **Resignation of the Minister over an informal payment (2016)**

At the end of January 2016, it was announced that the Minister of Health would resign in relation to a corruption scandal: *'Minister of Health admits that in the past she has given a bribe to physicians concerning an operation of her relative.'*<sup>46</sup> The former Minister revealed, during a radio interview, that approximately 10 years ago she herself had paid a so-called 'envelope'. Though it might be an accepted practice in society, offering a bribe is an illegal act punishable by law. Hence, after the Minister revealed this information, the Special Investigations Service began an inquiry. A few days later, the Minister announced that she would resign.

In one of the interviews during the fact-finding mission we briefly touched upon the case regarding the resignation of the former Minister of Health. The stakeholder emphasised that this Minister did not only leave because of the fact that she paid a bribe to a physician, but rather because of several conflicts with other people.

#### **Pre-trial investigation – Hospital's public procurement procedures I (2015/2016)**

This case concerns corruption in public procurement. There was a widespread corruption scheme in place that favoured particular companies in public procurement in return for bribes that were being paid to high profile officials in the accused hospital. The Executive Director, Strategic Management Director, and the Director of Infrastructure of the hospital were arrested on suspicion of abuse of office for personal gain, bribery as well as related/other crimes<sup>47</sup>. The case received considerable coverage in the press, including the following:

- *"A politician, ex Member of the Council of specific municipality, Ms 'X' is accused of alleged fraud and forgery which had allowed her to receive non lawful compensations. A Medic of the hospital and a medic of the central outpatient clinic that allegedly helped are also accused";*<sup>48</sup>
- *"High profile officials of the accused county hospital are suspected of corruption including counts on abuse of office and bribery. Court has ordered a sworn statement not to leave and to pay bail as procedural measures";*<sup>49</sup>
- *"Corruption scheme in the Hospital's pharmacy has been also allegedly involved. The director is suspected of trafficking influence".*<sup>50</sup>

#### **Pre-trial investigation – Hospital's public procurement procedures II (2016)**

Another hospital is also suspected of public procurement corruption. *"Special Investigation Service of Lithuania continues investigation on bribery during the public procurement procedures in the Hospital. As suspected, one clinics manager took a bribe from a company, which provides medical technics and tools. In another investigation the director of the Hospital is suspected of bribery and abuse of power during public procurement process concerning construction and medical technics. He has been suspended from the office for 9 months. In addition, another case has already reached the court – the accused is ex-deputy of the chief physician of the hospital, who allegedly took a bribe and made favourable conditions for one furniture company".*<sup>51</sup> As with the Hospital of the above described case, high level officials in the hospital are suspected of accepting/requesting bribes in return for favouring selected providers in the procurement procedures.

#### **Pre-trial investigation – improper marketing (2015-2016)**

One stakeholder briefly mentioned the case of a pharmaceutical company (which is part of a larger international pharmaceutical group). The case revolves around kickbacks that were given to physicians promoting a certain medicine. 11 employees of the pharmaceutical company, suspected of bribery, have been taken into custody by the Special Investigations Service. In addition, a number of physicians are under investigation. An interviewee mentioned that this is the first case ever where physicians will be prosecuted. Hence it may be an important case to send a signal that this behaviour will be punished.

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<sup>46</sup> <https://www.corruptioneurope.com/article/r-alaeviit-pripaino-pati-davusi-ky-medikams>.

<sup>47</sup> <http://www.delfi.lt/news/daily/lithuania/siauliu-ligonine-krecia-skandalas-stt-sulaike-vadovybe.d?id=69399354>.

<sup>48</sup> <https://www.corruptioneurope.com/article/politik%C4%97-bus-teisiama-d%C4%97l-dokument%C5%B3-klastojojimo-nustatat-negali%C4%85>.

<sup>49</sup> <https://www.corruptioneurope.com/article/korupcija-%C4%AFtariamiems-%C5%A1iauli%C5%B3-ligonin%C4%97s-vadovams-skirti-u%C5%BEstatai-daug%C4%97ja-%C4%AFtariam%C5%B3j%C5%B3>.

<sup>50</sup> <https://www.corruptioneurope.com/article/korupcines-iauli-ligonins-schemas-buvo-traukta-ir-vaistin-kriminalai>.

<sup>51</sup> <https://www.corruptioneurope.com/article/stt-pradjo-dar-vien-ikiteismin-tyrim-dl-kyininkavimo-panevio-ligoninje>.

**First two cases ever of physicians being convicted (2016)**

In 2016, two physicians were prosecuted and sentenced:

- A female physician was convicted for writing antedated sick leave notes. The Doctors' Accreditation Agency revoked her license for a period of 1 year;
- A male physician was convicted for asking for informal payments for injections he administered. This physician's licence has also been revoked for a period of 1 year.

These were the first two cases of physicians being convicted, and the hope is that these convictions will serve as an example for other physicians and have a deterrent effect.

### **3.3.7. Recent policy developments**

#### **Anti-corruption strategy**

In Lithuania, there are anti-corruption programmes in place at three levels:

- The national (not healthcare specific) anti-corruption programme of the Special Investigation Service<sup>52</sup>;
- The sector-specific anti-corruption programme of the Ministry of Health, which focusses on:
  - Bribery in medical service delivery (informal payments);
  - Public procurement; and
  - Reimbursement of medicines.
- Mandatory anti-corruption programmes at the level of healthcare institutions.

Each programme consists of multiple action points, and the programmes of the institutions should be aligned with those of the Ministry of Health and the Special Investigation Service. The Ministry of Health and the Special Investigation Service closely cooperate with each other and with the institutions in the fight of corruption. The results of the Lithuanian Corruption Map 2016 indicate that the perception of 57% of the public is that the Special Investigations Service is the institution most likely to contribute to the reduction of corruption (in 2014 this was only 43%). Government was mentioned by 50% of the population (53% in 2014).

Several stakeholders have expressed concern about the long list of action points for a relatively short implementation period and the apparent lack of focus. In addition, it was mentioned that particularly for healthcare institutions, it appears difficult to prioritise and set clear and measurable goals.

The Corruption Map 2016 indicated that 26% of the citizens had heard about the implementation of corruption prevention and mitigation measures. Though it may appear a relatively low number, it is already substantially better than in 2014. When asked what measures they think should be implemented, the front-runner is "penalties tightening", which is mentioned by 43% of the population.

#### **Policies and practices to prevent and control informal payments**

To reduce the risks for, and occurrence of, informal payments, different measures have been put in place. These are targeted at patients, medical professionals, and/or health care institutions.

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<sup>52</sup> The full plan, as well as a summary of the main points, are available online: <https://www.stt.lt/en/menu/corruption-prevention/anti-corruption-programmes/national-programme/#turinys>.

### ***Policies and practices targeted at patients***

Different measures have been implemented with the aim of increasing the information standards for patients and raise awareness about the issue of petty corruption. For example, by:

- Providing a list of the services that are free of costs;
- Providing access to health data through E-government so that they (patients) can see which services have been reimbursed for them and at what cost (to date this is not used very frequently by patients);
- Providing information on criminal liability;
- Providing information on how to report corruption on the websites of both the Special Investigation Agency and the Ministry of Health;
- Setting up two dedicated hotlines for whistleblowing (one at the Special Investigation Service and one at VLK);
- Implementing an address of the CEO/director of healthcare institutions consisting of both a written address as well as a verbal address (for example on a screen in the institution). These addresses should contain certain standard phrases that mention for example "this institution does not tolerate informal payments or gifts";
- Developing targeted advertising campaigns;
- Implementing IT technologies to increase transparency, such as the online waiting list for hip replacements.

The Lithuanian Corruption Map 2016 reveals that reporting has increased, but it is still at the lower end; 23% of the citizens indicated that they know where to report corruption. One way to increase reporting may be by introducing additional whistleblowing systems that do not appear as formal as the ones at the Special Investigation Service and at VLK. For example, hotlines could be set up at the level of the healthcare institution; it was suggested by a stakeholder that the opportunity to report to a manager of an institution might also reduce the barriers for reporting.

Another policy proposal targeted at patients is the setting up of a fund where patients could deposit voluntary additional payments to physicians, thereby essentially trying to formalise the informal payments. The plan for this has, however, been dropped; there were too many concerns with regard to definitions and practicalities.

### ***Policies and practices related to informal payments targeted at medical professionals***

Patients were the first target group of most anti-corruption measures, but now measures targeted at medical personnel are also being implemented. For example, a behavioural code has been developed, in accordance with the United Nations regulations. In addition, a decree of the Ministry stipulates that at least 3 training sessions on 'what to do about corruption' should be organised for employees of healthcare institution. Training sessions on how to resist informal payments are in the pipeline.

Another measure is the implementation of a new monitoring system for informal payments connected to the dedicated phone line where people can report instances of petty corruption. The number of calls to the dedicated phone line have been increasing since 2013. Follow-up on reported cases of corruption is therefore conducted either by the municipality or by the VLK, depending on the ownership of the particular institution.

### ***Policies and practices related to informal payments targeted at institutions***

Specific measures for institutions are also being put in place. For example, all institutions are required to introduce ISO quality standards. In addition, the plan is to also introduce ISO 3001 on bribery as a requirement. This ISO standard has been approved only recently (October 2016). As yet, not all institutions have these standards in place.

In addition to the prevention measures, there are also control measures in place for institutions. An example of such a control measure is the 'clean hands' programme<sup>53</sup>. For this programme, all healthcare institutions are separately assessed based on criteria that have been introduced by a decree of the Ministry of Health. In this assessment institutions are graded and subsequently categorised in three categories:

- Group 1: Transparent institutions;
- Group 2: Candidates for Group 1;
- Group 3: Institutions where not all criteria are in place and there is a higher probability of corruption.

No information is available on the exact number of institutions per group, but several stakeholders mentioned that institutions are rising from group 3 to group 2 and that the number of institutions in group 1 is still limited. The publication of the results gives the institutions clear indications on how to improve the current situation. The implementation of, and compliance with, this programme has not been evaluated and hence it is not possible to assess its impact.

## **Policies and practices to prevent and control improper marketing**

### ***Ban on gifts from sales representatives***

In 2014, the Ministry of Health introduced a ban on gifts from pharmaceutical sales representatives to physicians, which are not related to the professional activities of the physician. Before the introduction of this legislation, one would often see many sponsored items (such as chairs and stationary) in a physician's office. As of 2014, this is no longer the case.

### ***Self-regulation by the pharmaceutical sector***

The pharmaceutical sector in Lithuania has put in place several self-regulation measures to prevent and control corruption including an ethical code and a disclosure code.

The associations for innovative medicines (IFPA) and for generic medicines (VGA) jointly approved an Ethical Code for Pharmaceutical Marketing. The aim of this code is to "*govern pharmaceutical marketing and relations with pharmaceutical professionals and healthcare professionals as well as relations between the pharmaceutical industry and patient organisations*".<sup>54</sup> Furthermore, there is an Ethics commission in Lithuania, composed of 7 members – one independent chairperson, 3 members delegated by IFPA and 3 members delegated by VGA.<sup>2</sup> This commission has members with financial as well as medical backgrounds. It is important to note is that there is a law in place which states that at the end of every year, each healthcare professional can choose whether they want to have a disclosure or not. Hence, healthcare professionals need to give their consent to pharmaceutical companies for disclosure of the financial ties.

The Disclosure Code a self-regulation measure in the pharmaceutical sector, according to which pharmaceutical companies have to disclose their payments for scientific events to physicians. The Disclosure Code is a common code for both IFPA and VGA and is followed by 40 companies. It is estimated that the percentage of personal disclosure in Lithuania is 75%; this is higher than in all other CEE countries. This gives the impression that the Code has an impact, but this cannot be said with certainty however, as there has not (yet) been an evaluation of the impact of the implementation of the Disclosure Code. One problem for the (potential) effectiveness of the Code is that at the end of each year, physicians can choose – according to law – if they want the payment to them disclosed or not. Pharmaceutical companies can only disclose their financial ties with physicians if these physicians give consent for this. This may result in underreporting, a problem which was

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<sup>53</sup> [http://ec.europa.eu/europe2020/pdf/csr2016/nrp2016\\_lithuania\\_en.pdf](http://ec.europa.eu/europe2020/pdf/csr2016/nrp2016_lithuania_en.pdf).

<sup>54</sup> <http://transparency.efpia.eu/countries/16/16/Lithuania>.

also experienced by the Ministry of Health when, in 2014, they imposed a requirement on the industry - through the State Medicine Control Agency - to publicly provide information on the doctors that received funding from the pharmaceutical industry for scientific events. At that time, a substantial number of doctors refused to give consent for publishing their information.

The Disclose Code is currently self-regulated, but the Ministry of Health is exploring the possibility of introducing legislation on this. The pharmaceutical sector in Lithuania encourages this development as it will lead to one common administrative approach and easier management. The Ministry of Health emphasised that in developing this legislation, it is important to take note of how information should be provided so that it is understandable for the general public. In addition, the Ministry of Health will look into potentially expanding the scope of the disclosures to include, for example, also clinical trials or other payments that were made by the industry. The pharmaceutical sector would like to see this legislation be implemented for other healthcare sectors, e.g. medical devices, as well.

Other self-regulation initiatives in the pharmaceutical sector include:

- the drafting of a white paper together with the medical society about the interaction and collaboration between the medical society and the pharmaceutical industry (this paper is expected to be published in 2017); and
- a framework agreement on collaborating with authorities: in 2014 a framework agreement was signed between the pharmaceutical industry and the government with the aim to collaborate in a transparent way and to develop principles regarding ethical conduct.

### ***Introducing Health Technology Assessment***

One stakeholder suggested that one way to improve the allocation of resources is to implement Health Technology Assessment (HTA)<sup>55</sup>; it was noted that it was agreed already four years ago that HTA should be implemented, but that this has still not been done. The stakeholder mentioned that setting-up an HTA agency might not be feasible in Lithuania, given the lack of human resources. Nevertheless, a system of mutual recognition could be introduced. This in turn raises the question of which Member States would serve as good reference countries for Lithuania.

### **Reimbursement of medicines**

On 1 January 2016, the medicine law regarding the reimbursement of drugs was amended. The aim was to make the process more transparent. Amongst other things, a new reimbursement committee was established, consisting of representatives on behalf of the patient organisations, Ministry of Finance, Ministry of Social Affairs, Ministry of Health and representatives of the medical universities. A few stakeholders have expressed concerns with regard to the competence of this committee given the very broad background.

Another transparency increasing measure is that the applicant has the possibility to listen to the voice recording of the meetings at the Ministry of Health. One stakeholder suggested that transparency would be further increased by making the meetings open to all interested parties.

The impact of the increased transparency in the reimbursement process has not (yet) been evaluated and its effectiveness can therefore not be assessed.

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<sup>55</sup> "Health technology assessment (HTA) is a multidisciplinary process that summarises information about the medical, social, economic and ethical issues related to the use of a health technology in a systematic, transparent, unbiased, robust manner. Its aim is to inform the formulation of safe, effective, health policies that are patient focused and seek to achieve best value." (Source: EUnetHTA, <http://www.eunetha.eu/faq/Category%201-0#t287n73>).

### **Authorisation of pharmaceuticals - State Medicine Control Agency**

The State Medicine Control Agency deals, amongst other things, with the registration of medicines. The latest research on registration of medicines was conducted in 2013 and it was concluded that this is a complicated issue.

The centralised procedure is highly regulated by the European Medicines Agency (EMA). The aim of the State Medicine Control Agency is to design the national procedure in such a way that it is clear and transparent. An example of how this is implemented is the new procedure in which all the notes, also the expert notes, only have to be provided once. The selection of the members of the scientific committees – the participants in the registration procedure - is being done on the basis of the rules set out by EMA and all members yearly have to declare their private interests. Another measure regarding transparency is that the minutes of all the meetings of the scientific committee have been made public. Moreover, there is a procedure of appeal that pharmaceutical companies can use when they do not agree with the decision.

There is also a programme in place for assessing the probability of corruption occurring. There are yearly evaluations of compliance. Each year a survey is conducted amongst participants and they are given the opportunity to signal any drawbacks. Moreover, internal audits are conducted. On the basis of the results of the evaluations, surveys, and audits, corruption probability is introduced into the action plan of the Agency.

#### **3.3.8. Challenges and conclusions**

Lithuania is very active in the field of anti-corruption. Anti-corruption programmes have been implemented on three levels: the national level, the healthcare sector level, and the health institution level. Most of the implemented measures focus on creating awareness and increasing transparency. One of the challenges with this broad multi-layered approach is to create sufficient focus and measurable Key Performance Indicators (KPIs). Unfortunately, hardly any of the implemented policies and practices have been evaluated properly; this does not seem to be a priority and there are (almost) no funds made available for this. As a result, it is difficult to assess the impact and effectiveness of the efforts made in the fight against corruption.

Results of national surveys indicate that the perception of citizens is that healthcare institutions are the most corrupt public institutions and that corruption has increased in recent years. At the same time, these surveys also show that the percentage of people believing that corruption has increased is substantially lower than a few years ago and that also the number of people making informal payments has been decreasing. However, although some progress seems to be made, petty corruption remains a big challenge for Lithuania. This is largely due to the general acceptance of making informal payments by society. The Ministry of Health and VLK are putting a lot of effort into providing patients with higher information standards and opportunities for reporting petty corruption. In addition, measures for healthcare professionals and institutions are being put into place. Interestingly, while all stakeholders agree that the low wages for physicians is one of the main risks, this has not yet been addressed. In addition to preventative and awareness raising measures, systems for whistleblowing are being set-up, and this year for the first time ever two physicians have been convicted for bribery in medical service delivery – the hope is that this will have a deterrent effect. Citizens have said that they consider tighter punishment an important measure, so (high media coverage of) prosecution and convictions of physicians may be an important step in the right direction.

A positive development is that it seems that the mind-set of the Lithuanian public is slowly changing; the new generations of both physicians and patients are publicly outspoken against informal payments and do not accept it nor consider it common practice. This is confirmed by data about the acceptance and willingness to pay bribes in general: the Lithuanian Corruption Map 2016 reveals that the percentages of residents who believe that

bribery helps to solve problems and actually who pay a bribe to solve the problem decreased from 75% to 68% and from 68% to 40%, respectively, between 2008 and 2016.

As mentioned in the recent publication on Health Care and Long-term Care Systems & Fiscal Sustainability (2016), additional measures to incentivise good prescription practices, monitor prescription of drugs as well as outlining a clear policy on generics, combined with price regulation and direct expenditure control should be considered. These can be expected to have a beneficial effect on combating petty corruption. This also holds for the recommendation to improve data collection and monitoring of the entire healthcare process (inputs, processes, outputs, and outcomes).

As stated, petty corruption remains an important challenge for the country, but, increasingly, more focus is being directed to the corruption in public procurement; estimations indicate that a significant amount of money is lost to this form of corruption each year. Lithuania has a central procurement system in place, and the Ministry of Health tries to encourage institutions to use this system more frequently and to make joint purchases.

With regard to improper marketing, several self-regulation initiatives are in place in the pharmaceutical sector, including a Disclosure Code. This code will potentially be changed into a law and made applicable for other sectors within the healthcare system as well. Other legislation that is currently lacking, but mentioned as a priority by the minister, is that on lobbying. While the Ministry of health acknowledges that lobbying is not necessarily a problem, it is important to properly regulate it to avoid corrupt practices.

To conclude, although the problem of corruption is still widespread, attitudes are slowly changing; the generational shift seems to be accompanied by a growing intolerance for corruption. Moreover, many policies and practices have been implemented in recent years and it seems that significant progress has been made in the fight against corruption in the healthcare sector. However, given the lack of systemic evaluations of the implemented policies and practices, crucial information pinpointing what has worked and why (not) is lacking.



### 3.4. Hungary

#### 3.4.1. Overview/summary

The research trip to Budapest, Hungary, took place from 23 – 25 January 2017. Five interviews with stakeholders from different categories were undertaken in person. An overview can be found below.

**Table 3.13 Overview of interviewees**

Date	Organisation	Stakeholder category
23/01/2017	-	National Competent Authority
23/01/2017	-	Academic
24/01/2017	-	Patients
02/02/2017	Transparency International Hungary	Anti-corruption NGO
25/01/2017	Minister of State for Health	Regulator

Note: please mark in red the information for which the interviewee has not given explicit consent for publication.

#### 3.4.2. General description of the healthcare system

##### *Organisation*

Hungary has a single-payer health insurance system with (virtually) universal coverage, and has achieved a successful transition to a purchaser–provider split model, away from a previously (over-) centralised, integrated ‘Semashko-style’ system.<sup>56</sup> New payment methods that create incentives for increased technical efficiency have been introduced, such as the DRG-based payment system for hospitals that was adopted in 1993 and with which Hungary has accumulated a wealth of experience.

The National Health Insurance Fund (NHIF) was the most important national pool of financing in healthcare. In 2017 the NHIF was integrated into the Ministry of Human Capacities, and renamed as National Institute of Health Insurance Fund Management (or NEAK in Hungarian).<sup>57</sup>

Health insurance for Hungarians is mandatory, and the system is based on the provider payment model, which has become more output-based. Family doctor services are paid through capitation, while outpatient specialist care is funded through a fee-for-service point system. DRGs are used for acute inpatient services, and chronic care is funded through per diem rates.<sup>58</sup>

Municipalities are responsible for primary health care. The responsibility for secondary and tertiary care provision is shared among municipalities, counties, the central government, and private providers. There are substantial regional disparities in the provision of / access to services.

**Table 3.14 Responsibility for different parts of the healthcare sector**

Level of care	Responsibility
Family doctors / General Practitioners (GPs)	Local
Out-patient clinics	Local
Hospitals	National
University clinics and medical centres	National

<sup>56</sup> See the Health Systems in Transition profile of Hungary for this section, to be found online at <http://www.hspm.org/countries/hungary25062012/livinghit.aspx>.

<sup>57</sup> OECD Health at a Glance Europe (2016), <http://www.oecd.org/health/health-at-a-glance-europe-23056088.htm>.

<sup>58</sup> Gaál P, Szigeti S, Csere M, Gaskins M, Panteli D. (2011), Hungary: Health system review. *Health Systems in Transition*, 13(5):1–266.

## Financing

Public health expenditure is financed through a combination of contributions and tax revenue transfers, with the latter's importance increasing. Family doctors act as gatekeepers generally, but only have a weak gatekeeping role and some specialist services can be accessed without a referral.

The NEAK is responsible for the financing of new innovative medicines through its Reimbursement Department. Health technology assessments (HTAs) are mandatory, and are conducted by the National Institute for Quality and Organisational Development in Health Care, which uses the formula (2–3x Gross Domestic Product (GDP) per capita/Quality Adjusted Life Year (QALY)) as a soft reference point.<sup>59</sup>

In response to the crisis, the Hungarian government reduced the publicly reimbursed benefits package – mainly temporary sickness benefits.

In 2015 there were several demonstrations about the underfunded health-care system. The underfunded health-care system creates in two problems. Firstly, large numbers of medical professionals take jobs abroad, and secondly, there have been problems with the supply of medicines (which seem to have been addressed). This all contributes to a situation in which hospitals have a more difficult time to provide care of the highest standards for their patients.

Hungarian health care workers earn one-tenth as much as health care workers in other Western countries,<sup>60</sup> health care facilities cannot provide the minimum number of personnel necessary to run the facility and patients' health is jeopardized.

**Table 3.15 Indicators of the healthcare system in Hungary**

<b>Indicators of the healthcare system</b>			
<b>Financing of the healthcare system (1)</b>			
	2012	2015 (or nearest year)	EU average
Total health expenditure as % of GDP	7.5%	7.0%	10%
Public expenditure as % of total health spending	65.5%	67.0%	77.8%
Private insurance as % of total health spending (EC) <sup>61</sup>	2.7%	2.7% (2013)	2.2%
Private-out-of-pocket as % of total health spending	29.1%	28.1% (2013)	15%
<b>Organisation of the healthcare system (2)</b>			
Social insurance or tax-based system?	Tax-based		
Gatekeeping by a general practitioner (GP)?			
How are physicians paid? (e.g. salary, fee-for-service, capitation)			
Patient organisation involvement (3=good, 2=intermediary, 1=not-so-good)			
<b>Accessibility (3=good, 2=intermediary, 1=not-so-good)</b>			
Family doctor same day access			
Major surgery < 90 days			
Cancer therapy < 21 days			
CT scan < 7 days			

<sup>59</sup> Source: WHO (2014), Eurohealth incorporating Euro Observer. Volume 20:2. Online to be found at [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0017/252251/EuroHealth\\_v20n2.pdf?ua=1](http://www.euro.who.int/__data/assets/pdf_file/0017/252251/EuroHealth_v20n2.pdf?ua=1).

<sup>60</sup> See Budapes Beacon (March 5th, 2015), Hungarian health care workers earn 1/10th that of their western counterparts', last consulted 25 July 2017 at <http://budapestbeacon.com/public-policy/hungarian-health-care-workers-earn-110th-that-of-their-western-counterparts/20371>. In this article Western European countries are Germany, England or Sweden. Note: these are not purchasing power parity (PPP) numbers and so do not take into account the cost of living.

<sup>61</sup> European Commission (2016), Joint Report on Health Care and Long-Term Care Systems and Fiscal Sustainability, [http://ec.europa.eu/economy\\_finance/publications/eeip/ip037\\_en.htm](http://ec.europa.eu/economy_finance/publications/eeip/ip037_en.htm).

Sources: (1) OECD Health at a Glance Europe (2016), OECD 'Health expenditure indicators' DOI: 10.1787/data-00349-en, Health at a glance (2015) DOI:10.1787/health\_glance-2015-graph156-en, Eurostat healthcare expenditure by financing agent, (2) World Bank healthcare statistics and underlying data for indicators, Eurostat healthcare statistics and underlying data for indicators, European Commission (2016), Joint Report on Health Care and Long-Term Care Systems and Fiscal Sustainability.

**Table 3.16 Corruption in healthcare perceptions in Hungary**

<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>			
	2011*	2014**	EU average**
(% of respondents agree - Eurobarometer)	50%	56%	33%

Sources: \* Special Eurobarometer 374, table QC4 (fieldwork September 2011); \*\* Special Eurobarometer 397, 2014 (fieldwork February - March 2013); own research (fieldwork February/March 2013). No new information was found in the Eurobarometer of 2013.

**Table 3.17 Corruption Perception Index (CPI), Hungary**

<b>Corruption Perception Index</b>	
	2016
<b>Score</b>	48*
<b>Rank</b>	57***

Source: www.transparency.org; \* CPI score is based on a scale ranging from 0 to 100, a score of 0 indicates a country is perceived as very corrupt and a score of 100 indicates a country is perceived as very clean; \*\* the 2012 CPI ranked 174 countries, where a lower rank indicates a cleaner country; \*\*\* the 2016 CPI ranked 176 countries, where a lower rank indicates a cleaner country.

### 3.4.3. General perception of corruption

Hungary has moved down on the Transparency International (TI) corruption list of 2015, which indicates that Hungary is one of the most corrupt countries in Europe. Only Romania and Bulgaria performed worse in the EU.<sup>62</sup> A recent TI survey (published November 2016) showed a declining willingness to file reports with the relevant authorities for suspected corrupt practices. Although young people are seen to be more willing to step up against corruption, only 14% of all respondents said they believed average people can act against corruption.<sup>63</sup>

### *Risks and obstacles*

The Hungarian government under Orbán, on 7 December 2016, withdrew from the Open Government Partnership, a multilateral pro-transparency agency, citing bias in favour of NGOs and against government responses as the reason.<sup>64</sup>

The Hungarian Ombudsman is independent and the judiciary also acts independently. However, in recent years the healthcare specialists at the Ombudsman have become less visible, i.e. it is not known to the public who these person(s) is (are). Moreover, the procedure for filing complaints with the Ombudsman has been made more onerous, so that it has become more difficult to directly reach the Ombudsman: for many issues you have to go through the State.

<sup>62</sup> See <http://index.hu> - Hungary corruption health news.

<sup>63</sup> See [http://bbj.hu/economy/hungarians-see-corruption-worsening-ti-survey-says\\_124852](http://bbj.hu/economy/hungarians-see-corruption-worsening-ti-survey-says_124852).

<sup>64</sup> See [http://bbj.hu/politics/hungarian-govt-quits-pro-transparency-organization\\_125900](http://bbj.hu/politics/hungarian-govt-quits-pro-transparency-organization_125900).

The representative of the patient rights' body is now also a member of the Ministry of Human Capacities, even though it is by law required to be independent (ACT CLIV/2017 on Healthcare).

A vice president of the governing party recently declared that NGOs are 'foreign agents' that need to get out of Hungary.<sup>65</sup> NGOs need to declare their financial statutes and show where their funding came from, even though this information is, for the majority of NGOs, already publicly available on their websites.

In the past, the Hungarian national government had formalised consultation with medical professionals, trade unions, patient organisations and local governments, under the National Health Council (NHC). This had an elected president and two vice-presidents, one of which needed to be a patient representative. The NHC functioned as an advisory council to the government. The NHC was abolished when the Ministry was reorganised in 2010, because the Minister saw it as no longer relevant.

Over the last few years, the State Secretary for Health has regularly been replaced. Many healthcare policy changes are not clearly communicated in official media, and the media that ask questions are very weak. The general population therefore does not 'see' what is changing in terms of healthcare policies, much less sees a reason to protest.

There are signs that informal pressure is exerted on certain national associations, to prevent them from directly communicating on healthcare issues to the press without prior approval from the State Secretary.

#### **3.4.4. Types of healthcare corruption**

The Special Eurobarometer 397 on anti-corruption showed that some 19% of Hungarians feel they are affected by corruption in their daily life, and 89% of the population thinks corruption is widespread in their country.<sup>66</sup> Furthermore, 10% of Hungarians (stated that they) had to give an extra payment or valuable gift to a nurse or physician (or other donation) to the hospital in order to receive treatment.<sup>67</sup>

This is the highest rate in Europe after Romania, Latvia, and Greece. Of those who indicated they had to give an extra payment, 32% indicated they did so before the care was given, 47% after the care was given, 7% indicated the physician or nurse directly asked for an extra payment/gift in advance, and 9% indicated that they were asked to pay for a privileged treatment.<sup>68</sup>

The study team also spoke with the State Minister for Healthcare on the state of the Hungarian healthcare system. Because of his background as a healthcare manager, the Minister of State's approach to (reforms of) the healthcare system is different compared to his predecessors. He usually transposes best practices from other sectors into the health sector, convinced that the health sector could benefit from them.

In an effort to promote data-driven policymaking in healthcare, the Minister of State / Ministry has been looking at the utilisation of healthcare by households, i.e. at the micro-level. This showed them how much healthcare was consumed by the population, irrespective of which institution provided the healthcare services. The data came from the database of the Hungarian National Health Fund. This was the first time the data was analysed from the user-perspective.

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<sup>65</sup> See The Guardian (13 January 2017), Hungary defends planned crackdown on foreign-backed NGOs. To be found online at <https://www.theguardian.com/world/2017/jan/13/hungary-defends-planned-crackdown-on-foreign-backed-ngos>.

<sup>66</sup> See Special Eurobarometer 397, [http://ec.europa.eu/public\\_opinion/archives/ebs/ebs\\_397\\_en.pdf](http://ec.europa.eu/public_opinion/archives/ebs/ebs_397_en.pdf).

<sup>67</sup> See Special Eurobarometer 397, [http://ec.europa.eu/public\\_opinion/archives/ebs/ebs\\_397\\_en.pdf](http://ec.europa.eu/public_opinion/archives/ebs/ebs_397_en.pdf).

<sup>68</sup> Multiple answers could be indicated per respondent.

It turned out that there were large differences between the smallest and the largest health care consumers: a factor of three for the consumption of in-patient care, a factor of five for out-patient care, and a factor of eight for chronic care. This is an indication that the actual consumption of health care is not determined by the needs of the population but by the needs of institutions (i.e. practice variation).

Data about quality of care are not systematically collected, which is perceived as being problematic. As a result, there are no quality-related incentives. When you drill down through the data to analyse them, it is very obvious how institutions are making an effort to offset their losses for certain procedures with other, profitable procedures.

### ***Transparency of data***

An electronic healthcare system will be put in place in November 2017, through which patients will be able to retrieve information on what has happened to them, and what funding was attached to those procedures. They will be able to see all the invoiced procedures. Although no further details were available to the researchers, from the perspective of transparency, this would be a major step forwards. However, every step towards reforming the current system may weaken the position of the Minister of State, because hospital directors and other powerful actors in the system are not interested in doing this.

The department of Health will introduce a unified basic data sheet, which every GP will have to use, to survey and assess the population of every GP practice. The intended duration for this (self-) assessment is three years. Currently, different suppliers have different (electronic) data sheets. In the new situation, all GPs and hospitals will use the same data sheet. It will be a cloud-based approach, and the pilot phase is closing. On the 1st of November every state-owned hospital which has a license of operation and is funded by the state, will have to participate in using this unified data sheet. In the next year, every private practice will also have to join this system if they want to keep their licenses. (Private practice currently still only represents a small share, approximately 2-3%, of the healthcare system, and is mostly focused on cosmetic surgery).

On the 1st of November, all practices will have to retrospectively upload the information from the past 5 years into the cloud, which will mean 10 million in-patient records and almost 100 million out-patient records. The question is how to protect this data from third parties. The personal information is owned by the patient, but after the data has been processed and anonymised it is owned by the government.

### ***Communication of healthcare reforms to citizens***

Awareness about the intended increase in transparency (via e.g. electronic patient dossier, electronic procurement) is not actively communicated at present. To some extent, this will revolve around the introduction of electronic identity cards, through which citizens will be able to retrieve their medical dossier as well. This is a new development. Patients will be able to see the procedures that are invoiced by healthcare professionals as well as the funding involved. Separately, with regard to the quality of care indicators, in the recent months hospitals have been motivated to publish about these issues by the (political) opposition parties. The Minister of State thinks this will have raised awareness among citizens as well.

### ***Informal payments***

The distribution of informal payments is very skewed, as it is mostly the head physicians who receive these payments. About 60% of all informal payments go to 5% of all physicians.<sup>69</sup> The younger generation receive less informal payments, and also does not want to rely on them. As a consequence, younger healthcare professionals often go work abroad. This is particularly relevant for nurses; whose wages are low and who do not benefit from the informal payments at all.

In many studies the main reason to justify informal payments is that healthcare professionals' salaries are too low. As it is, the healthcare sector 'survives' through informal payments. As the EU Anti-Corruption report (2014) highlighted,<sup>70</sup> a law prohibits informal payments before treatment, but it is allowed when given after treatment has taken place.<sup>71</sup> There is a separate clause in the labour law prohibiting 'gratitude' payments, but this can be (legally) overruled by the director of a hospital, whose formal approval removes the prohibition.<sup>72</sup>

### ***Double practice***

Double practice is allowed in Hungary, and most physicians engage in it. Although no update has been made for all the 2013 study's data, it is clear that 50% of patients make an informal payment for hospitalisation (with an average worth of 100 EUR), and 20% of patients make an informal payment worth 15 EUR for physician visits.<sup>73</sup> Under this study, one specific area has been more closely examined: informal payments and double practice in delivery and maternity care.

In Hungary, most women choose a specific physician for the delivery of their baby. Some of the physicians steer patients to private practice for pre-natal care, while delivery may be steered towards a public hospital. Women want to deliver their babies with their physician present, which is the main motivation for informal payments as this would not fall under the traditional duties of a physician.

The quality of care has been compared for those women who choose their physician and those who do not. Women who chose their physician felt much more satisfied and felt they were treated with more respect. However, the 'chosen' physicians appeared to perform much more interventions, many of which might not have been necessary and could even be potentially harmful. Informal payments may offer an explanation for this situation. Physicians feel they need to justify why they are present, which they can do through performing an intervention – they can for example induce birth or perform a caesarean.

The Minister of State for Healthcare has noted that the large outflows of healthcare professionals make taking legislative actions precarious. Introducing double practice legislation would be a challenge, as Hungary is well-connected to the rest of Europe and the physicians would all leave for London if they saw a substantial dip in their salaries.

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<sup>69</sup> See Gaal P, Evetovits T, McKee M. (2006), 'Informal payment for health care: evidence from Hungary'. In *Health Policy* 77(1):86-102.

<sup>70</sup> See EU Anti-Corruption report (2014), Hungary chapter: p.13. To be found online at [https://ec.europa.eu/home-affairs/sites/homeaffairs/files/what-we-do/policies/organized-crime-and-human-trafficking/corruption/anti-corruption-report/docs/2014\\_acr\\_hungary\\_chapter\\_en.pdf](https://ec.europa.eu/home-affairs/sites/homeaffairs/files/what-we-do/policies/organized-crime-and-human-trafficking/corruption/anti-corruption-report/docs/2014_acr_hungary_chapter_en.pdf).

<sup>71</sup> See the Criminal Code, section 291 (1), criminalising the acceptance of a promise of a payment.

<sup>72</sup> See the Labour Code, section 52 [2012. évi I. törvény a munka törvénykönyvéről] [http://net.jogtar.hu/jr/gen/hjegy\\_doc.cgi?docid=A1200001.TV](http://net.jogtar.hu/jr/gen/hjegy_doc.cgi?docid=A1200001.TV).

<sup>73</sup> See Bajji P., Pavlova M., Gulácsi L., Farkas M., Groot W. (2014), The link between past informal payments and willingness of the Hungarian population to pay formal fees for health care services: results from a contingent valuation study. In *European Journal of Health Economics* 15(8): 853:67.

### **Public procurement**

The main areas of corruption are public procurement and EU funds projects. TI has calculated that public procurement procedures are 20 – 25% more expensive than they should be because of corruption.<sup>74</sup> As a result, every Hungarian citizen pays EUR 130 extra per year for public procurement.

Access to information on fraud with EU funds is restricted to what is made available by the European Commission (EC), the European Anti-Fraud Office (OLAF) and the Hungarian government. According to TI Hungary, fraud with these funds goes back at least 10 years and must have been present since Hungary's accession to these funds. It is difficult to judge, because the first full cycle of EU funds programming that Hungary was part of started in 2007, and the results of this cycle are only now emerging.

As stated, public procurement (by hospitals) has been centralised. This is not necessarily an improvement, as transparency about the process has not increased accordingly. Health Technology Assessment (HTA) reports for expensive drugs are not made public either, although this is the case in many countries. Overall, it is not clear how procurement decisions are made.

Since the current government came into power the institutional set up of organising the use of these funds has been centralised. In TI's view, it is probable that the quantity (size) of corruption has not changed, only the quality (or institutional level). Whereas previously corruption originated mainly at the level of local government, now all projects are overseen by the Prime Minister's office (central level).

#### **3.4.5. Recent cases**

On January 4<sup>th</sup> 2016, 781 Hungarian health-care professionals protested against the government's inadequate response and efforts to combat corruption in hospitals, and demanded substantially increased wages. The medical professionals also asked the Hungarian citizens to cooperate and send an email to the Ministry in the interest of 'moving health-care forward'.<sup>75</sup> In more recent protests (May 2017), pro-EU protesters united under the banner of 'Momentum' demanded more government accountability and improved healthcare.<sup>76</sup>

Recently an oncologist, who was sentenced, was in the news;<sup>77</sup> he received informal payments but also broke ethics rules by not even telling some of his patients that they were going to die soon, in order to receive more informal payments from them. One patient refused, and took him to court. In first instance, this physician was convicted, but in higher court his punishment was reduced. The court argued that the physician was an important specialist whose expertise was needed to help Hungarian society. His colleagues supported the professionalism of the physician. This case is now under arbitration by the third and highest level of the court.

As indicated by representatives from patient organisations, there are two aspects that patients share stories about: waiting lists for orthopaedic treatment, for example, and access to new and expensive oncology drugs. There is strong governmental pressure to

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<sup>74</sup> See TI factsheet on public procurement corruption, <https://transparency.hu/wp-content/uploads/2016/02/Public-Procurement-Corruption.pdf>.

<sup>75</sup> See <http://budapestbeacon.com/featured-articles/rtl-klub-names-maria-sandor-person-of-the-year-in-hungary/30474>.

<sup>76</sup> See <https://www.theguardian.com/world/2017/may/01/hungarians-send-message-to-orban-in-march-supporting-european-union>.

<sup>77</sup> See <http://nepszava.hu/cikk/1135381-dontottek-nem-praktizalhat-a-rakos-betegektol-penz-kikovetelonyogyasz> and [http://hvg.hu/itthon/20170520\\_magyar\\_orvosi\\_kamara\\_halapenz\\_etikai\\_eljaras](http://hvg.hu/itthon/20170520_magyar_orvosi_kamara_halapenz_etikai_eljaras).

reduce the budget for these oncological drugs, which reduces their availability to the public and with that restricts access for patients. An open letter by various patient organisations was recently sent to the Prime Minister, in which the risks of this issue were flagged.<sup>78</sup>

Additionally, there is a Hungarian corruption database where press articles can be searched: <http://adatbazis.k-monitor.hu/index.html>.

### ***Public procurement***

The Economic Competition Office (GVH) has imposed penalties on a few Budapest-based hospitals – they informed in a consortium to buy pharmaceuticals. The idea was to make the pharmaceuticals cheaper through larger volumes. This led to 2.5 billion HUF of savings. However, in a criminal proceeding, emails from a lawyer appointed by pharmaceutical companies were intercepted which showed that the process was organised [corrupted], as the pharma companies reconciled their prices during the procurement process. The economic GVH imposed a fine of more than 840.000 EUR on these companies.<sup>79</sup> The Minister of State indicated this is only the tip of the iceberg; nevertheless a start has been made. The government has shown its resolve, and indicated in which direction it intends to go.

One smaller case related to public procurement in a hospital. This related to a suspicion of corruption in public procurement of medical devices (CT, MR) in hospitals. In this case, there was little to no competition and prices were high, with a total value of 30 billion HUF.<sup>80</sup>

### ***Quality of healthcare***

Just before Christmas 2016 a story broke that a dead body had been found in one Budapest hospital, which had already been there for two days. However, to date this incident had not led to any consequences for the hospital. The hospital has publicly stated that, because they outsource their cleaning work, this is not the responsibility of the hospital. Although not necessarily representative of the entire healthcare system, it is indicative of how overall quality controls and checks in the current system can be lacking.

#### **3.4.6. Recent policy developments - healthcare**

In 2010, Fidesz became the governing party and some ministries were reorganised. As a result, there is no separate Health Ministry anymore: it resides under the Ministry for Human Capacities.

Since then, there have been a number of institutional changes in Hungary. As of January 2017, the National Health Insurance Fund (NHIF) has been reorganised and now falls under the State Secretary for Health, whose cessionary is the Ministry of Human Capacity.<sup>81</sup> This is in line with a more general tendency towards centralisation. This can be seen in the hospital sector where responsibility for ownership rights has moved from the local to the national level. Public procurement (for hospitals) has also been centralised.

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<sup>78</sup> See [http://pharmaonline.hu/cikk/betegszervezetek\\_nyilt\\_levele\\_lazar\\_janosnak](http://pharmaonline.hu/cikk/betegszervezetek_nyilt_levele_lazar_janosnak) [Hungarian].

<sup>79</sup> Hungarian Competition Authority (2016), 'Press Release. The GVH imposed fines for coordination of bids in tenders of hospitals'. Last consulted 13 February 2017 at [http://www.gvh.hu/en/press\\_room/press\\_releases/press\\_releases\\_2016/the\\_gvh\\_imposed\\_fines\\_for\\_coordination\\_of\\_bids\\_in\\_.html](http://www.gvh.hu/en/press_room/press_releases/press_releases_2016/the_gvh_imposed_fines_for_coordination_of_bids_in_.html).

<sup>80</sup> See <http://nepszava.hu/cikk/1092529-hadhazy-ujabb-leleplezese---korrupcio-az-egeszsegugyben> [Hungarian].

<sup>81</sup> See [http://medicalonline.hu/eu\\_gazdasag/cikk/itt\\_a\\_a\\_megszuno\\_hivatalok\\_hatterintezmenyek\\_listaja](http://medicalonline.hu/eu_gazdasag/cikk/itt_a_a_megszuno_hivatalok_hatterintezmenyek_listaja) [Hungarian].



### ***Healthcare expenditure***

The OECD statistics (2015)<sup>82</sup> on Hungary show that expenditure on healthcare has not increased over the past years (it is currently 7% - well below the OECD average - 9%), and may have even slightly decreased as a percentage of GDP. Even compared to neighbouring countries, the share of public expenditure on health care in Hungary is the lowest. It is worrying that the share of out of pocket expenditures is increasing (at the moment about one third of the total expenditure), as this means more of the burden falls on citizens. This relates mostly to co-payments for pharmaceuticals (70%), informal payments, and private sector services (whose share is increasing).

### ***Transparency***

In recent years many improvements took place at the NHIF that increased transparency.<sup>83</sup> They published more data and made these available on-site. The website was renewed, statistical yearbooks were accessible, and even some contracts were made public. The NHIF database had become accessible for academic researchers, and joint research projects had started between universities and the NHIF.

The NHIF was collecting data from all the providers, and reimbursement was based on this data. As the NHIF was abolished in January 2017, some tasks, such as handling cash benefits were delegated to the pension funds. Other tasks (e.g. reimbursement of providers) remained at the same institute under the same infrastructure but under a different Hungarian name. It is difficult to judge what the changes mean for quality of care. As for providers, a new public hospital is planned to be built in Budapest, but one can see that more and more private clinics are appearing as well.

### ***Waiting lists***

In 2012 the government introduced legislation that made the introduction of waiting lists mandatory across the country. Five years later, waiting lists have decreased. OECD studies indicate that regarding waiting lists, Hungary is in the 2<sup>nd</sup>, 3<sup>rd</sup> or 4<sup>th</sup> position for some of the procedures (for example, hip or knee replacements, although not for access to new and innovative medicines). For one procedure, a waiting list that used to be 70,000 patients now stands at 28,000; each year 180,000 surgeries are performed. This means the capacity is about six times bigger than the waiting list, which ensures that hospitals are no longer in a position to dictate to the government in the old way - blackmail or extortion, through raising public outcry.

#### **3.4.7. Recent policy developments – corruption**

No evidence has been found that the situation has changed since 2013. Informal payments are still an important issue, as there are less public resources in the system. There was an initiative for residency training for physicians, who could receive an extra scholarship if they signed an anti-corruption statement.<sup>84</sup> This initiative led to some controversies, as the younger people earned more than older people.

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<sup>82</sup> See OECD Health Statistics 2015, to be found at <https://www.oecd.org/els/health-systems/Country-Note-HUNGARY-OECD-Health-Statistics-2015.pdf>.

<sup>83</sup> From Health Systems in Transition (HiT) profile of Hungary: 'There is a unique patient identification system that provides information on pharmaceuticals consumption and use of specialist inpatient and outpatient services at the level of individual patients. This is a rich, integrated data set. However, the government is not (yet) asking for health-policy related research from academia'. See <http://www.hsptm.org/countries/hungary25062012/livinghit.aspx>.

<sup>84</sup> See <http://www.edupress.hu/index.php/felsooktatasi/222-havi-tamogatasi-kapnak-a-frissen-szakvizsgazott-orvosok> [Hungarian].

The perception of most Hungarian health care consumers towards informal payments is that they are 'inevitable due to the low funding of the health care system' (Bajj, Pavlova, Gulácsi & Groot, 2013).

### ***Anti-corruption training***

There is a specialised course for public procurement lawyers, which contains a module on preventing corruption. This course included examples of instances where members of the public objected to informal payments being termed corruption. In addition, there are ethics classes at Medical Universities, which include anti-corruption. However, TI is not aware of targeted anti-corruption classes at Medical Universities.

### ***Informal payments***

The Medical Chamber has adopted ethics rules, which have a long section devoted to informal 'facilitation' payments. They try to distinguish between different forms of corruption and facilitation payments. The regulation that legalised informal payments after treatment is in line with the Medical Chamber's advice: as long as informal payments take place after treatment and happen voluntarily, it is argued that they are legal and acceptable.

Due to their lower position in the hierarchy, the younger generation receives fewer informal payments. Multiple interviewees also indicated that the younger generation of healthcare professionals does not wish to rely on those payments.

However, this is not matched by top-down good practices, and according to TI, the government is susceptible to the influence of the medical lobby. This was shown when the government decided about 1.5 years ago to change the definition of corruption and bribery under the criminal code, legitimising after-treatment informal payments. The change was a symbolic gesture, as in reality, physicians were not being prosecuted or convicted in any case.

The Minister of State for Healthcare on the other hand noted that two strategies are in place to address the problem of informal payments. The first regards patient safety projects. Over half of the funds received from the EU today will be spent on patient safety issues, and the government will develop quality indicators to assess patient safety. The Minister of State believes that when the processes become more transparent and patients know what happens to them, the feeling that there is a lack of safety will disappear.

### ***Healthcare salaries***

The other strategy concerns an increase in the wages of healthcare professionals. In many studies the main justification offered to justify informal payments is that healthcare professionals' salaries are too low. In an effort to address this, last year the government was able to conclude an agreement with the trade unions. As a result, healthcare professionals (other than physicians) will see their salaries doubled over the next four years. For physicians a two-year agreement was concluded, in which their salaries increase by 500 EUR a month this year, and a further 500 EUR a month next year.<sup>85</sup>

If the wage increases are implemented as planned on the 1<sup>st</sup> of November 2017, this will put the salaries of healthcare professionals at around the average of the Visegrad group countries.<sup>86</sup> This means that wages can no longer be used as an argument to justify

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<sup>85</sup> Please note that, as the financing of GPs is based on capitation they were not included. Their remuneration has however increased by 50% over the past 6 years.

<sup>86</sup> A political grouping of Central and Eastern European countries, including the Czech Republic, Hungary, Poland and Slovakia. See <http://www.visegradgroup.eu/>.

informal payments. The Minister of State wonders when citizens will start calling informal payments 'corruption' instead of 'gratitude payments'.

### **3.4.8. Challenges and conclusions**

#### ***Healthcare-related***

The main structural problem is that there are fewer nurses and family doctors (general practitioners, GPs); on the one hand because people do not have enough money to come up with the informal payments required, and on the other because many younger people do not want to work in such an environment. Many younger physicians go abroad and, as a consequence, the average age of GPs is increasing. Some of these GPs may need the informal payments to supplement relatively low salaries, and generally GPs do not see the informal payments as being unaffordable. There seems to be a form of acquiescence, as there is no general public discussion about informal payments.

Promoting the role of GPs and avoiding unnecessary use of secondary and tertiary care is important. Financial incentives should accompany this, to attract more GPs and enhance the labour supply. Strengthening the referral system through control and organisational measures, as well as developing more data-driven approaches to healthcare, should limit the use of specialist and hospital care.

These challenges were also reported in the recent publication on Health Care and Long-term Care Systems & Fiscal Sustainability (2016).

#### ***Corruption-related***

There are no directed policies to tackle corruption, and there is a general apathy about corruption among citizens. The government denies that what is happening is a form of corruption, and argues that it aims to promote the Hungarian owner-class.

Hungary lacks adequate whistle-blower protection. There is legislation in place, as prescribed by the UN convention against corruption and the European Commission. However, this is viewed by TI as a 'box ticking exercise', which has no real effect in practice.

In addition, there is no specialised anti-corruption process, nor a specially designated anti-corruption agency – and indeed, there is no public discussion on whether one should be designated. You can go to the Ombudsman or turn to the police to report corruption, but according to TI this is insufficient to tackle corruption effectively.



### 3.5. Poland

#### 3.5.1. Overview/summary

The fact-finding mission to Warsaw, Poland took place from 25 - 27 January 2017. In total, six interviews with stakeholders from different categories (e.g. regulators, industry, consumer associations, payer and others) were conducted. An overview of the details can be found in the Table below.

**Table 3.18 Overview of Interviewees**

Date	Organisation	Stakeholder category
25 - 01	Infarma Poland	Industry
26 -01	Ministry of Health	Regulator
26 -01	MedTech; IPDDL and Polmed	Industry
26 -01	Batory Foundation	Civil society
27-01	Polish Consumer Federation	Consumer association
27-01	National Health Insurance Fund (NFZ)	Payer

#### 3.5.2. General description of the healthcare system

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 (calculated on the basis of monthly salary) is regressive.

The health system in Poland is highly decentralised: the Ministry of Health is the key policy maker and regulator. The Ministry of Health focusses mainly on policies and guidelines, and aims to monitor and control the different departments and healthcare facilities. In addition to the Ministry of Health, three levels of territorial administration and self-government exist (i.e. gmina, powiat, voivodeship), each having 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.

#### *Perception of corruption in the Polish healthcare system*

Transparency International<sup>87</sup> ranked Poland 30/168 countries on the Transparency International corruption list. The score given to Poland was 62, whereby 0 stands for highly corrupt and 100 for very clean. A study published in 2013 showed that the public perceived the healthcare sector as the second-most corrupt sector in Poland, after politics. Furthermore, in Poland 15% of the respondents admitted paying for a bribe in 2014, for which nine out of ten were in the healthcare sector.<sup>88</sup>

<sup>87</sup> <https://www.transparency.org/country/POL#>.

<sup>88</sup> <http://www.economist.com/news/europe/21647087-central-and-eastern-europe-low-paid-doctors-accept-bribes-and-patients-offer-them-patients-bearing>.

### Healthcare delivery

In Poland most hospitals are public and most primary and ambulatory care provision is private. The private sector is still relatively young and only recently developed. Another important development is the increase in number of public hospitals.

A study published in 2013, shows that 65% of all patients use private healthcare facilities. 91% of pregnant women prefer private healthcare over public healthcare. Private care is also used to bypass waiting lists in the public hospitals (please refer to section 3.5.4. for more details).

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 a 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 donors, have a priority status within the waiting list system.

**Table 3.19 Indicators of the healthcare system in Poland**

Indicators of the healthcare system			
Financing of the healthcare system (1)			
	2012	2015 (or nearest year)	EU average
Total health expenditure as % of GDP	6.2%	6.3%	10%
Public expenditure as % of total health spending	70.0%	71.6%	77.8%
Private insurance as % of total health spending	0.8%	4.0% (2013)	2.2%
Private-out-of-pocket as % of total health spending	24.3%	23.6% (2013)	13.9%
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)	Salaries, Capitation & Fee -for-service		

Sources: (1) OECD 'Health expenditure indicators' DOI: 10.1787/data-00349-en, OECD: DOI:10.1787/health\_glance-2015-graph156-en, Eurostat healthcare expenditure by financing agent, (2) World Bank.

**Table 3.20 Corruption in healthcare perceptions in Poland**

Corruption in healthcare perceptions			
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?			
	2011*	2014**	EU average**
(% of respondents agree - Eurobarometer)	48%	53%	33%

Sources: Special Eurobarometer 374, table QC4 (fieldwork September 2011); Special Eurobarometer 397, 2014 (fieldwork February - March 2013), Annex IV.

**Table 3.21 Corruption Perception Index (CPI), Poland**

Corruption Perception Index	
	2016
Score	62*
Rank	29***

Source: www.transparency.org; \* CPI score is based on a scale ranging from 0 to 100, a score of 0 indicates the country is perceived as very corrupt and a score of 100 indicates a country is perceived as very clean; \*\* the 2012 CPI ranked 174 countries, where a lower rank indicates a cleaner country; \*\*\* the 2016 CPI ranked 176 countries, where a lower rank indicates a cleaner country.

### 3.5.3. Risks and obstacles

The main obstacles and risks for the Polish healthcare system are:

- Different perceptions of what corruption is;
- Low public healthcare expenditure;
- Long waiting lists for specialist public healthcare;
- Lack of knowledge on medical equipment at small hospitals.

Each of these risks is described in more detail below.

#### *Different perceptions of corruption*

One of the main findings of the fact finding mission was the different understanding among stakeholders regarding corruption. The general public in Poland seems to perceive under-the-table payments as a form of corruption, while using your contacts, e.g. family and friends, to obtain a higher place on a waiting list, is seen as a normal practice. People do not recognise the unethical aspects of such behaviour and the fact that other people may have reduced access to healthcare services is not seen as an outcome of such behaviour. One of the explanations might be that many Poles have both a public and private insurance. In order to bypass a waiting list, a patient first goes to the private clinic where a referral to the public hospital can be obtained. Many of the treatments are only available in public hospitals. However, by obtaining a referral from a private clinic to a public hospital, one gets to be placed higher on the waiting list.

All in all, one can conclude that informal payments are perceived as corrupt behaviour, while unethical behaviour regarding privileged access is apparent standard behaviour.

#### *Low public healthcare expenditure*

The public healthcare expenditure in Poland is 5.4% of GDP compared to 10% on EU average. This means that in Poland around 700 US dollars per capita is spent on healthcare. Compared to similar countries, the Polish expenditure is rather low. For instance, the per capita spend in the Czech Republic and Slovenia equals 2,000 US dollars. For other EU countries the per capita spending is much higher. For example, spend on healthcare in the Netherlands and Germany amounts to 7,000 US dollar per capita. Low public healthcare expenditure may lead to physicians looking for jobs – with better working conditions – abroad, which in turn results in long(er) waiting lists.

The Polish government aims to increase the spending on public healthcare to 6% before 2020. In addition, several healthcare reforms have been proposed. Currently, the system is based on an income related system. A percentage is deducted from the employee's salary and directly transferred to NFZ, the sole payer in the Polish system. The government proposes to transform this system into a tax-based system, where people need to transfer the contributions themselves. Although the contribution will become more visible, stakeholders doubt whether the budget will be actually increased as, based on some calculations, the amount collected seems to remain equal.

### ***Long waiting lists in order to receive specialist public healthcare***

Long waiting lists pose a severe risk for the Polish healthcare system. Due to a lack of physicians, waiting lists are long. In addition, most Poles are insured twice; they are publicly insured and, when they are employed, they are also privately insured. When visiting a physician, the patient can either opt for public or private healthcare. However, when more specialised care is required, the patient can only go to a public hospital as most private clinics only offer basic care. In order to get easier access to a public hospital, the patient visits the physician in the private clinic and obtains a referral for the public hospital.

Although several attempts have been made to make waiting lists more transparent, the initiatives have not been successful so far. Patients can only see how long the lists are, but remain unaware of their own position and the positions of others. Some stakeholders also indicated that lists are not frequently updated and therefore contain much outdated information.

### ***Lack of knowledge on medical equipment at small hospitals***

Public procurement is organised at a decentralised level and each hospital or medical facility is responsible for its own procurement. However, most hospitals do not have specialised personnel that could support the procurement process and therefore the physicians themselves have to engage in a tender process. The tender specifications are written by the physicians who have to base such specifications on their own knowledge of medical equipment. Where physicians are not able to write down the required level of detail they sometimes request the help of industry players. It can happen that the medical company drafts the technical specifications in such detail that only one specific company can win the tender.

#### **3.5.4. Types of healthcare corruption**

In Poland different forms of corruption exist. The main ones identified are:

- Informal payments;
- Privileged access;
- Double practices;
- Procurement of medical devices;
- Improper marketing;
- Improper influencing of patients.

#### ***Informal payments***

Informal payments used to be very common in Poland. However, during the last couple of years it has become less common to pay the physician before treatment is received. Several reasons for this decline in under-the-table-payments have been given. First and foremost, the salaries of medical personnel have increased substantially and most physicians, aside from those who have just finished their studies, earn a decent income. The higher salaries have taken away the incentive to ask for additional favours from patients. Second, more physicians have opted to work both in a private and public hospital, which is legally allowed in Poland. By combining the two jobs, the physicians have increased their salaries in a legal manner. Third, the anti-corruption bureau has been active in prosecuting physicians who accepted bribes. These cases also received much media coverage and were publicly debated. As a result, physicians also became more scared of taking bribes and patients became aware of the fact that they do not have to pay a physician.

Although informal payments to get access to physician have decreased, other payments are still made. Stakeholders explained that each patient is insured for a minimum level of care. To receive this care no additional payments have to be made, as it is insured either by the public or private insurance. However, if a patient requires some additional service, payment may be needed, unless the physician is of the opinion that the care needs to be



given. For example, giving birth in a natural way is insured for all women. However, where a woman would prefer a caesarean, but there is no medical need to perform one, she is required to pay the additional costs herself and in such cases, pays the physician directly instead of paying the insurance company.<sup>89</sup>

### ***Privileged access***

Waiting lists may pose a risk for irregularities/corruption. The previous government made progress in regulating waiting lists and creating much more transparency. The main aim is to introduce one central waiting list which should ensure more or less the same level of access to certain medical treatment in each region. However, in some regions patients can still face problems with waiting lists; particularly in terms of specialised treatments the waiting list might not provide insights into the real waiting time.

In order to be ranked higher on the waiting list it is common to first visit a physician via a private appointment before being admitted to a public one where the same physician is also working. This current system enables privileged access and creates a 'grey area' of corruption. The current system works as follows:

1. Patients gather information about where they want to receive treatment, i.e. in which public hospital;
2. They search for the best public specialist working in that field;
3. They search for the private clinic this physician works in;
4. Visit the clinic and make an appointment with the preferred specialist;
5. Mention their interest being treated at the public hospital, and the physician gives them the contact details of the secretary in the public hospital;
6. The patients get privileged access to the public healthcare facilities.

### ***Double practices***

Closely linked to the above mentioned form of privileged access, is the problem of double practices. Many physicians work both in public and private hospitals. As most private hospitals only offer basic care, patients need to be referred to public hospitals to receive more specialised care. In the public hospital, they are treated by the same physicians. This leads to the risk of double practices.

### ***Public procurement of medical devices***

As already mentioned above this type of corruption is quite common in Poland, especially with regard to high tech medical equipment. Due to the lack of knowledge on the side of the procuring body (i.e. the hospital itself) and the wrong incentives of the healthcare procurement system (i.e. no system of checks and balances at hospital level), corruption occurs frequently. Physicians ask medical service providers to assist them in drafting the tender specifications. Such specifications become so detailed that only one company can successfully bid. Medical service providers also use other strategies to influence the procurement processes of hospitals.

### ***Improper marketing***

Improper marketing was a recurrent theme during the interviews. Many stakeholders indicated actions taken to reduce improper marketing. All initiatives taken can be qualified as self-regulation and focus on what can and what cannot be reimbursed by the industry. Such codes of conduct are adopted both at government level, e.g. within the Ministry of Health and NFZ, and at industry level. For example, a code of good practices exists for the

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<sup>89</sup> <http://www.economist.com/news/europe/21647087-central-and-eastern-europe-low-paid-doctors-accept-bribes-and-patients-offer-them-patients-bearing>.

pharmaceutical industry and the medical equipment providers have adopted the MedTech Europe code of conduct. Despite having much self-regulation in place, improper marketing still takes place, as not all industry is party to the codes of conduct.

### ***Improper influencing of patients***

Besides offering physicians extras when prescribing certain medication or advising on small medical equipment, the industry also targets patients. Although it does not directly relate to corruption, several examples were mentioned during the fact finding mission, where patients were treated improperly.

An example mentioned related to patients with a relatively rare illness. This group could potentially become victims of improper marketing, as their medication is often expensive and prices might have been set too high. The patients are made aware of new medications during conferences and meetings of support groups for patients with rare diseases. However, often it is unclear if the medication promoted by the industry will be useful. Nevertheless, patients are willing to pay high prices for such medications (as they are often desperate).

Another example relates to case 3 (see next section) which is described in more detail below. In this case patients are called by one pharmaceutical company that tries to sell patients expensive medication, although it is not clear whether the patient needs this type of medication.

### **3.5.5. Recent cases**

#### ***Most recent types of cases***

During the interviews held, some general types of cases occurring in Poland were mentioned. Below the main types are presented:

1. Physicians deliver fictional services and get reimbursement for these treatments without actual delivery of the services;
2. Patients receive treatment in the private sector, although it is reimbursed by the public sector;
3. Prescribed medicines are not delivered to patients;
4. Medicines are procured in Poland for a relative low price and sold to, for example, Germany (parallel export).

In other cases, patients are asked to pay for medication that is also covered by the public health fund (i.e. NFZ). In such cases, the patient pays twice, without actually realising this is the case. It also happens that potential customers are asked to fulfil other requirements, all of them unnecessary (and sometimes illegal).

#### ***Cases***

During the fact-finding mission different stakeholders mentioned the following recent cases.

##### **Case 1 (2017) – Treating fake patients**

On the 20th of January 2017, there was a scandal in the media; it was a story about a physician who lives near the German Border and worked as a GP. Besides acting as a GP, the accused also worked, simultaneously, at the branch office of NFZ (the national insurer), where she got access to the patients' database. Based on this 'double practice' she created her own database of more than 3,000 patients. She claimed that all these 3,000 came for regular consults and received treatment. With the help of the integrated patient system (in which all treatment data for each patient are included) it was possible to establish that half of the patients had never consulted this GP or received any treatment from her.

**Case 2 (2017) – Bribery in the form of medical devices**

In January 2017, an investigation was launched regarding bribery in the form of medical devices. The academic hospital in Krakow was accused of receiving expensive medical equipment (worth PLN 600,000) from medical companies to use in the hospital. However, the equipment was not used in the hospital, but was transferred to a private clinic. Only patients in the private clinic could benefit of this equipment. The police searched 16 medical facilities, including the academic hospital, and several private companies. No people have been arrested yet, as the prosecution has not yet been able to establish who benefits from this deal.<sup>90</sup>

**Case 3 (2016) – Offering of medical packages by phone**

A recent case, brought to the attention of the Polish Consumer Federation, relates to direct sales of medication packages to elderly people. One company approaches elderly people by phone and convinces them that they need a certain type of medication package. However, it is unclear whether that specific type of medication is effective and the scope of the treatment offered is unclear as well. The explanations offered to the potential customer are very vague and are often not understood by the elderly people. In some cases, the information is also misleading.

Often this medication is very expensive (ranging from EUR 1,000 to EUR 4,000) and the potential customer is not able to pay for the medication. In order to ensure that the potential customer can afford the medication, the company offers additional services, e.g. a bank loan or another form of additional financing. By offering this additional product, the potential customer becomes a consumer and the Polish Consumer Federation could assist them in filing a complaint.

**Case 4 (2016) – Bribery for sick leave statements**

The Silesian police gathered evidence regarding a 66-year old physician that falsely provided patients with sick leave letters in return for bribes in the period 2010 - 2014. The physician had three accomplices who were also arrested by the police. Overall, the police collected evidence for 169 charges of which 152 are currently being heard by a judge. The case of the physician is currently pending in court and the verdict could be up to 10 years imprisonment.<sup>91</sup>

**Case 5 (2016) – Bribery and false documentation**

This case concerns bribes of six suspects and a total of 60 charges. Detailed investigations showed that a 53-year-old physician accepted bribes in exchange for the so-called sick leave statements, while a 49-year old physician changed personal details on medication prescriptions and therefore falsely claimed reimbursement for the medication. In addition to these to physicians, four other people were arrested for actively paying bribes. The 53-year-old physician faces up to 10 years imprisonment. In addition, the four other suspects can face prison sentences of maximum 10 years. In contrast, the 49-year-old medic could be sentenced to 3 months to 5 years for falsifying the documents.<sup>92</sup>

**Case 6 (2016) - Bribery for sick leave statements**

The police collected evidence regarding a 62-year old physician who issued sick leave letters in return for money, alcohol, and cigarettes. The criminal dealings lasted for almost 10 years. The physician confessed to the accusations and will stand trial for 40 charges. The case is pending in court.<sup>93</sup>

**Case 7 (2016) – Requesting bribes for extended hospital stays**

A 44-year old physician told his patients that they could no longer remain on the ward and would need to go home, although the patients still needed medical assistance that could only be given to them in the hospital. In return for a payment, the patients could stay longer and receive the care required. Awaiting the court case, the physician is temporarily suspended and has had to pay bail of PLN 50,000. He faces up to 10 years in prison.<sup>94</sup>

**Case 8 (2014) – Bribery in prescription of medicines**

A foreign drug company and eleven Polish medical specialists have been charged with corruption. These medical specialists had signed contracts with pharmaceutical company and received payments when prescribing their specific drug to their patients.<sup>95</sup>

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<sup>90</sup> <http://www.dziennikpolski24.pl/aktualnosci/a/afeta-ze-sprzetem-do-poszerzania-tetnic,11672662>.

<sup>91</sup> <http://www.antykorupcja.gov.pl/ak/aktualnosci/12177,169-zarzutow-korupcyjnych-dla-lekarki-posrednikow-i-pacjenta.html>.

<sup>92</sup> <http://www.antykorupcja.gov.pl/ak/aktualnosci/12175,60-zarzutow-za-tzw-lewe-zwolnienia-recepty-i-lapowki.html>.

<sup>93</sup> <http://www.antykorupcja.gov.pl/ak/aktualnosci/12110,Korupcyjne-zarzuty-dla-lekarza.html>.

<sup>94</sup> <http://www.antykorupcja.gov.pl/ak/aktualnosci/12146,Slascy-policjanci-zwalczajacy-korupcje-zatrzymali-nieuczciwego-lekarza.html>.

<sup>95</sup> <http://www.bbc.com/news/business-26970873>.

### **3.5.6. Recent policy developments and best practices**

Since the 2013 Ecorys study on corruption in the healthcare sector, several policy initiatives have been taken by the Polish government and other relevant stakeholders. The main initiatives are:

- Adoption of the anti-corruption plan;
- Initiatives taken within the government to prevent corruption;
- Patient related initiatives;
- Self-regulation in the industry.

#### ***Anti-corruption plan 2014 - 2019***

During the last couple of years, some recent policy developments were made. The most important development is the adoption of the anti-corruption plan by the national government. The anti-corruption plan (2014 – 2019) applies to the entire government. The plan does not specifically focus on the healthcare system, but also covers other sectors. The relevant article for the healthcare sector is article 7 of the strategy, which deals exclusively with the actions envisaged for preventing corruption in the healthcare sector.

Article 7 identifies the following areas that need specific tools and measures to combat corruption:

- Reimbursement of medication;
- Public procurement; medication and medical technology;
- The physician-patient relationship;
- The relation between the physician and the pharmaceutical industry and vice versa;
- The relation between the insurers and the physicians and vice versa;
- The contracting of the national health insurance fund.

Based on the program, both the Ministry of Health and NFZ (the national health fund) have taken several actions.

As part of this program, the National Health Fund established an internal working group, which from early 2016 onwards, performed an extensive audit of all internal documents and procedures, especially the ones in relation to business trips and contact with contractors. By the end of 2016, the final report of the working group was sent to the Ministry of Health.

An example of a procedure reviewed was the procedure regarding business trips, which are heavily regulated. NFZ employees are not allowed to take reimbursements from industry. They are only entitled to a DSA and travel costs. Even if they deliver a speech or a presentation at a congress, they are not allowed to get paid by the industry. In addition, entrance fees to conferences cannot be sponsored by the industry.

#### ***Initiatives to prevent corruption taken within the government***

At a governmental level, several initiatives have been taken to prevent and combat corruption. The main initiatives are presented below.

The Ministry of Health has established a reimbursement commission, which assesses whether or not certain payments are in line with the Ministry's guidelines. The reimbursement committee needs to make detailed minutes of all meetings held, and these minutes will be publicly available. A one-on-one meeting is prohibited, as it is qualified as a meeting with a high risk for corruption.

Another initiative is the so-called anti-corruption shield that monitors all actions of staff members, including their spouses, regarding agreements on reimbursements and other promotional activities. The shield aims to protect the employees and tries to ensure that they are not involved in any unwanted practice.

Furthermore, new staff is not allowed to have contact with the industry and vice versa. If a person wishes to switch from the private sector to the Ministry of Health or vice versa, a waiting period has to be followed. During this period, the person is not allowed to work in either of the two sectors.

National consultants who give advice to the Ministry of Health about policies need to sign statements in which they claim that they do not work for private companies as well. Moreover, staff members and the national consultants need to give inside in their salaries.

The national insurance fund has appointed two employees fulltime at its headquarters to perform internal monitoring and to ensure that nothing irregular happens. At each of the 16 branch organisations, one employee per branch is appointed. The branches control and check each other in order to ensure that all procedures are followed. In addition to that, there are subject-based controls of different units. Each year, 3-4 branch offices are controlled / checked in respective departments / units, for example on accounting, financing, Human Resources and international financial settlement.

Moreover, the financial budget plans are controlled by the finance departments of the Ministry of Health and the Ministry of Finance. The two different stakeholders check the plan. Parliament, more specifically the Commission on Health and the Commission on Public Finance also control the budget.

### ***Patient related initiatives***

A recent development made by the national insurance fund enables patients to see the general waiting lists (i.e. number of people on it). In the near future patients will also see their own position on the list (they will have a number with their name attached to it). During the interviews, it became clear that there are different opinions about the usefulness of these waiting lists. A stakeholder mentioned that the waiting lists that are available on internet are not up-to-date. In addition, there is no external pressure to update these waiting lists. This is the reason why patients call friends and family to gather information about waiting times and to exchange experiences on healthcare received.

Another development of the national insurance fund is the central patient information system. Each patient can check his/her file online and receives in-depth information on the care received. Based on this information, the patient can file a complaint when he/she discovers that care not actually received, has been included on the form.

### ***Self-regulation in the industry***

Within the Polish industry, in terms of both pharmaceutical companies and medical equipment providers, several self-regulating codes have been adopted. In addition to these codes, some tools and training programs have been developed, all aiming to make medical professionals and industry players aware of the right business ethics that needs to be followed in order to combat corruption.

The pharmaceutical industry has taken several measures that aim to prevent and control corruption:

- Ethical code – Code of good practices + supporting web-based tool;
- Transparency code;
- Internal disciplinary court;

The code of good practices, implemented in 2008, provides guidance on 'the promotion and advertising of medicinal products, the organisation of symposia, congresses and other scientific meetings, the administration of research, and collaboration with representatives

of medical professions and patients' organisations.<sup>96</sup> The code is based on the code adopted by EFPIA, the EU association for pharmaceutical companies.

Organisers of conferences and other events need to ensure that their conference or event is in line with the standards laid down in the code of good practices. Once the event is in line, the organiser can receive a certificate that serves as proof of compliance with the ethical standards set. Members of the code are able to attend the event, without the risk of attending an event that is not in line with the ethical standards.

Closely linked to the code of good practices, the pharmaceutical association has established a working group, which is developing a web-based tool, which will automate the process of certifying events. This tool is country / sector specific and is currently in testing phase. The official launch is planned for 2018. An event will fall into one of three categories of certificates (green, amber and red) depending on its compliance with Infarma codes. Green certificates are a sign for member companies that the event is safe to attend and thus in line with the ethical standards. The red certificate can be corrected once the venue, program or other is modified in line with codes and standards.

The transparency code of EFPIA governs disclosures regarding cooperation between healthcare professionals and healthcare organisations. This code was implemented in 2015 in Poland.<sup>97</sup> There is, moreover, a transparency register in place. Currently 22% of physicians are registered, providing insights into their salaries and financial benefits received, for the pharmaceutical industry.

The last initiative of the pharmaceutical industry is the internal disciplinary court. Whenever members of Infarma violate the above-mentioned codes, member companies can resort to the internal disciplinary court. The court can exercise its power to educate and discipline member companies.

In addition, the medical equipment suppliers also have codes of ethics. Several associations, e.g. one for distributors of medical devices and one for laboratory personnel, represent these companies. These associations have adopted the Code of Ethics of MedTech Europe and as a result, the same rules apply to the associations and their members. The code has been translated in Polish and is fully in line with the MedTech Code.

The medical supplier associations also have introduced training programs in which they inform their members about the new code and its implications. The main aims and benefits of the training are:

- To spark an open dialogue between suppliers and healthcare professionals;
- To raise awareness and esteem of certain medical professions through continuous education of health care practitioners in the fields of law, ethical standards and best practices;
- Strengthen self-regulation of the IVD sector and standardisation of best practices by leading companies operating in the Polish market.

### **3.5.7. Challenges and conclusions**

The main challenge in Poland is the underfunding of the healthcare system. As indicated before, the total public spending on the sector is 5.4% of the GDP, while the EU average is 10%. Although the government aims to increase the spending to 6% and some reforms are proposed, these actions do not seem to tackle the problem of underfunding. One of the most important changes will be the shift from a social insurance system to a tax based

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<sup>96</sup> <https://en.infarma.pl/ethics/code-of-good-practices/>.

<sup>97</sup> [http://transparency.efpia.eu/countries/download/20/document\\_3/transparency-code\\_edit\\_3\\_140814-9effective-27-09-2014\).pdf](http://transparency.efpia.eu/countries/download/20/document_3/transparency-code_edit_3_140814-9effective-27-09-2014).pdf).

system. However, preliminary calculations indicate that the total amount collected will not change as a result of this change.

Another large problem in the Polish healthcare system is the long waiting lists, which are caused by a lack of physicians. There are not enough medical professionals available in the Polish system, which leads to long waiting lists.

Closely related to the problem of long waiting lists, is the lack of transparency of the waiting lists. Patients are not able to obtain any insight into their position on the lists, let alone be able to compare their position with that of other patients. In addition, the waiting lists are not frequently updated and often present old information.

Together, these problems regarding waiting lists, the lack of physicians, and the non-transparency of the lists themselves, create the potential for corruption, as many Polish people use the combination of private and public health insurance to quickly bypass the long waiting lists. As was indicated several times in the report, bypassing the waiting lists is common in Poland. As was also indicated, many Poles do not consider this as a form of corruption, but as standard practice.

The Polish government has adopted many procedures and guidance regarding improper marketing. The guidance adopted can be qualified as self-regulation and is often strongly internally focused, so the relation between government staff and the industry is clear. However, the Polish government has adopted less guidance or initiatives on combatting other types of corruption. There is an anti-corruption plan (2014 – 2019), but the actions for the healthcare sector laid down in this plan are rather generic and it is not yet clear how they will be fully implemented.

In addition, the industry itself has adopted self-regulation, e.g. the Code of good practices and the Transparency Code adopted by the pharmaceutical industry and the Code of Ethics for the Medical equipment providers. Although these Codes form a good basis for combatting improper marketing, it should be noted that several companies active in Poland are not bound by these Codes, as they are not members of the associations that have adopted the Codes. Therefore, the Codes only apply to part of the industry active in Poland.

Corruption in the public procurement systems is still common in Poland; however, there is not much information about the prevalence of this type of corruption. The main risks for this type of corruption are the lack of knowledge on the side of the hospitals responsible for the procurement, and gaps in the legislation.

As mentioned in the recent publication on Health Care and Long-term Care Systems & Fiscal Sustainability (2016), the Ministry of Health is particularly vulnerable to lobbying, informal pressures and corruption proposals by external stakeholders, particularly the pharmaceutical industry. Steps have been taken in collaboration with the EHFCN to improve transparency and decrease risks.

It seems that petty corruption in healthcare is becoming less common in Poland, as the informal payments are decreasing. The decrease in informal payments can be explained by the stronger likelihood that corrupt physicians will be caught and prosecuted. Another explanation given for the decrease in informal payments is the rise in salaries, which also make it less essential for physicians to ask for additional payments.





### 3.6. Romania

#### 3.6.1. Overview

The fact-finding mission to Bucharest, Romania, took place between 6 and 8 December 2016. During this mission, four face-to-face interviews were held. In addition to the mission to Romania, phone interviews were conducted with the World Bank, a civil society representative, and a representative of the Ministry of Justice. An overview of the interviews conducted is presented below.

**Table 3.22 Overview of interviews in Romania**

Date	Organisation	Stakeholder category
6 December 2016	Centre for Legal Resources	Civil society
7 December 2016	DNA (anti-corruption Bureau)	Public Prosecution
7 December 2016	Association for consumers' protection – APC	Patients
7 December 2016	Dutch Embassy	Other
13 December 2016	World Bank	Other
23 May 2017	-	Civil Society
25 May 2017	Ministry of Justice	Regulator

#### 3.6.2. General description of the healthcare system

The Romanian healthcare system is a social healthcare system that provides a comprehensive healthcare benefits package to 85% of the population.<sup>98</sup> As the state guarantees the right to health for every Romanian citizen (according to article 34 the Romanian Constitution), the remaining population has access to a minimum benefits package (for example emergency services).<sup>99</sup>

The Romanian healthcare system is highly centralised, despite efforts to decentralise some of the regulatory functions.<sup>100</sup> The Ministry of Public Health (MoH), is the central authority in developing healthcare policies, the provision of inspections and control, and the administration of national health programmes.<sup>101</sup> 42 districts (*judet*), including the municipality of Bucharest, are responsible for ensuring healthcare provision at local level. District public health authorities (DPHAs) represent the MoH at local level.

In 1998 Romania introduced a national fund for social health insurance, the National Health Insurance Fund (NHIF), which is managed by the National Health Insurance House (NHIH). NHIH enters into contracts with healthcare providers, for healthcare procurement and the reimbursement of medical services. NHIH is represented by 42 district National Health Insurance Houses (DNHIHs), which are responsible for contracting services from public and private healthcare providers and the reimbursement of medical services. The services to

<sup>98</sup> European Observatory on health Systems and Policies, Romania Health system review, Health Systems in Transition, Vol.18 NO.4 2016.

<sup>99</sup> There are two types of medical services: the basic medical services provided to the insured individuals (art. 221, 1, c of the Law no. 95/2006 on the healthcare reform) and the minimum package of medical services that applies to all persons in Romania irrespective of the insurance status. These second type of services that are secured unconditionally are emergency medical services, epidemic disease, monitoring pregnancy and lactation, family planning services, community health care prevention (art. 221, 1, d of the Law no. 95/2006 on the healthcare reform). In order to be insured you have to pay the contribution to the national health funds. Payment to the fund is mandatory (article 219, 3, e of the Law 95/2006) and it retained and paid by the employer or employment service (article 228, 1) for all employees and social security beneficiaries (article 222, 1). Automatically insured without having to pay are pensioners, children, and youngsters during education years, persons with disability, pregnant women, and patients with chronic illness etc (article 224). There are people that do not have any legal income, do not have social security benefits and are not among those automatically insured (ex. people that work without legal forms). They are uninsured, but they may become insured if they pay a monthly contribution at the level of contribution for minimum wage (article 224, 4).

<sup>100</sup> European Observatory.

<sup>101</sup> Law no. 95/2006 on healthcare reform.

be contracted are stipulated in an annual Framework Contract that is agreed upon between the NHIF, the Ministry of Public Health and the College of Physicians.

Traditionally, each ministry in Romania has its own medical facilities and apparatus (service providers). Until 2013, the Ministry of Transport had its own Insurance House that financed the service providers of the Ministry. In 2013 the Transport Insurance House was closed and the duties, service providers and the persons insured were taken over by the Ministry of Health and NHIF (Emergency Ordinance no. 8/20013). As such it still functions the Health Insurance House for Defence, Police, National Security and Justice (OPSNAJ). OPSNAJ was put by law under the supervision of NHIF (article 276 of the Law no 95/2006). In fact, OPSNAJ functions like a *Matryoshka doll* – a little House within a bigger House. OPSNAJ has its own insured persons, and finances the medical services provided by the service providers established under these ministries. Nevertheless, there is only one insurance fund to which all contribute, although the fund is split afterward between NHIF and OPSNAJ.

MoH and NHIF are central in the provision of healthcare in Romania, including the control of corruption and abuse, in particular in direct relation to corruption in public procurement in hospitals and, for example, insurance fraud.<sup>102</sup>

Romania spends around 6% of GDP on healthcare, substantially below the EU average of 10% (Table 3.23). About 80% is publicly funded, which is slightly more than the EU average. Most public funding comes from the direct social insurance contributions to the National Health Insurance Fund (NHIF)<sup>103</sup> plus a small percentage of taxes allocated to the Ministry of Public Health. Out of pocket payments are the second largest revenue source (about 19%), which appear as co-payments on covered services, direct payments to private providers and payments for uncovered services. In addition informal payments are an important source of financing. However, it is not known what the size of this is relative to official healthcare payments.

Healthcare delivery in Romania is based on a gatekeeping system, which assigns a primary role to the general practitioner in the provision of healthcare access. Patients need a referral from their general practitioner to be eligible for reimbursed hospital care. 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, whose calculation methods differ by service. Hospital payments for inpatient services are calculated per case based on a DRG system. Costs for outpatient services are reimbursed by fee for service.

Although the right to healthcare for every Romania citizen is secured in the Romanian Constitution, there are widely noticed inequalities in the access to healthcare (among social-economic groups as well as geographical differences).<sup>104</sup> In addition quality of healthcare is mixed, while the monitoring of quality also needs to be improved.<sup>105</sup> Inequality in access to healthcare and differences in quality of the services provided are core issue of concern from the perspective of the fight against corruption in the relations between patients and healthcare providers.

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<sup>102</sup> Radu Nicolae, Healthcare corruption – patterns and vulnerabilities in Romania, in: Narrative on Organised Crime in Europe. Criminals, Corrupters & Policy. Petrus C. van Duyne, Miroslav Scheinost, Georgios A. Antonopoulos, Jackie Harvey, Klaus von Lampe (eds.), Wolf Legal Publishers 2016 Nijmegen.

<sup>103</sup> Collected by the Fiscal Administration National Agency of the Ministry of Finance and 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.

<sup>104</sup> European Observatory.

<sup>105</sup> European Observatory.

**Table 3.23 Indicators of the healthcare system in Romania**

<b>Indicators of the healthcare system, 2015 (or nearest year)</b>			
<b>Financing of the healthcare system (1)</b>			
	2012	2015 (or nearest year)	EU average
Total health expenditure as % of GDP	5.48%	5.57% (2014)	10%
Public expenditure as % of total health spending	80.27%	80.4% (2014)	77.8%
Private insurance as % of total health spending	0.2%	1.1% (2014)	2.2%
Private-out-of-pocket as % of total health spending	19.5%	18.9% (2014)	13.9%
<b>Organisation of the healthcare system (2)</b>			
Social insurance or tax-based system?	Social insurance		
Gatekeeping by a general practitioner (GP)?	(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)	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) WHO Health expenditure ratio, per country, 1995-2014, Eurostat healthcare expenditure by financing agent (2) Joint Report on Health systems (2016), HEIDI WIKI and Euro Health Consumer Index 2012, (3) Euro Health Consumer Index 2012.

**Table 3.34 Corruption in healthcare perceptions in Romania**

<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>			
	2011*	2014**	EU average**
(% of respondents agree - Eurobarometer)	61%	67%	33%

Sources: \* Special Eurobarometer 374, table QB7 (2014), \*\* Special Eurobarometer 397, 2014 (fieldwork February - March 2013), Annex IV; own research (Feb - March 2013).

**Table 3.25 Corruption Perception Index (CPI), Romania**

<b>Corruption Perception Index</b>	
	2016
<b>Score</b>	48*
<b>Rank</b>	57***

Source: www.transparency.org; \* CPI score is based on a scale ranging from 0 to 100, a score of 0 indicates the country is perceived as very corrupt and a score of 100 indicates a country is perceived as very clean; \*\* the 2012 CPI ranked 174 countries, where a lower rank indicates a cleaner country; \*\*\* the 2016 CPI ranked 176 countries, where a lower rank indicates a cleaner country.

Another weakness in the Romanian healthcare system is the relatively low salaries for healthcare providers (compared to other professions in Romania and compared to doctors and nurses in other European countries), in combination with the low status of medical work and unfavourable working conditions and career development opportunities.

For example, in 2015, some 13 500 physicians were working in Romanian hospitals, which has been calculated as about half the number actually needed. This is, to a large extent,

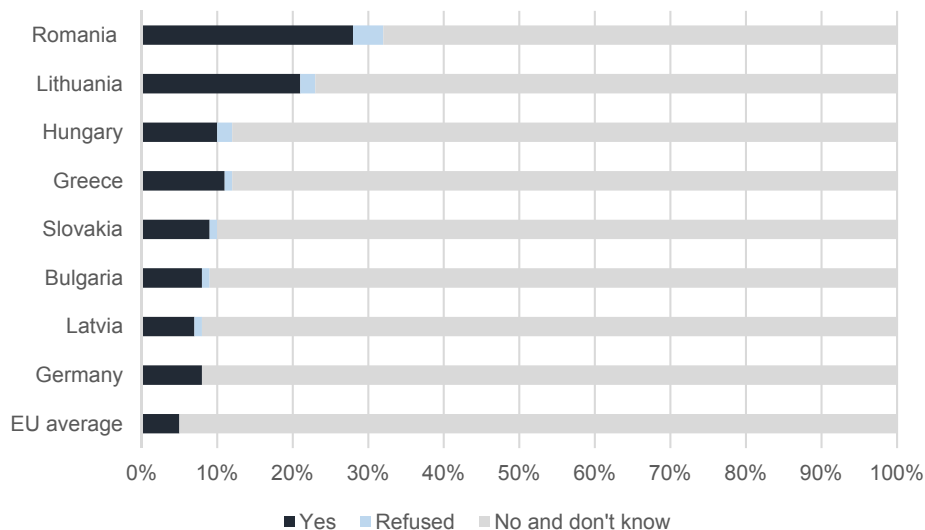
due to a high rate of migration to other countries.<sup>106</sup> Wages that start at EUR 250 a month and top out at EUR 500 incentivise many to go abroad, or accept additional informal payments or other forms of irregular salary supplements.

In comparison with other European countries, Romania ranks low in the general quality of healthcare and high in perceived levels of healthcare corruption. For example, Romania ranks lowest out of all European countries on the Euro Health Consumer Index of 2016.<sup>107</sup> And according to the Special Eurobarometer 397 (published in 2014), Romania emerged as be the EU country most prone to bribery in medical service delivery. In response to question QB2 – “Apart from official fees did you have to give an extra payment or a valuable gift to a nurse or a physician, or make a donation to the hospital? – 26% of interviewees answered ‘yes’, with an additional 4% of spontaneous refusals, which are the highest scores across Europe (Figure below).

**Figure 3.1 Bribery in Medical service delivery (Special Eurobarometer 2014)**

*Question B2. Apart from official fees did you have to give an extra payment or valuable gift to a nurse or a doctor, or make a donation to a hospital?*

Answers from countries with ‘yes’ above European average



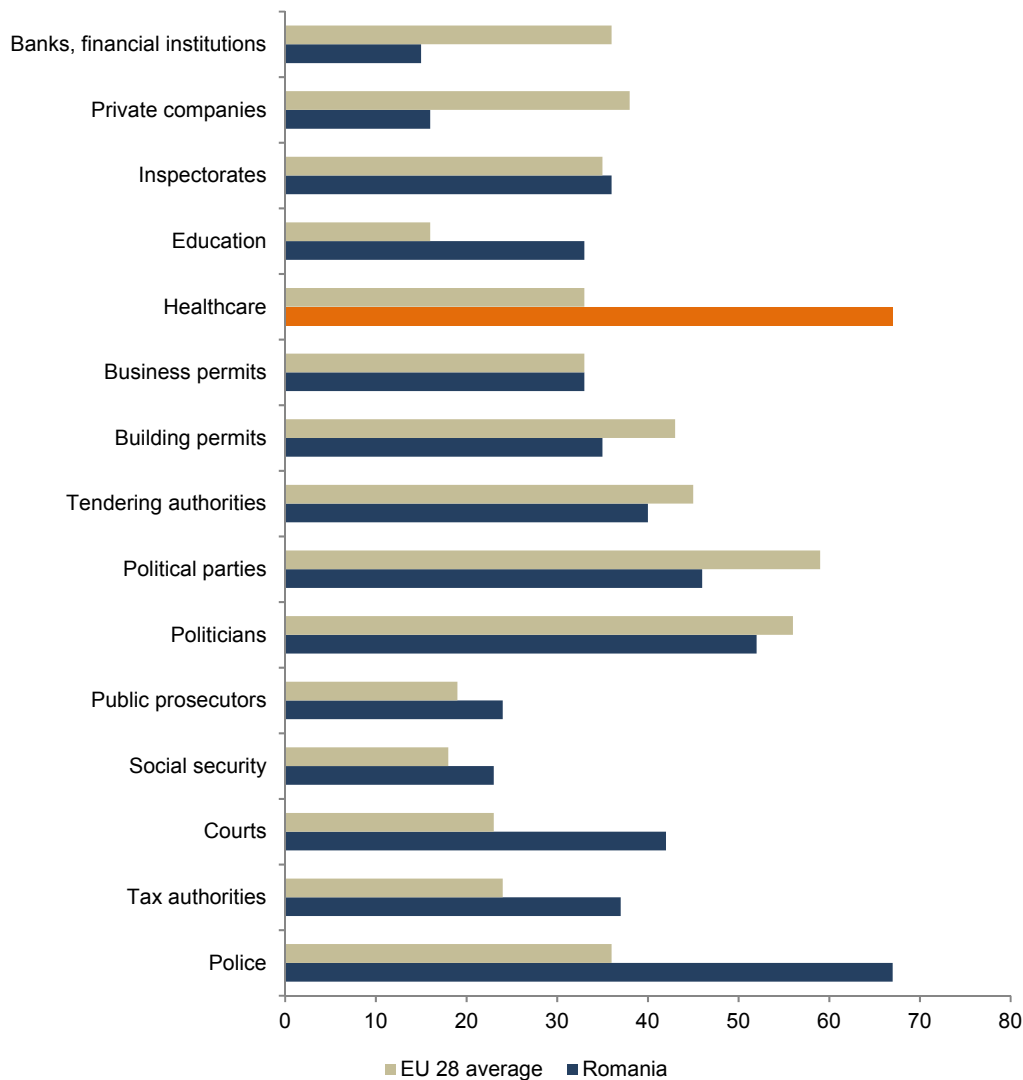
Source: Special Eurobarometer 397, 2014 (fieldwork February – March 2013), p.89.

The special Eurobarometer also contextualises corruption in healthcare within other sections of Romanian society and compared to the EU averages. Figure 3.2 shows that the perceived levels of corruption in Romania are highest in healthcare (67%) and the police (67%) – and are much higher than EU averages.

<sup>106</sup> See <http://www.politico.eu/article/for-paper-hold-til-wed-romanian-victor-ponta-surgery-european-health-care-prime-ministers-surgery-abroad-raises-eyebrows/>.

<sup>107</sup> See <http://www.healthpowerhouse.com/en/news/euro-health-consumer-index-2015/>.

**Figure 3.2 Perceived levels of corruption in Romania, compared to EU averages**



Source: Ecorys, data from Special Eurobarometer 397, 2014.

High levels of corruption and relatively low (and mixed) levels of the quality of the services are strongly intertwined. Corruption affects the quality of services, as resources are drained from the provision of healthcare services. In addition, problems with the quality of the medical system also stimulate corruption.

### 3.6.3. Types of corruption in the healthcare system

The striking features about corruption in the Romanian healthcare system are that (a) corruption is widespread, and occurs among all corruption in healthcare typologies as described in the previous study on corruption in the European healthcare system, on behalf of DG HOME. In addition (b) the debate on corruption in healthcare in Romania is being conducted very openly, with healthcare corruption cases appearing regularly in the headlines of the national press, and high-profile cases being actively investigated and prosecuted by the National Anticorruption Directorate DNA.

Corruption in healthcare occurs in Romania in relations across all types of stakeholders in the healthcare sector, such as: the widespread practice of informal payments in order to get access to (better) medical treatment or to obtain false medical certificates providing entitlement to social benefits (between patients and healthcare providers), the occurrence

of double practice (patients, healthcare professionals, and hospitals), procurement of medical devices (involvement of industry and payers), authorisation and procurement of pharmaceuticals (also involvement of industry and payers), corruption in the appointment of hospital or MoH managers, and corruption within the healthcare educational system. Other forms of corruption in the healthcare system are, for example: illegal sponsorship (sponsorships are not illegal per se, but bribes and conflicts of interests are sometimes hidden in sponsorships) with several high-profile investigations relating to this practice, and parallel exports (doctors prescribing medicines to their patients without delivery; medicines are sold to other EU countries, at higher prices).

Nicolae (2016) stipulates that corruption occurs at every layer of the Romanian healthcare system<sup>108</sup>, from the highest level of policymaking to mid-level policy implementation, up to the day-to-day level of the provision of healthcare services.

### ***Policy making***

At the highest level, corruption patterns resemble 'state capture', involve misuse of (high) level positions and undue influence over health care regulations, corruption related to privatisation decisions, and the allocation of large funds.

#### **The Hospital case<sup>109</sup>**

On 9 December 2016, DNA – the anti-corruption Bureau- brought in a former Hospital Manager for questioning. The former manager of the Hospital was suspected of embezzlement of the hospital budget through cash withdrawals'. Total amount embezzled was estimated to be 2 million RON (EUR 430,000). The manager asked his subordinates to produce false invoices and bills for services that were never provided, to cover the missing money.

The former manager was also accused of asking a company benefiting from hospital contracts to cover some 470 trips for the manager and colleagues. The firm provided plane tickets, accommodation, restaurant meals and rental cars worth some 800,000 RON (EUR 178,000).

Besides these formal accusations of embezzlement and bribery, which are under investigation by DNA, investigative journalists have obtained evidence that the manager was involved in other scandals as well. For example, the manager invited several politicians to the opening of a new nursing home. The manager apparently obtained money for this nursing home using his foundations, which claimed to be affiliated to the Knights of Malta. The nursing home was closed a day after the official opening.

### ***Policy implementation***

At policy implementation level corruption patterns involve a wide variety of modus operandi including procurement of medical equipment, authorisation and procurement of pharmaceuticals, but also corruption in the nomination of managers or in the university system.

#### ***Procurement of medical devices***

Procurement of medical devices may take many forms, as the payment of kickbacks to hospital managers or government officials for the selection of a specific company, meddling with the quantities ordered or prices that are being paid. There are also cases in which hospital managers buy state-of-the-art equipment (in return for a kickback), that is not needed or where the hospital does not have the staff to operate it. Many cases are known where significant amounts of are spent on equipment that is never used. According to a recent estimate by the President of the National Agency for Public Procurement (ANAP) about 25 to 30% of public procurement contracts are suspected of fraud or corruption,

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<sup>108</sup> Radu, N. (2016), 'Healthcare corruption – patterns and vulnerabilities in Romania'.

<sup>109</sup> <http://www.romania-insider.com/hospital-manager-romania-arrested-bribery-embezzlement-journalistic-investigation/>.

including the common practice of splitting large contracts in order to avoid the obligation to an open call for tender.<sup>110</sup>

### ***Authorisation and procurement of pharmaceuticals***

Pharmaceutical lobbying is a common practice in Romania. Pharmaceutical companies try to get on a governmental list of subsidised drugs. When they are on the list, the companies encourage physicians to prescribe their drug. Physicians are willing to do that, as they receive additional payments from the pharmaceutical companies. They even prescribe the drug in cases where it is not needed (the patient has another disease). The drugs prescribed are often expensive and, as a result, take money from the public healthcare budget.

### ***Appointment of hospital managers***

In general, the Romanian healthcare system is still characterised by a clientelist system of nomination and promotion of hospital managers, MoH and NHIH officials.<sup>111</sup> The supervision of hospitals in Romania is divided between various players. Several hospitals fall under the competence of the Ministry of Health, while many others fall under the competence of other Ministries, such as the Ministry of Internal Affairs, the Ministry of Transport, the Ministry of Defence, etc. There are also hospitals, which fall under the supervision of local councils.

The Ministry or council responsible for the hospital is also responsible for appointing the management. Each Ministry and council therefore has a large influence on the appointment of the hospital manager and other staff on the board. The appointment procedure is unclear and it is often vague on what grounds a person is appointed, making nepotism and favouritism possible. In 2016, the Government adopted an emergency ordinance to combat this type of corruption. The previous government (which ruled until 11 December 2016) aimed to radically change the system of appointing hospital managers. However, the newly elected government, until now, has no intention to further implement the proposed system.

### ***Corruption in the healthcare education system***

Corruption is widespread in the education system for physicians. Medical students learn from the start that if they want to achieve certain goals, they have to bribe their professors. In order to pass certain exams or obtain a position as an intern at a certain department in the hospital, money needs to be paid.

### ***Healthcare professionals***

Corruption strategies by healthcare professionals in order to cope with the system and/or to supplement their salaries, or simply 'profit from the system's vulnerabilities' may involve a wide variety of activities, such as: reimbursement for medical activities that have not been taken place; false prescription of medicines; directing patients to specific pharmacies (in exchange for a kickback); reimbursements on inflated patients lists (fake names); reporting fictitious medical services and patients by hospitals; corruption in human organ and egg donation (see box text); corruption in clinical testing; informal payments for (better) treatment; informal payments for illegitimate disability certificates; and corruption in double practices.<sup>112</sup>

### ***Control bodies reports on irregularities within the National Transplant Agency<sup>113</sup>***

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<sup>110</sup> <https://www.romania-insider.com/one-four-direct-hospital-procurement-contracts-romania-suspicious/>.

<sup>111</sup> Radu, N. (2016), 'Healthcare corruption – patterns and vulnerabilities in Romania'.

<sup>112</sup> Radu, N. (2016), 'Healthcare corruption – patterns and vulnerabilities in Romania'.

<sup>113</sup> Website :Ministry of Health -23 November 2016.

The Ministry of Health commissioned the Control Body to investigate the National Transplant Agency and its related hospitals that are accredited to conduct organ transplants. During a sample in which four accredited hospitals were checked it became clear that in all four hospitals, procedures were not followed and the minimum criteria set out in law were not enforced. Based on the 100% result, the Ministry decided that all active transplant centres in the country need to be checked thoroughly in order to see whether more irregularities can be detected.

The Control Body also showed that the criteria for allocation of organs to patients who need a transplant are not clear, and that the National Transplant Agency does not register organs available for transplant, even though a legal obligation to develop one overall register exists. As a result, each hospital still has its own list for organ transplantation and uses its own waiting times, instead of using one nationwide list. Thus Law 95 of 2006 is violated which clearly states that the National Transplant Agency manages the national registers, which provide continuous monitoring of transplant activities.

### ***Informal payments***

Informal payments are one of most common types of corruption in Romania. Informal payments are to a certain extent motivated by the fact that patients are accustomed to offering gifts after services (in particular older patients and in more rural areas). However, payments are offered in advance in exchange of (faster) access to healthcare, access to better healthcare, or in exchange of a false certificate that entitles the patient to social benefits such as sickness leave, disability and early retirement. Informal payments do not only involve physicians, but extend to all hospital related staff. Nurses, catering people and cleaners may also receive money for services provided.

### ***Double practice***

Double practice occurs frequently in Romania. Double practice is not against the law: physicians are allowed to increase their income with private money earned during evening and weekend hours. However, there are several cases in which physicians make use of the infrastructure of public hospitals for their private (double practice) activities, and are being paid for this by the NHIF.<sup>114</sup> When making use of a double practice medical service, the patient pays twice for the same service; via their mandatory health insurance (to get hospital access) and directly to the physician (who uses the same hospital facilities, which are already paid for). The patients that are able to pay for the 'private' treatment face lower waiting times.

#### **Visual proof double practice**

One of the hospitals in Bucharest is visibly linked to a private clinic, by a bridge. Patients in the private clinic are treated in the hospital, while paying private clinic prices. The clinic is mainly used as a recovery centre (i.e. hotel). The facilities in the hospital are not used for patients who cannot afford private care.

A specific feature of (the fight against) healthcare corruption in Romania is the regular stream of corruption cases that have been disclosed or described by the press over the past few years and the attempts to actively investigate and prosecute corruption in general, including healthcare corruption. A few high-profile cases, such as the disinfectants scandal revealed by investigative journalists, caused much public outcry.

#### **Pharmaceutical case after fire in a night Club**

This scandal started with a fire in a night Club, which took place at the end of October 2015. In its wake, the fire left a trail of 64 dead people. Several of them died during the fire, while others died during their stay in hospital. Although most of the patients died of their wounds, five patients died because of the usage of diluted disinfectants.

Romanian investigative journalists dug deeper into the matter and discovered that the use of diluted disinfectants was widespread in the Romanian health system. The Romanian state purchased these diluted disinfectants for hospitals across the country from a pharmaceutical company that had already been involved in a similar scandal in 2006, at prices that were ten times higher than prices asked by other suppliers.

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<sup>114</sup> Radu, N. (2016), 'Healthcare corruption – patterns and vulnerabilities in Romania'.



### Analysis of DNA cases

Romania's National Anti-Corruption Directorate (DNA) has increasingly targeted high-level corruption since 2007, when intensive EU monitoring was introduced through the Cooperation and Verification Mechanism (CVM) Reports.<sup>115</sup> The research team received a file of 54 cases of corruption in healthcare that have been under investigation by DNA since 2012 (closed and on-going cases). An analysis of file reveals a steady annual increase in the number of cases that have been opened: from 3 in 2012 to 23 cases in 2016:

**Table 3.4 Number DNA cases involving corruption in healthcare (2012-16)**

Year	# of cases
2016 (up until November 2016)	23 cases
2015	14 cases
2014	11 cases
2013	3 cases
2012	3 cases
<b>Total</b>	<b>54 cases</b>

Source: National Anti-Corruption Directorate (DNA).

An analysis of the 'typologies' of corruption in healthcare of these 54 cases (along the typologies defined in the first study on corruption in the European healthcare system), reveals that DNA has investigated and prosecuted particularly high level cases and cases related to policy implementation. The health system in Romania is captured at the policy making level, excessive bureaucracy, poor management, and loopholes deliberately not challenged and even developed in order to drain resources and maintain status-quo.

The underlying charges show a wide variety of offences, often a combination of several offences, such as 'creation of an organised crime group' in combination with 'complicity to giving bribe' and 'complicity to abuse of office'.

**Table 3.5 Typologies of DNA cases involving corruption in healthcare (2012-16)**

Typology	# of cases	Level
Misuse of high-level positions	33	Policy making
Procurement corruption	18	Policy implementation
Bribery in medical service delivery	13	Healthcare professionals
Fraud (various forms)	12	Policy implementation
Undue reimbursement claims	6	Policy implementation
Improper marketing relations	1	Policy implementation

Types of offences (more than 1 per case possible): Bribe giving (complicity to) 10; Bribe taking (complicity to) 39; Abuse of office (of which 3 with extremely serious consequences) 19; Influence peddling / buying influence 15; Conflict of interests 3; Conducting financial transaction incompatible with job description 2; Tampering with official documents 2; Use of false documents 7; Creating false documents 8; Forgery 4; Fraud (complicity to) (of which 1 regarding the quality of goods) 4; Using or presenting bad faith 1; Receipt and sale of stolen goods 1; Creation of an organised crime group 1; Money laundering 2; Instigation to false statements 1; Instigating to forgery documents under private signature 1; Aiding and abetting the perpetrator 1; Allow access to unauthorised information 1.

Source: Ecorys' analysis, based on National Anti-Corruption Directorate (DNA).  
More than one typology per case possible.

#### 3.6.4. Recent policy developments

Since the 2013 (SCH1) publication several policy initiatives have been taken up by the Romanian government. The main ones are policies on:

<sup>115</sup> See e.g. [http://ec.europa.eu/dgs/home-affairs/what-we-do/policies/organized-crime-and-human-trafficking/corruption/anti-corruption-report/docs/2014\\_acr\\_romania\\_chapter\\_en.pdf](http://ec.europa.eu/dgs/home-affairs/what-we-do/policies/organized-crime-and-human-trafficking/corruption/anti-corruption-report/docs/2014_acr_romania_chapter_en.pdf).

- Introducing co-payments;
- Taxation of bribes;
- Adopting an anti-corruption policy;
- Increasing transparency in the appointment of hospital managers;
- Introducing a special phone line;
- Uptake of the electronic health card;
- Wage increases for medical staff.

### ***Policy to introduce co-payment***

Legalising informal payments by creating a co-payment system, was one of the priority policies of the large healthcare reform program that started in 2006. In the original proposal, which was supported by the World Bank, it was proposed that patients needed to pay a small contribution for receiving care (5 EUR for a family doctor, 10 EUR for a specialist physician and 10 EUR per day for a hospital admission). It was estimated that this system would generate 340 million EUR annually, an amount equal to the informal payments currently paid.

The initiative has been long debated in the Romanian Parliament. The law was drafted in 2010 and adopted in 2011. The policy was changed twice in 2012 and finally adopted in April 2013. By then, the co-payment regime had changed. A co-payment only has to be paid in case of hospital admissions, and has a value between 5 – 10 RON (1 – 2 EUR) irrespective of the number of days admitted. Also, many exemptions have been introduced. Patients exempted are pregnant women, children, students, pensioners with an income lower than 740 RON and the unemployed. As a result, the additional income generated by physicians and hospitals is low. In addition, the distribution of the additional income is unequally divided, with some hospitals receiving quite a significant sum of additional money, while for others, especially the small local hospitals the additional income is less than 25 EUR on a yearly basis.

It could be concluded that this policy has failed. On the one hand, the co-payments are low and therefore do not generate much additional income; on the other hand, patients still pay physicians informally. As a result, patients make an informal payment twice rather than just once. It should be noted that besides the informal payments, patients also pay via their insurance to the healthcare system. Although this policy initiative has failed, the government is not planning to change it.

### ***Policy to tax bribes***

A policy initiative linked to the policy of introducing a system of co-payments is the taxation of bribes.<sup>116</sup> The government and several MPs proposed, in 2015, to impose taxation on the bribes received. Although this proposal was heavily criticised, it is still pending in Parliament. The general public holds mixed views with regard to paying bribes and the potential taxation of bribes. During a recent survey conducted by the Ministry of Health<sup>117</sup> 46% of the respondents indicated that bribes should not exist, while another 46% indicated that bribing is an entrenched practice. 22% believe that paying informal payments are a form of reward, while 10% indicated that giving gifts is normal for them, and nothing has changed.

### ***Adoption of the National Anti-Corruption Strategy***

On 10 August 2016, the new National Anti-Corruption Strategy (NAS) 2016-2020 was adopted, building upon the previous anti-corruption strategy covering the years 2012-2015. Approximately 90 public institutions, non-governmental organisations, business

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<sup>116</sup> Prime-Minister declarations: Romania considers legalizing bribery to keep doctors by Vlad Odorescu – The Washington Times- Tuesday, October 6, 2015.

<sup>117</sup> Radu, N. (2016), 'Healthcare corruption – patterns and vulnerabilities in Romania'.

association as well as state-owned and private companies were involved in the development of the new strategy.

In addition to six overall objectives (develop a culture of transparency, increase institutional integrity, strengthen integrity and reduce corruption risks in priority sectors, increase awareness and understanding, consolidate performance in combating corruption through criminal and administrative means, increase the recovery of proceeds of crime), specific actions for the healthcare sector (as one of the priority sectors) have been formulated. These actions include:

1. Create a mechanism with a clear prioritisation of budgetary allocations and assessment (evaluation) of the decisions and their implementation;
2. Enhance transparency of the use of public resources, by centralised aggregation of data on the portal [transparenta.ms.ro](http://transparenta.ms.ro);
3. Evaluate the performance of the centralised procurement system of the MoH;
4. Create within the MoH and NHIH a joint mechanism for monitoring and controlling suppliers in the social health insurance system;
5. Create a mechanism for the traceability of medicines on the Romanian market;
6. Strengthen the control and integrity structures within the MoH and extend their competence;
7. Improve accountability mechanisms for managers and other decision makers in hospitals;
8. Develop a new mechanism for the financial support of continuous medical education, with a view to eliminating sponsoring by the pharmaceutical industry and sponsoring by medical equipment suppliers to the benefit of the medical staff;
9. Identify the situations which can generate conflicts of interest among the clinical and managerial staff;
10. Review the patient feedback mechanism.

The estimated necessary budget for implementing those actions is 19.800.000 Lei (approx. 4.3 million EUR). Main responsible institutions are the Ministry of Health and the National Insurance House. Actions 2 – 5, 9 and 10 needed to be realised by the end of 2016. Actions 1, 6 and 7 should be completed before the end of 2017 and action 8 should be finalised by the end of 2018.

### ***MoH Integrity department***

As mentioned in the initial study on Corruption in the Healthcare Sector,<sup>118</sup> in 2011, an Integrity Department was set-up in the Ministry of Health. This department has the responsibility to develop and implement strategies to fight corrupt practices and counter corruption risks within the healthcare system. Romania's National Reform Programmes of 2015 and 2016 under the Europe 2020 Strategy, mention a number of healthcare reforms undertaken with the aim of reducing informal payments.<sup>119</sup> One of the reforms was the signing of a financing agreement under the European Social Fund for 'Good Governance through Integrity and Responsibility in the Health System'. The aim of the agreement is to develop a coherent policy to combat corruption in the healthcare system, with special assistance from the Ministry of Health's Integrity Department. In addition, more staff for the Integrity Department were hired and a complaints monitoring system was adopted. Measures to be implemented in 2017 are a corruption risk analysis in all medical structures, monitoring of public procurement, monitoring of hospitals spending, and implementing a patient feedback mechanism.<sup>120</sup>

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<sup>118</sup> Study on Corruption in the Healthcare Sector, 2013, p.296.

<sup>119</sup> See [http://ec.europa.eu/europe2020/pdf/csr2015/nrp2015\\_romania\\_en.pdf](http://ec.europa.eu/europe2020/pdf/csr2015/nrp2015_romania_en.pdf).

<sup>120</sup> [http://ec.europa.eu/europe2020/pdf/csr2016/nrp2016\\_romania\\_ro.pdf](http://ec.europa.eu/europe2020/pdf/csr2016/nrp2016_romania_ro.pdf).

### ***Increasing transparency in the appointment of hospital managers***

In addition to the adoption of the NAS 2016-2020, the Government adopted an emergency ordinance (EO no. 79/2016) which aims to modify the selection of hospital managers.<sup>121</sup> The ordinance states that managers should be selected through open competition, and thereby reducing the charge on favouritism. In addition, the ordinance also extends the list on potential conflicts of interests to a wider category of hospital management staff. Early in 2017, the ordinance was rejected by the Senate. In May 2017 the Chamber of Deputies overruled the Senate decision and adopted the law approving EO 79/2016 but repealing certain key anti-corruption provisions regarding conflicts of interest and incompatibilities between management positions and political affiliations. The Romanian president refused to promulgate the law and sent it back to Parliament in June 2017 for re-examination. The Senate is expected to start the re-examination process beginning in September 2017.

### ***Introduction of a phone line to report corruption***

Another recent initiative – introduced in December 2016 - was the introduction of a special phone line where patients, doctors or witnesses of corruption cases can report on potential breaches, including public procurement suspicions.<sup>122</sup> Setting up the phone line was an initiative of the Ministry of Health. The system is managed by the General Anti-Corruption Directorate (DGA). DGA provides the Ministry of Health with data analysis, reports, case studies and other relevant material, and the Ministry can take further action if necessary.

### ***Uptake of the electronic health card***

An initiative that seems to be more effective is the use of the electronic health card.<sup>123</sup> This card was already introduced in 2015, but technical failures occurred which hampered a successful introduction. System failures occurred throughout 2016, but their frequency is diminishing. The aim of the card is to reduce the opportunities for social insurance fraud. Due to the technical failures, it is currently not possible to assess its impact.

### ***Wage increase medical staff***

As of January 2016, a portal to monitor public procurement contracts was under way and a part of the procurement of goods is now centralised at Ministry level.<sup>124</sup> Wages of medical personnel have been raised by 25%, which may be instrumental in reducing the incentive to ask for informal payments, and are scheduled to be doubled in 2 to 3 years. In July 2017, the new public sector wage law came into force (Law no. 153/2017). According to the new law, Romanian doctors' and nurses salaries should double next year, with a 25% increase in January 2018 and the rest in March 2018.

While there is common agreement that salaries are too low and the healthcare system is underfinanced, which are the main factors driving the exodus of Romanian healthcare professionals, there is still doubt that the increase, in itself, will be enough to end a deeply entrenched culture of bribery.<sup>125</sup> Moreover, the new law providing salary increases for all state employees, raises concerns about the budget deficit.

The government's intention to hike the salaries of medical staff has sparked debate in Romania. While everyone agrees that the healthcare system is underfinanced and numerous doctors and nurses leave the country each year due to the low salaries, pundits

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<sup>121</sup> SWD(2017) 25 final: Romania: Technical report (CVM).

<sup>122</sup> SWD(2017) 25 final: Romania: Technical report (CVM).

<sup>123</sup> SWD(2017) 25 final: Romania: Technical report (CVM).

<sup>124</sup> SWD(2017) 25 final: Romania: Technical report (CVM).

<sup>125</sup> Interviews for this study and <http://www.business-review.eu/featured/government-approves-25-pct-salary-increase-in-healthcare-system-86488>.

argue that the increase by itself will not address the issue nor will it help end a deeply entrenched culture of bribing. In addition, there are concerns that the public sector salary increases will raise the budget deficit. For the five months of 2017 the budget deficit was 0,27% of GDP according to the Ministry of Finance (three times more than in the same period in 2016). Eurostat issued in July 2017 data confirming the deficit trend, Romania being on second place, after France, with a deficit of 3,2% of GDP in the first trimester of 2017.

### ***National Agency for Public Procurement***

A new National Agency for Public Procurement has been set up, which will integrate control and verification procedures previously performed by two agencies, and will have a role in policymaking as well.

#### **Initiative to decriminalise corruption**

In January 2017, the newly established Romanian government adopted an emergency law that, should it become effective, would decriminalise certain forms of corruption. The motivation for adopting this new law is the overcrowded condition of Romanian prisons. Government officials indicated that decriminalising offences up to 200,000 LEI (EUR 45,000) per case, would lead to a substantial decrease in the number of prisoners, enabling the prisons to function in a more optimal way. Opponents to this new law suggested that this law would particularly benefit the new Prime Minister who is under investigation over abuse of power allegations and had also previously received a two-year suspended sentence for an elections offense.

In addition to the above described initiative, the government also adopted a decree that would allow for the release of some officials who are currently in prison after being convicted for corruption.

The new initiatives sparked a strong reaction from the Romanian public. Many people demonstrated against the two new decrees and protested for several days throughout the country. After more than a week of severe demonstrations, the Romanian Minister of Justice, who is responsible for the two new decrees, resigned. Although the government announced that the decrees would not be implemented in their current form, they are still working on revised versions, which will be sent to Parliament shortly.

The European Commission expressed its concerns over the situation in Romania stating that *'The fight against corruption needs to be advanced, not undone. We are following the latest developments in Romania with great concern.'*<sup>126</sup>

### **3.6.5. Challenges and conclusions**

Corruption in healthcare is widespread and occurs in many different forms and at all levels of the healthcare system. On the positive side, there is an open debate on corruption, as over the past few years a large number of cases have been revealed by the authorities and by investigative journalists and widely debated in the press. Following a few high-profile scandals in recent years, corruption in healthcare has been brought to the attention of the public. Romania has made progress in fighting corruption in healthcare via criminal law, however the main challenge now will be to bring corruption in healthcare down via other preventive measures. The new National Anti-corruption Strategy (NAS) and measures specifically targeted at the healthcare sector are a step in this direction.

One major problem is the volatility of the National Health Insurance House (NHIH). The House is the only public insurer and in principle all Romanians are required to have insurance provided by this house<sup>127</sup> The National House is supported by local houses. Jointly they pay for medication and treatment however the municipalities, which receive the money from the Houses, invest in equipment. Municipalities can request money for investment, but once the money is transferred from the Houses to the municipalities, there are no further checks. It often happens that the municipalities do not use the money for the purposes for which they received it, and it is then lost in the system. In addition to the

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<sup>126</sup> <http://edition.cnn.com/2017/02/01/europe/romania-protests/>.

<sup>127</sup> It is possible to obtain private insurance as well, but the private insurance is complimentary to the public insurance.

weak financial structure, the National Health Insurance House is not party to the anti-corruption strategy adopted for the healthcare system. They are one of the last few players not participating.<sup>128</sup>

Recent government actions to reverse or stall several key reforms in healthcare, may prove a serious drawback in the Romanian fight against corruption. Several interviewees indicated that, since the start of 2017, many policies aiming to reduce corruption, including healthcare corruption, have come under pressure. In February 2017, the new governmental majority faced the largest protests since the fall of Communism because of their agenda to repeal anticorruption reforms.

While the previous (technocratic) government had a focus on preventing and combatting corruption (in the healthcare sector by increasing the number of inspections, trying to introduce a system of checks and balances, and changing the appointment system of hospital managers), this seems no longer under the attention of the new government. For example, in the new Governance program for the healthcare sector, combatting corruption is not mentioned and the word "corruption" is mentioned just twice in 62 pages.

Besides the risks and obstacles described above, the risks identified during the SCH1 are still relevant:

- Health sector rules and regulations are weak or non-existent;
- Over-regulation;
- Lack of accountability;
- Limited offer of services (i.e., more demand than supply);
- A poor representation of the social partners at the decision level of the National Health Insurance Fund, which renders the anticorruption guarantees ineffective or even eliminates them;
- A broad asymmetry in information;
- Aspects of inequity in the use of healthcare;
- Lack of transparency related to the health reforms and especially in terms 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;
- Incrimination of corruption.

Future progress of Romania in its fight against corruption in general and in healthcare specifically will also depend on political will, and initiatives by the Romanian government. Independent investigative journalism will remain crucial in questioning illegal practices in the healthcare sector. An independent and critical prosecutor's office (DNA) is vital in fighting corruption in a strict way. However, criminal law has its limits. Therefore, active prosecution of corruption cases should be paired with preventive measures, behavioural changes and structural reform of the healthcare sector.

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<sup>128</sup> Although officially no reason for their non-participation is given, interviewees indicated that the House does not want to participate, as there is too much corruption within the House itself

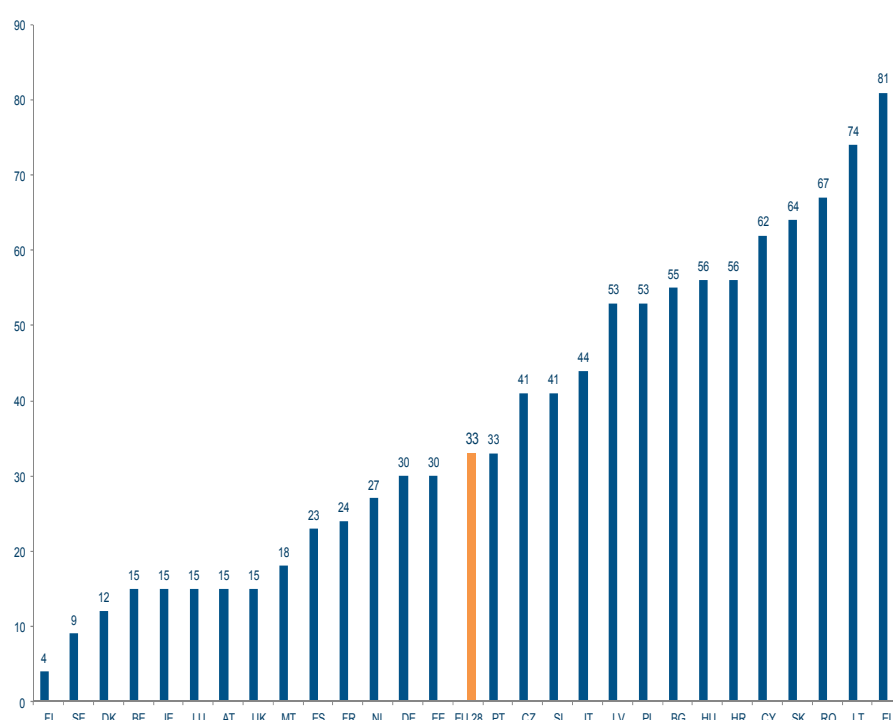
## 4. UPDATE SHC1 AND THEMATIC DEEPENING

### 4.1. Introduction

The Special Eurobarometer 397 serves as an important point of reference for this study: it was published in February 2014 and based on fieldwork in February and March 2013, which was parallel with the fieldwork of our initial study on Corruption in the European Healthcare Sector (SHC1). At the time of the publication of the SHC1, the results of the special Eurobarometer were not yet made public. One important factor included in the Special Eurobarometer is the perception of corruption in each EU Member State. Respondents were asked whether they think that giving or taking bribes, and the abuse of power for personal gain are widespread among the healthcare sector. The answers to this question are presented below.

**Figure 4.1 Perceptions of corruption in healthcare (Special Eurobarometer 397, 2014)**

*QB7 In (OUR COUNTRY), do you think that the giving and taking of bribes and the abuse of power for personal gain are widespread among healthcare?*



Source: Special Eurobarometer 397, 2014 (fieldwork February - March 2013), Table QB12, p.97.

The top-10 countries (with the highest levels of perceived healthcare corruption) are presented in Table 4.1 below. The Table shows that the focus countries for this study are ranked at levels 1, 2, 3, 6, 7 and 10, amongst countries with the highest levels of perceived healthcare corruption and far above the EU average, which stands at 33% (detailed overview, see Annex IV).

**Table 4.1 Top-10 EU countries with highest levels of perceived Corruption in Healthcare (Special Eurobarometer 397, 2014)**

*QB7 In (OUR COUNTRY), do you think that the giving and taking of bribes and the abuse of power for personal gain are widespread among healthcare?*

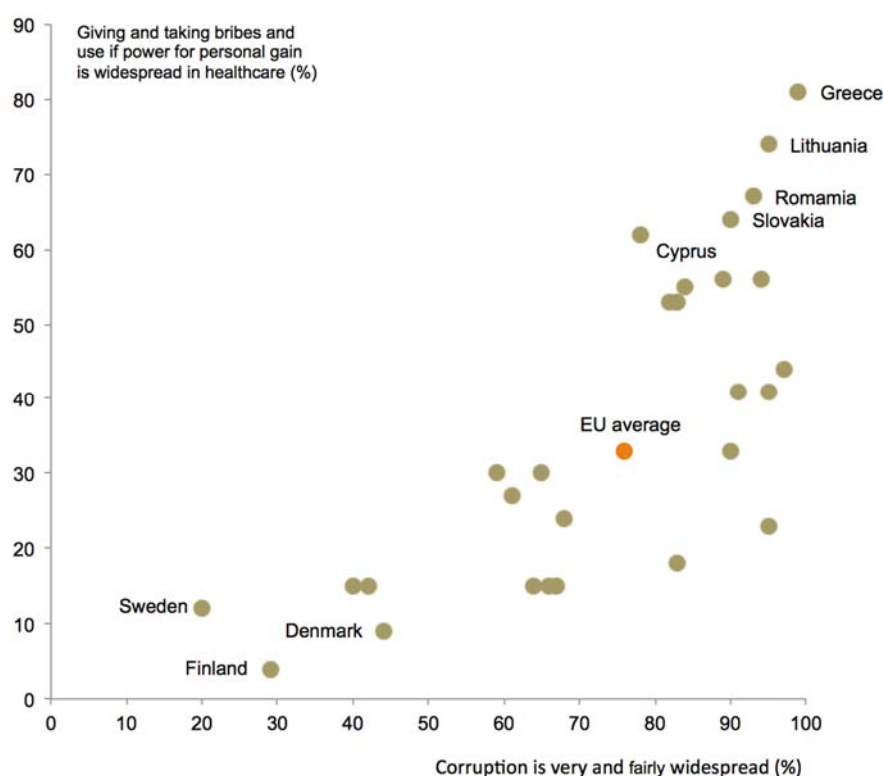
Rank	Country	%
1	Greece	81
2	Lithuania	74
3	Romania	67
4	Slovakia	64
5	Cyprus	62
6	Hungary	56
7	Croatia	56

8	Bulgaria	55
9	Latvia	53
10	Poland	53
EU average		33

Source: Special Eurobarometer 397, 2014 (fieldwork February - March 2013), Table QB12, p.97.

Corruption in healthcare is not an isolated phenomenon. In Figure 4.2, the perceptions of corruption in healthcare are compared with the general perceptions of the existence of corruption. The figure reveals that, in general **perceived corruption in healthcare is correlated with general levels of perceived corruption**. Greece, Lithuania, Romania, Slovakia, and Cyprus are among the countries with both the highest levels of perceived general corruption and specific healthcare corruption, while on the other side of the continuum the Scandinavian countries score well of both indicators.

**Figure 4.2 Correlation between perceptions of corruption in healthcare and general corruption**



Source: Ecorys 2016, derived from Special Eurobarometer 397, 2014 (fieldwork February - March 2013), Table QB7 and QB5.

#### 4.2. Update SCH1

In the initial study on Corruption in the Healthcare Sector (SCH1), 13 general conclusions were drawn:

1. Convictions of (high-profile) corruption cases have a deterrent and norm-setting effect
2. Centralisation of procurement is a method to lower the risks of corruption
3. Central procurement systems can become vulnerable as targets for lobbyist and more politically inspired types of corruption
4. Bribery in medical service delivery cannot be contested with only targeted policies against the phenomenon as such, but need to be supplemented with accompanying (structural) measures
5. Raising salaries does not have a significant preventive effect on reducing bribery in medical service delivery



6. The root causes of corruption in healthcare are related to (i) ineffective managerial structures, (ii) inappropriate financing mechanisms, (iii) insufficient health care capacity, (iv) insufficient funding for independent medical research, (v) unequal allocation of resources and (vi) a general acceptance of corruption in society
7. The introduction of transparent waiting lists has a positive effect on reducing healthcare bribery
8. Prescription of generics instead of branded pharmaceutical products has a positive effect on reducing healthcare bribery
9. Self-regulation between the industry and healthcare providers is needed to fight corruption in healthcare
10. Self-regulation among players (such as within the pharmaceutical industry or among physicians) is needed to fight corruption in healthcare
11. Awareness raising campaigns and fraud and corruption reporting hotlines are an effective instrument to fight corruption in healthcare
12. The government should play a (more) active role in creating transparency in the relations between the industry and healthcare providers
13. The importance of active – independent – media involvement and pressure from 'civil society' watchdogs is essential to fight corruption in healthcare.

During this study, stakeholders were asked whether they believe that these conclusions are still relevant. In order to collect information, the conclusions were included as statements in the survey and interviewees were also asked their opinion during the fact-finding missions. To further complete the information, the conclusions were discussed (whenever relevant) during the EU-level interviews.

In the following sections, we present the results of the survey, the fact-finding missions and EU-level interviews per conclusion. For the analysis of the survey results, the answers are bundled into geographical groups. It should be noted that not all EU-28 Member States are included in the different groups, as we did not receive responses from all countries. We received answers from 19 Member States<sup>129</sup>.

The following groups have been defined, with the total number of respondents per category indicated in brackets:<sup>130</sup>

- Group 1- Mediterranean [10]
  - consisting of Italy, Spain, Portugal and Croatia
- Group 2 - Eastern Europe [16]
  - consisting of Slovenia, Czech Republic, Estonia, Latvia, Lithuania, Romania and Bulgaria
- Group 3 - North West Europe [18]
  - consisting of Austria, Belgium, Denmark, Finland, France, Germany, the Netherlands and the United Kingdom.

#### **4.2.1. Conclusion 1: Convictions of (high-profile) corruption cases have a deterrent and norm-setting effect**

##### **Survey results**

In the survey, a total of 31 respondents indicated whether they agree with the first conclusion of the SHC1 study. In the Table below, the results per answering category are presented. As can be seen, the majority of the stakeholders (65%) agree that convictions in (high-profile) corruption cases have, at least to some extent, a deterrent and norm-

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<sup>129</sup> Countries from which we did not receive responses are: Cyprus, Greece, Hungary, Ireland, Luxembourg, Malta, Poland, Slovakia and Sweden.

<sup>130</sup> An overview of the respondents per country can be found in Section 2.2 above.

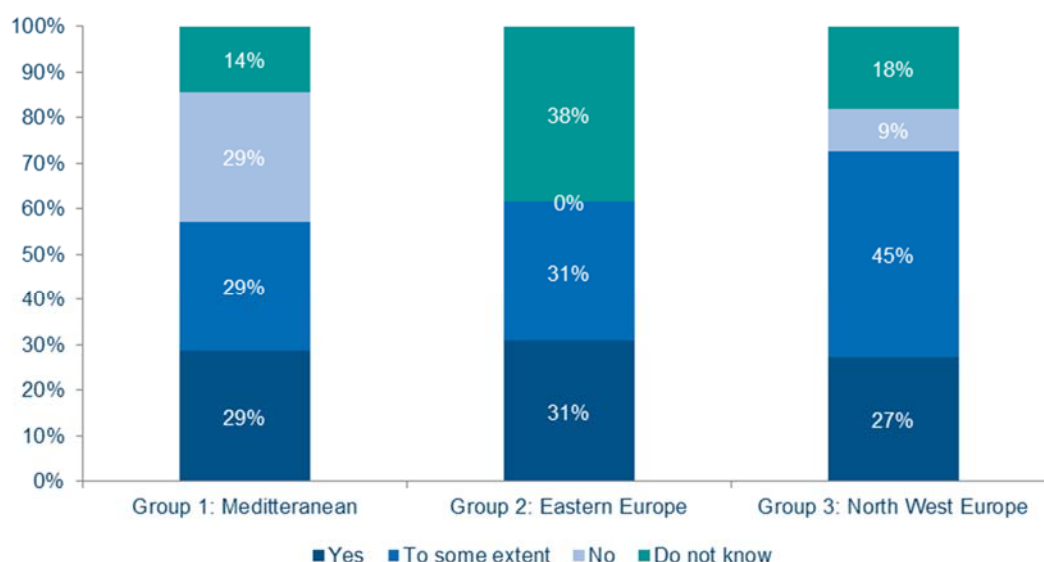
setting effect. It is interesting to see that only 10% (3 respondents in total) disagree with this conclusion. 25% of the respondents answered that they do not know.

**Table 4.2 Answers to statement #1 (n=31)**

Convictions in (high-profile) corruption cases have a deterrent and norm-setting effect (n=31)	
Yes	9
To some extent	11
Not	3
Do not know	8

In the Figure below, the geographical spread for each of the three defined regions is presented. It appears that in Eastern Europe, none of the stakeholders indicated that they disagree with the conclusion; however, the share of respondents not knowing whether convictions will have a norm-setting effect is also the highest in this region.

**Figure 4.3 Geographical spread conclusion #1 (n=31)**



The number of respondents in each group: n= 7 (group 1), n= 13 (group 2), n= 11 (group 3).

### Fact finding missions

**Greece:** Most Greek stakeholders indicated that convictions in (high profile) corruption cases have a norm-setting effect, at least to some extent. However, it should be noted that in Greece hardly any cases of corruption are brought to court. On the one hand, this is caused by the fact that many cases are not reported and / or investigated. On the other hand, cases that are investigated are often not brought to court due to major backlogs in the judicial system. Some stakeholders indicated that it could take between 10 – 15 years before a case can be brought to court.

**Croatia:** Stakeholders in Croatia agreed that convictions of high-profile corruption cases have a deterrent and norm-setting effect on combatting corruption.

**Lithuania:** Overall, most stakeholders agreed with the statement that convictions of high-profile corruption cases have a deterrent and norm-setting effect on combatting corruption. However, one stakeholder mentioned that he/she was unsure whether this applies to Lithuania, as experience in some areas is limited; in 2016, two physicians were convicted for bribery and this was the first time in history that this happened. The hope was that these cases would serve as an example for the future.

**Hungary:** The Hungarian stakeholders interviewed agreed that convictions of high-profile cases would have a deterrent and norm-setting effect, but remarked that this had not yet happened in Hungary.

**Poland:** All stakeholders agreed that convictions of high-profile corruption cases have a deterrent and norm-setting effect on combatting corruption.

**Romania:** Overall, stakeholders did agree with the statement that convictions have a norm setting effect. DNA, the anti-corruption bureau, is seen as a success factor in the fight against corruption. The high number of cases investigated and prosecuted by DNA, specifically focused on high-profile people (both politicians and physicians), is seen as value added. The appointment of the current chief prosecutor (2013) has further increased the effectiveness of DNA, according to the stakeholders interviewed.

### EU-level interviews

Speaking in a personal capacity, representatives of MedTech Europe, the International Association of Mutual Benefit Societies (AIM) and ASSPRO (an EU joint research project) agreed that convictions can be effective, with the nuance made by AIM that it is only effective when followed up by sustained political action.

#### 4.2.2. Conclusion 2: Centralisation of procurement is a method to lower the risks of corruption

##### Survey results

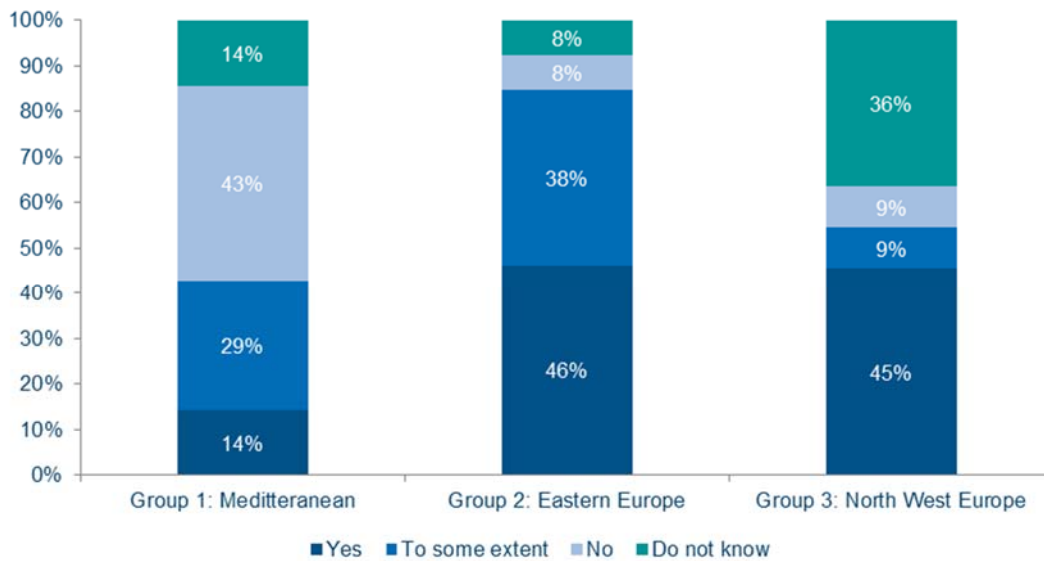
The conclusion of the SHC1 study that centralisation of procurement is a method to lower the risks of corruption is supported by the majority of the stakeholders responding to the survey. Out of 31 respondents, 20 (65%) indicated that they agree, at least to some extent, with this statement. Five respondents (16%) indicated that they do not see centralised procurement as a method to reduce the risks of corruption.

**Table 4.3 Answers to statement #2 (n=31)**

Centralisation of procurement is a method to lower the risks of corruption (n=31)	
Yes	12
To some extent	8
Not	5
Do not know	6

In the Figure below, the geographical spread is presented. Notably, almost half of the respondents from the Mediterranean area are of the opinion that centralised procurement is not a suitable method to reduce the risks of corruption. In contrast, the majority of the respondents from Eastern Europe (84%) indicated that centralised procurement is at least to some extent a solution. Respondents from North West Europe represented the largest group of respondents who do not know whether centralised procurement is a solution. The strong division between the three regions might be explained by the current experiences in public procurement, with the Mediterranean and Eastern Europe experiencing higher levels of procurement corruption than North West Europe.

**Figure 4.4 Geographical spread conclusion #2 (n=31)**



The number of respondents in each group: n= 7 (group 1), n= 13 (group 2), n= 11 (group 3).

### Fact finding missions

**Greece:** Many of the stakeholders consulted indicated that central procurement could be a good method to lower the risks on corruption. It should, however, be noted that in Greece some initiatives for central procurement have already been undertaken. For instance, a central procurement committee has been established, but is perceived as not effective. Since its establishment, only one public procurement process was started, and this took several years. Public procurement processes take over three years before they are concluded. In addition, since the economic crisis hardly any tenders have been procured, due to a lack of budget.

**Croatia:** Croatian stakeholders interviewed by the study team agreed that centralisation of procurement is a method to lower the risks of corruption. The representative of the pharmaceutical association mentioned that it is also important to have (public) registries of products and prices.

**Lithuania:** The opinions in Lithuania regarding this statement were divided: multiple stakeholders did not agree with the statement that centralisation of procurement is a method to lower the risks of corruption, while others did agree. One stakeholder partially agreed. It was noted by several stakeholders that in both centralised and decentralised procurement systems there are risks for corruption.

**Hungary:** Hungarian stakeholders did not agree that centralisation of procurement would lower the risk of corruption. On the contrary, if not accompanied by transparency-increasing measures, it has the opposite effect.

**Poland:** Polish stakeholders agreed that centralisation of procurement is a method to lower the risks of corruption. Stakeholders mentioned that the current decentralised procurement system might lead to problems, especially in smaller hospitals, where not enough technical knowledge is available to formulate proper tender specifications. As a solution, they ask the suppliers of medical equipment for more information and for help in writing the terms of reference, which can lead to improper tendering.

**Romania:** The majority of the stakeholders agreed that centralisation of procurement, especially of medical equipment, could lead to lower risks of corruption. Currently, procurement of medical equipment is conducted at the local level. Due to a lack of checks and balances at the local level, much corruption occurs. Although centralising the

procurement of medical equipment might reduce the risk of corrupt behaviour, stakeholders also indicated that its success would depend on who would be responsible for the central procurement. Not all central government bodies are seen as reliable bodies.

### EU-level interviews

Representatives from MedTech Europe (speaking in their personal capacity), AIM and ASSPRO (speaking in their personal capacity) agreed that centralisation of procurement can lower corruption risks. However, the interviewees added a general note that any change in the status quo always brings risks with it as well.

### 4.2.3. Conclusion 3: Central procurement systems can become vulnerable as targets for lobbyists and more politically inspired types of corruption

#### Survey results

More than 70% of the survey respondents agree that central procurement systems can become vulnerable to lobbyists. Around 10% (3 in total) were of the opinion that central procurement systems are not vulnerable at all. The remaining 20% answered that they did not know. Overall, 31 respondents answered the question.

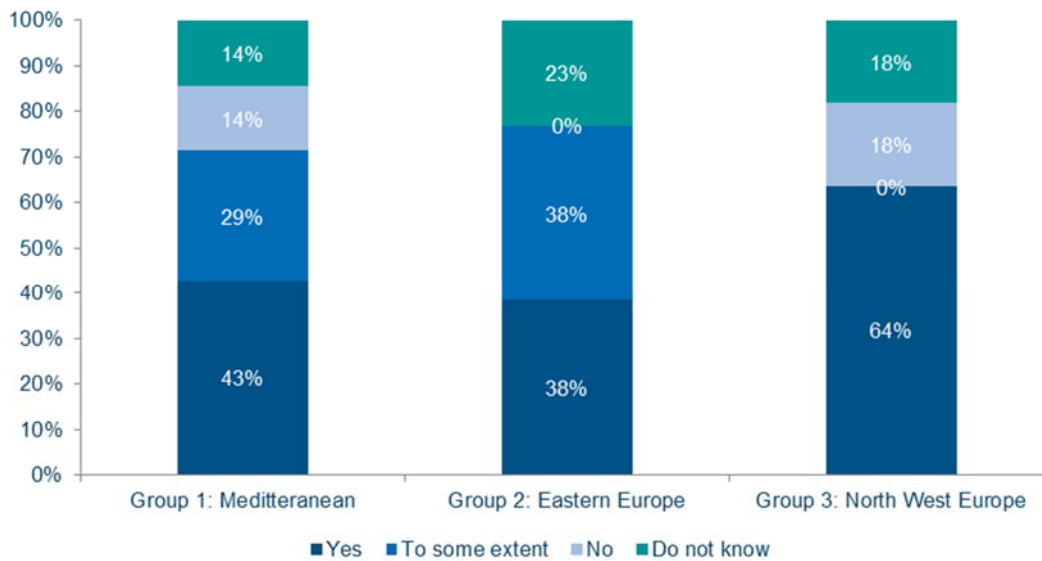
**Table 4.4 Answers to statement #3 (n=31)**

Central procurement systems can become vulnerable as target for lobbyist and more political inspired types of corruption (n=31)	
Yes	15
To some extent	7
Not	3
Do not know	6

As shown in the Figure, in North West Europe only two-thirds of the respondents agreed with the conclusion that a centralised procurement system can become vulnerable to lobbyists. In the Mediterranean and Eastern Europe, more than 70% of the respondents were of the opinion that centralised systems can become vulnerable. Also noteworthy is that none of the Eastern Europe respondents disagreed with this conclusion.

The outcomes might indicate that the risks on lobbying and political inspired types of corruption are perceived to be higher in the Mediterranean and Eastern Europe area compared to North West Europe.

**Figure 4.5 Geographical spread conclusion #3 (n=31)**



The number of respondents in each group: n= 7 (group 1), n= 13 (group 2), n= 11 (group 3).

### Fact finding missions

**Greece:** Greek stakeholders agreed that central procurement is vulnerable as a target for lobbyists, at least to some extent. One stakeholder indicated that it would be important to find the right balance. Central procurement is more favourable than decentralised procurement; nevertheless, appropriate measures should be adopted to ensure that the central procurement should remain free of political corruption. Still, it is difficult to establish the right system under the current Greek conditions, i.e. the economic downturn and the political unwillingness to fight corruption.

**Croatia:** Croatian stakeholders held diverging views about this issue: patient representatives held that decentralised procurement is only to some extent vulnerable to lobbyists, and there was disagreement between the Ministry of Justice – who is of the opinion that central procurement can indeed become vulnerable, and the Ministry of Health – which holds the opposing view.

**Lithuania:** The opinions of the Lithuanian stakeholders on this statement were divergent. As mentioned previously, stakeholders noted that both centralised and decentralised procurement systems have inherent risks for corruption. Improper marketing, which may result from this risk, is observed in Lithuania, and recently initiatives and legislation for the healthcare sector were put in place to combat this form of corruption.

**Hungary:** Hungarian stakeholders agreed that central procurement systems could become vulnerable to lobbyists and a higher level of (political) corruption.

**Poland:** Polish stakeholders held different opinions regarding this statement. Some stakeholders indicated that the current decentralised procurement is also prone to lobbyists and more political inspired types of corruption. According to those stakeholders, introducing a central procurement system will not solve this problem. Other stakeholders indicated that a centralised system might be vulnerable for lobbyists; however, centralised procurement is still preferable as it is easier to protect a centralised system than a decentralised system from lobbyists.

**Romania:** Romanian stakeholders agreed with this statement. One of the problems mentioned is the central medication list. Only medication included on this centrally adopted list will be (partially) reimbursed by the National Health Insurance House (the sole payer in the Romanian system). Lobbyists already try different tactics to get their products

included on the list, even when it is known that their products are not effective. The lobbyists also try to influence physicians to prescribe their medication, even for diseases other than for which it is indicated.

### EU-level interviews

Representatives from AIM and ASSPRO agreed that centralisation of procurement can, to some extent, increase the risks of more political inspired corruption.

#### 4.2.4. Conclusion 4: Bribery in medical service delivery cannot be contested with only targeted policies against the phenomenon as such, but need to be supplemented with accompanying (structural) measures

### Survey results

As stated in Section 4.1, corruption in healthcare is not an isolated phenomenon: it is correlated with corruption in society as a whole. It is therefore interesting to see that the question whether bribery in medical service delivery can be contested with only targeted policies is a topic of debate. As the answers to this survey question show, about 50% of the respondents (out of a total of 31) indicated that accompanying (structural) measures need to be taken to effectively combat bribery in medical services delivery. The other 50% indicated that they either disagree with this statement or did not know.

This wide variety of answers given in the survey is in line with the findings of the country missions, desk research and the previous study.

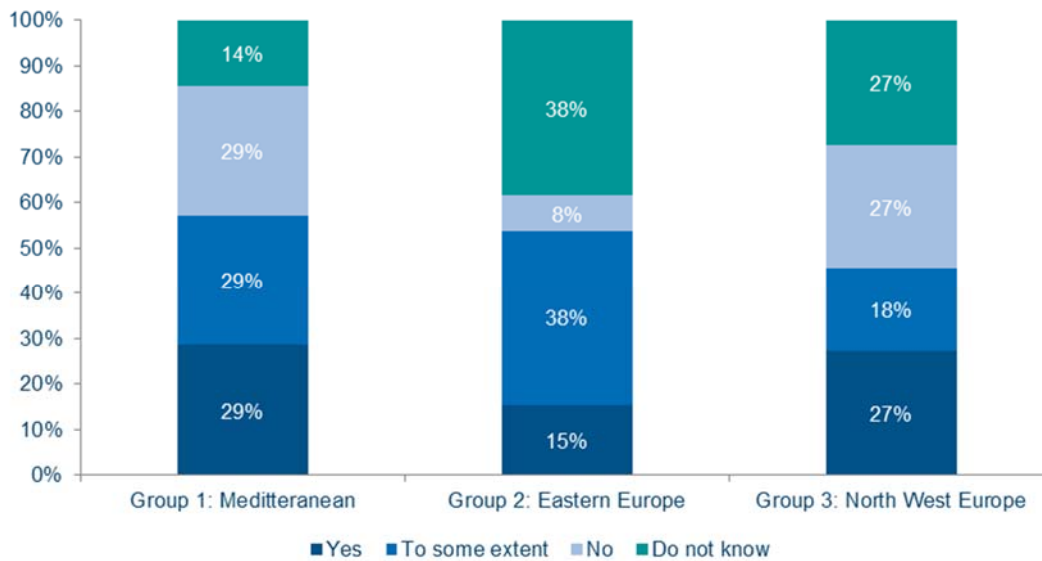
**Table 4.5 Answers to statement #4 (n=31)**

Bribery in medical service delivery cannot be contested with only targeted policies against the phenomenon as such , but need to be supplemented with accompanying (structural) measures (n=31)	
Yes	7
To some extent	9
Not	6
Do not know	9

Bribery in medical service delivery cannot be contested with only targeted policies against the phenomenon as such, but need to be supplemented with accompanying (structural) measures (n=31)

The differences in opinions can also be seen when analysing the results per region. In North West Europe, the minority had the opinion that besides targeted policies, more structural changes are needed. However, it should be noted that bribery in medical services is less common in this region. In regions where bribery in medical service delivery is still common, the majority of the respondents (51%, or 72% excluding 'don't know') agreed that both targeted policies and structural measures are required to fight this problem.

**Figure 4.6 Geographical spread conclusion #4 (n=31)**



The number of respondents in each group: n= 7 (group 1), n= 13 (group 2), n= 11 (group 3).

### Fact finding missions

*Note: the fact-finding missions to Croatia, Hungary and Romania found that respondents in these three countries evaluated this statement almost identically.*

Interviewees pointed to a variation of accompanying measures: strengthening of the judicial system, changes in the healthcare system and changes in attitudes towards corrupt practices.

**Greece:** All stakeholders interviewed fully agreed with conclusion #4. In order to make targeted policies effective, the interviewees indicated that the judicial system should also be strengthened. Enough capacity should be freed up to deal with cases of corruption and the people caught should be brought to justice and receive punishment. Only under these conditions, targeted policies and a well-functioning judicial system, can corruption be combatted.

**Croatia:** All Croatian stakeholders, apart from the Ministry of Health, agreed that bribery in medical service delivery cannot be contested only with targeted policies against bribery, but have to be supplemented by accompanying (structural) measures. As in both Hungary and Romania, bribery in medical service delivery was and still is, to some extent, deeply embedded in the Croatian healthcare system and culture. The government has made an effort to make it clear to patients that paying the physician is unethical and undesirable. While a change in culture may still take years, respondents observed that younger generations are already less inclined to pay the physician for services received.

**Lithuania:** One stakeholder fully agreed with this statement, one partially, and the others answered 'do not know'. This may be related to the fact that the effectiveness of implementation of new measures and legislation has not been systematically evaluated.

**Hungary:** Hungarian stakeholders agreed that bribery in medical service delivery cannot be solved solely by targeted measures against bribery, but need to be supplemented by accompanying (structural) measures. Like both Croatia and Romania, bribery in medical service delivery is deeply embedded in the Hungarian healthcare system and culture. The only way to reduce informal payments is to make it clear to patients that paying the physician is unethical and undesirable. While a change in culture may still take years, respondents were hopeful as younger generations are already less inclined to pay the physician for services received.



**Poland:** Polish stakeholders agreed that bribery in medical services delivery cannot be solved solely by targeted measures. In order to successfully combat informal payments, the Polish government actively investigated and prosecuted physicians accused of bribery. Many of them were convicted and had to pay a fine. Several of them also lost their license. According to the stakeholders, the convictions were effective and both physicians and patients became aware of the undesired effects of bribery. As a result, the number of informal payments has decreased strongly during the last few years.

**Romania:** Much like both Croatia and Hungary, bribery in medical service delivery is deeply embedded in the Romanian healthcare system. Stakeholders indicated that paying the physician for medical services delivered is part of Romanian culture. The only way to reduce informal payments is to make it clear to patients that paying the physician is unethical and undesirable. Only a change in culture could tackle the problem of bribery in medical service delivery. According to stakeholders, this could still take years. Nevertheless, they are hopeful as younger generations are already less inclined to pay the physician for services received.

### EU-level interviews

Representatives from AIM and ASSPRO agreed that bribery in medical service delivery cannot be addressed only through targeted policies, but need accompanying (structural) measures.

#### 4.2.5. Conclusion 5: Raising salaries does not have a significant preventive effect on reducing bribery in medical service delivery

##### Survey results

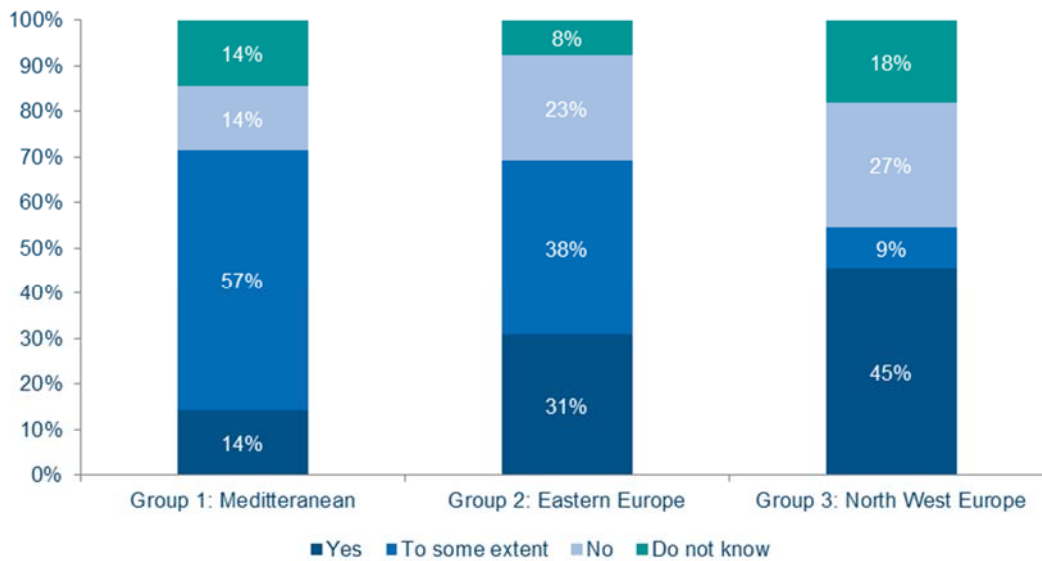
In the survey, the majority of the stakeholders (65% of the 31 respondents) indicated that raising salaries, at least to some extent, does not have a significant effect on reducing bribery in medical service delivery. Nevertheless, 23% of the respondents held the opinion that raising salaries will help to solve the problem with regard to bribery in medical service delivery.

**Table 4.6 Answers to statement #5 (n=31)**

Raising salaries do not have significant preventive effect on reducing bribery in medical service delivery (n=31)	
Yes	10
To some extent	10
Not	7
Do not know	4

Based on the geographical spread, as presented in the Figure below, respondents in the Mediterranean and Eastern Europe generally agreed with the conclusion of SHC1. These are regions where bribery in medical service delivery is common and is also seen as a major problem. In North West Europe, the responses were more diverse, and this region had the relatively largest group of respondents that indicated raising salaries would help to solve the problem. However, it should be noted that bribery in medical service delivery is less common in this region.

**Figure 4.7 Geographical spread conclusion #5 (n=31)**



The number of respondents in each group: n= 7 (group 1), n= 13 (group 2), n= 11 (group 3).

### Fact finding missions

**Greece:** The opinions of the stakeholders consulted differ in regard to this conclusion. Some stakeholders indicated that raising salaries would help in reducing bribery in medical services delivery. Other stakeholders indicated that salaries should increase substantially, before they could have any effect. One stakeholder indicated that the salaries would have to be increased multiple times before some effect might be observed and suggested that other measures should be taken in order to combat bribery in medical service delivery.

**Croatia:** Croatian stakeholders agreed that raising salaries does have a significant effect on preventing bribery, although it was stressed that this alone cannot solve the problems.

**Lithuania:** Some Lithuanian stakeholders mentioned that raising salaries might have a preventative effect, whereas others are of the opinion that this effect would be (very) limited. One stakeholder mentioned that evidence from other countries shows that only raising salaries cannot solve the problem.

**Hungary:** The Hungarian stakeholders we spoke with agreed that raising salaries is a necessary element of reducing bribery, but is not sufficient in itself, particularly because a small proportion of healthcare professionals only receive informal payments. Transparency International stressed that it may also lead to higher bribes.

**Poland:** Stakeholders in Poland agreed that raising salaries cannot be successful as a standalone measure to prevent bribery in medical service delivery. The salaries of physicians, particularly specialists, have increased during the past few years. In addition to the rise in salaries, physicians that accepted bribes have also actively been prosecuted. The combination of the two instruments has reduced the number of informal payments made to physicians. In addition, awareness on the part of patients has increased as they became more aware of the unethical aspects of bribery.

**Romania:** Salaries for physicians and other medical personal are extremely low in Romania. Stakeholders indicated that these low salaries are a trigger to accept bribes as it provides physicians and other medical staff with some additional income. Several stakeholders indicated that raising the salaries would persuade some physicians to stop accepting bribes. However, stakeholders also indicated that offering bribes (especially

gifts following medical services delivery) is very common, and this does not depend on the level of the salaries paid. It can therefore be concluded that raising salaries might provide incentives for physicians to refuse bribes (as there is no need to expand their income); however, it will not discourage the offering of bribes (as this is not influenced by the physician's salaries, but has a more cultural aspect).

### EU-level interviews

Representatives from AIM and ASSPRO held similar views on this statement, namely that raising salaries can at most only help to some extent. AIM stressed that although raising salaries may have some effect, it does not protect against misuse, and, in addition, many countries cannot afford it.

#### 4.2.6. Conclusion 6: The root causes of corruption in healthcare are related to different factors

Important root causes of corruption are (i) ineffective managerial structures, (ii) inappropriate financing mechanisms, (iii) insufficient health care capacity, (iv) insufficient funding for independent medical research, (v) unequal allocation of resources and (vi) a general acceptance of corruption in society.

### Survey results

In the stakeholder survey, respondents were asked which root causes contribute to corruption in the health care sector. 29 respondents answered the question. As can be seen in the Table below, the most frequently mentioned root causes were; a general acceptance of corruption (23), ineffective managerial structures (22), inappropriate financing mechanisms and unequal allocation of resources (both 20 times mentioned). 19 respondents mentioned insufficient health care capacity and 17 respondents mentioned insufficient funding for independent medical research.

**Table 4.7 Answers to statement #6 (n=29)**

The root causes of corruption in healthcare are related to: (n=29)	
<b>Ineffective managerial structures</b>	
Yes	18
To some extent	4
Not	1
Do not know	6
<b>Inappropriate finance mechanism</b>	
Yes	13
To some extent	7
Not	4
Do not know	5
<b>Insufficient healthcare capacity</b>	
Yes	11
To some extent	8
Not	5
Do not know	5
<b>Insufficient funding for independent medical research</b>	
Yes	12
To some extent	5
Not	3
Do not know	9
<b>Unequal allocation of resources</b>	
Yes	10
To some extent	10
No	6
Do not know	3

A general acceptance of corruption in society	
Yes	14
To some extent	9
No	1
Do not know	5

The results per region are presented in the Figures below.

Figure 4.8 Geographical spread conclusion #6 (Mediterranean)

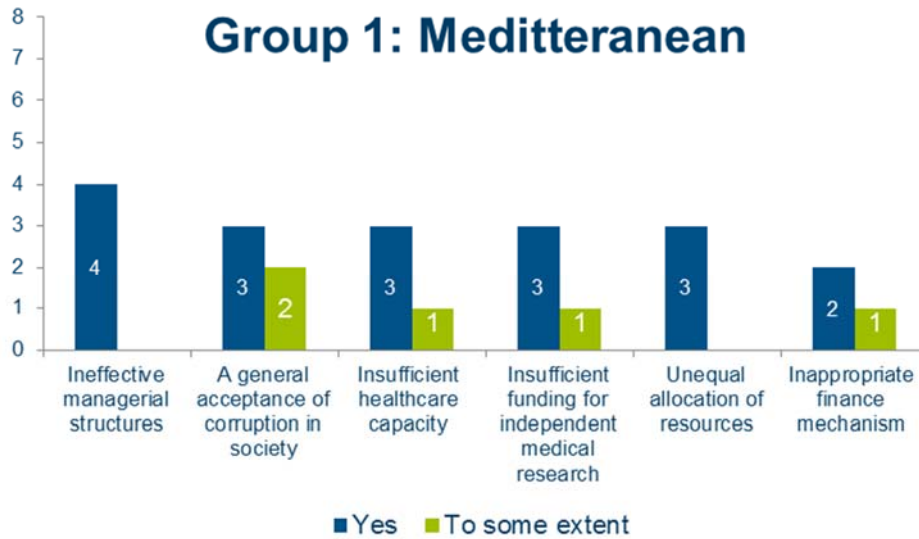


Figure 4.9 Geographical spread conclusion #6 (Eastern Europe)

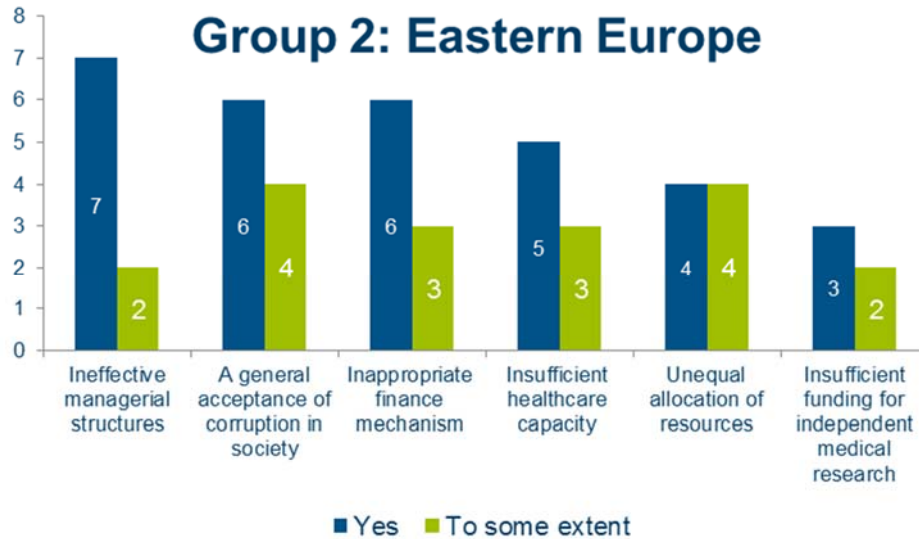
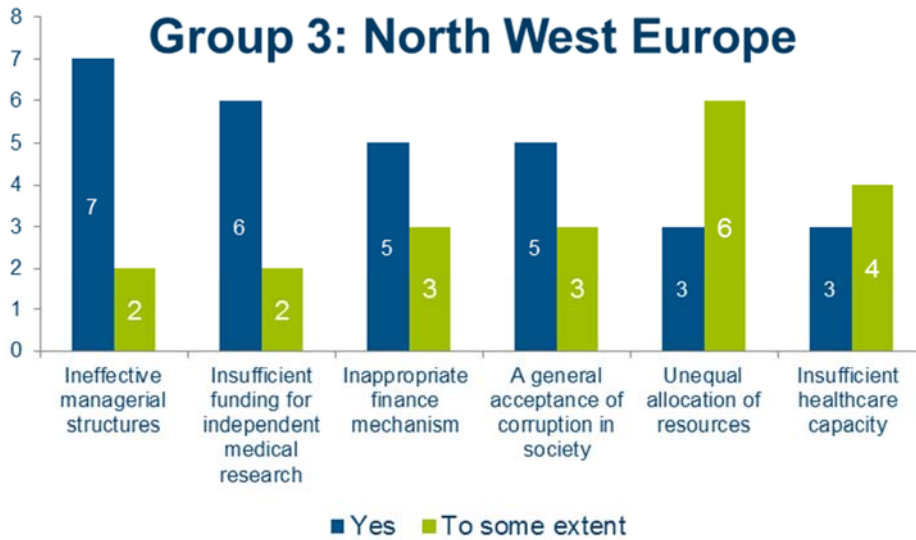


Figure 4.10 Geographical spread conclusion #6 (North West Europe)



### Fact finding missions

**Greece:** The Greek system has to deal with many of the highlighted root causes. Stakeholders indicated that the current managerial structures are insufficient (hospital managers are appointed based on political affiliation, not on experience), the financing mechanisms are inappropriate (there is only one general budget, resource allocation to specific hospitals is missing), the healthcare capacity is not efficient (there are too many physicians which increases competition), and corruption is generally accepted. Several stakeholders indicated that 'under the table'-payments are part of Greek culture and are therefore very difficult to erase.

**Croatia:** Croatian stakeholders were most in agreement about unequal allocation of resources, inefficient managerial structures, and insufficient funding. Disagreement existed with regard to the role of 'a general acceptance of corruption in society', which the governmental stakeholder argued is an important cause, but is not one according to representatives of the Medical Chamber and pharmaceutical association.

**Lithuania:** Stakeholders reported multiple root causes for corruption in Lithuania, of which the most commonly mentioned, and most important according to the stakeholders, are ineffective managerial structures, the general acceptance of corruption in the society and the unequal allocation of resources.

**Hungary:** General acceptance of corruption in society was mentioned by all Hungarian stakeholders who provided feedback on the different statements. Insufficient healthcare capacity, insufficient funding, inappropriate financing mechanisms and an unequal allocation of resources were also highlighted as important, by the patient association and Transparency International. Ineffective managerial structures were also deemed an important cause, although the academic respondent stressed that causation could be reversed, and an ineffective managerial structure may also be a consequence of corruption.

**Poland:** The root causes for corruption mentioned by the Polish stakeholders were mainly the general acceptance of corruption in the society, insufficient healthcare capacity (i.e. long waiting lists) and inappropriate financing mechanisms. The general public in Poland does not support corruption in the form of informal payments. Nevertheless, they accept other forms of corrupt behaviour, for example using both public and private insurance in order to receive quicker and better access to public healthcare facilities. Furthermore, public expenditure on healthcare is low, which enables industry and healthcare professionals to be involved in other corrupt activities (e.g. corruption in procurement processes, improper marketing and double practice).

**Romania:** The main problem in the Romanian healthcare system is the deep embeddedness of corruption. All stakeholders indicated that it is seen as common practice to pay a bribe for medical services delivery, during a procurement process for medical equipment, or to have drugs placed on the medicine list. Other causes for a high level of corruption are insufficient managerial structures (hospitals managers are physicians, without managerial experience), a lack of physicians (many of the Romania physicians have moved abroad), unequal and unfair allocation of funding, and a lack of checks and balances in the system. The causes are multiple, which also creates difficulties when trying to combat the problem.

### EU-level interviews

Both AIM and ASSPRO agreed that 'ineffective managerial structures' and 'inappropriate financing mechanisms' are root causes of corruption in healthcare. ASSPRO further listed 'a general acceptance of corruption in society' as another root cause. AIM did not list this as a factor, and instead added 'insufficient healthcare capacity' as another additional root cause.

#### 4.2.7. Conclusion 7: The introduction of transparent waiting lists has a positive effect on reducing healthcare bribery

### Survey results

75% of the survey respondents (29 in total) agreed to the statement that the introduction of transparent waiting lists, at least to some extent, would have a positive effect on healthcare bribery. Only two respondents indicated that they did not agree, while five respondents answered 'do not know'.

**Table 4.8 Answers to statement #7 (n=29)**

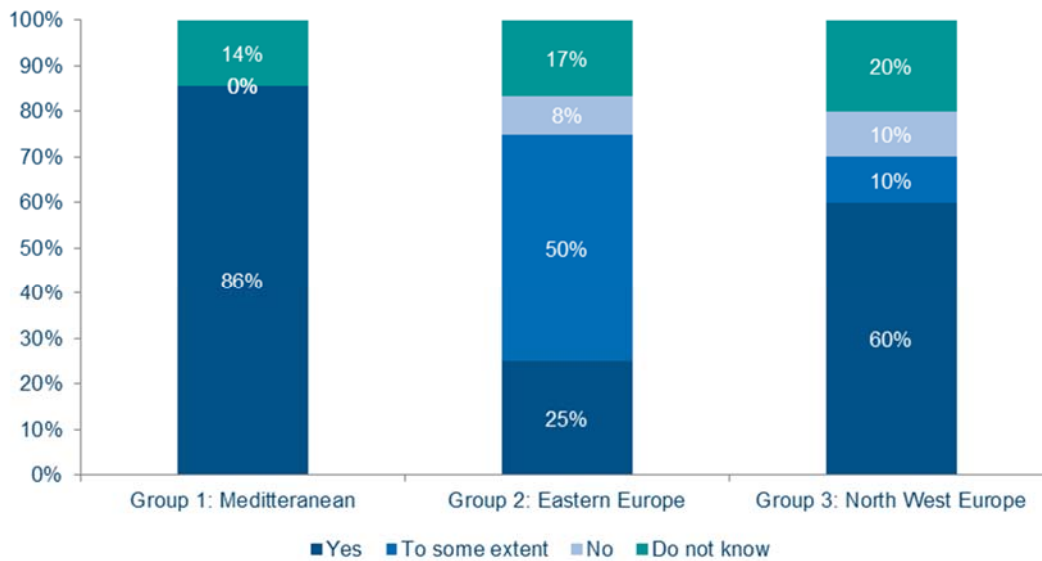
The introduction of transparent waiting lists has a positive effect on reducing healthcare bribery (n=29)	
Yes	15
To some extent	7
Not	2
Do not know	5

As can be seen in the Figure below, in all regions the majority of the stakeholders agreed that transparent waiting lists would have, at least to some extent, a positive effect on reducing healthcare bribery. Of the respondents from the Mediterranean area, 86% had the opinion that transparent waiting lists are a solution to the problem.

Although 75% of the respondents from Eastern Europe believed that transparent waiting lists would have a positive impact on the problem, only 25% were fully convinced of this fact. The remaining 50% were more cautious and indicated that transparent waiting lists will only contribute to some extent.

In North West Europe 70% of the respondents had the opinion that transparent waiting lists would have a positive effect. This region has the highest share of respondents doubting the effect of transparent waiting lists, or not knowing what the effect could be.

**Figure 4.11 Geographical spread conclusion #7 (n=29)**



The number of respondents in each group: n= 7 (group 1), n= 12 (group 2), n= 10 (group 3).

**Fact finding missions**

**Greece:** All stakeholders agreed that introducing transparent waiting lists would have a positive effect on healthcare bribery. Currently, patients use their private insurance to obtain easier access to public hospital services. This means that people who cannot afford private insurance and therefore solely depend on public healthcare services have a reduced access to public healthcare. The creation of transparent waiting lists would enable all patients to see their position on the list. Unexpected jumps in position could be an indication of bribery.

**Croatia:** All Croatian stakeholders agreed that transparent waiting lists would have a positive effect on reducing healthcare bribery.

**Lithuania:** The majority of Lithuanian stakeholders believed that transparent waiting lists have the potential to reduce bribery in healthcare delivery.

**Hungary:** Hungarian stakeholders agreed that transparent waiting lists could have a positive effect on reducing healthcare bribery, although it may also only indicate to patients when and where they should provide a bribe to get preferential access.

**Poland:** In general, Polish stakeholders agreed that transparent waiting lists would be an effective tool to combat corruption in the healthcare system. However, recent attempts to introduce such lists have not been successful. Currently, it is possible for a patient to check general waiting lists before going to a hospital, e.g. how many weeks it will take before a certain surgery can take place. The patient is, however, not able to see his/her position on a specific list and therefore does not receive actual information. In addition, waiting lists are infrequently updated, which leads to outdated information being provided to the patients.

**Romania:** There is no clear link between waiting lists and bribery in the public sector, as bribes are typically given after treatment has taken place ('gratitude payment'). Within the private sector, a clearer link between waiting lists and bribery can be seen. Patients that can afford private care go to private clinics and make sure that they are referred to public hospitals where the required treatment can be given. By paying twice, these patients are able to bypass the waiting lists.

### EU-level interviews

The AIM representatives strongly agreed that increasing transparency in waiting lists has a positive effect, whereas ASSPRO’s representative classified its effect as only helping ‘to some extent’.

#### 4.2.8. Conclusion 8: Prescription of generics instead of branded pharmaceutical products has a positive effect on reducing healthcare bribery

##### Survey results

In the survey 62% of the respondents (out of 29 respondents in total), indicated that they are of the opinion that the prescription of generics instead of branded pharmaceuticals has, at least to some extent, a positive effect on reducing healthcare bribery. Nonetheless, almost 30% had the opinion that such a measure would not be effective in the fight against bribery in healthcare.

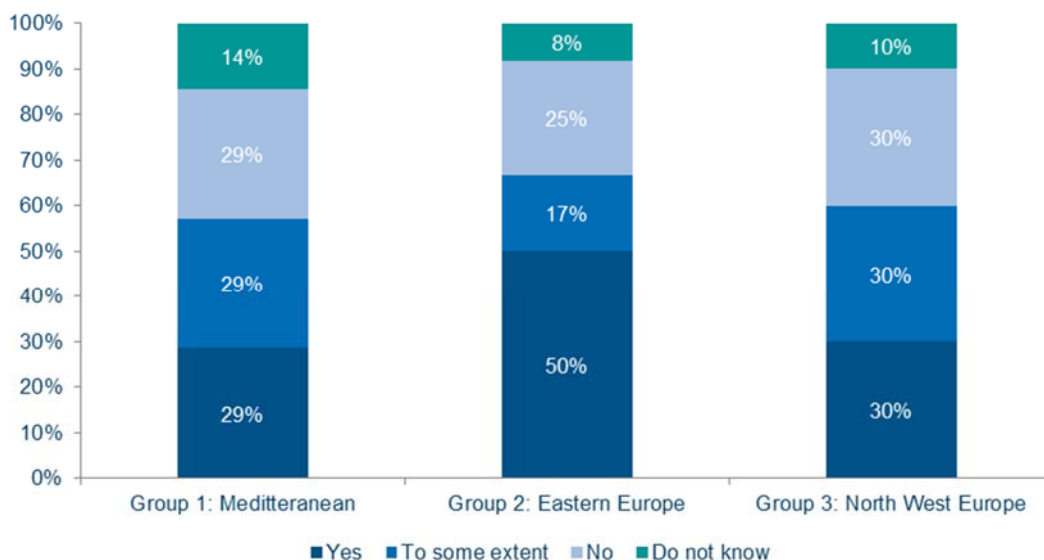
**Table 4.9 Answers to statement #8 (n=29)**

Prescription of generics instead of branded pharmaceutical products has a positive effect on reducing healthcare bribery (n=29)	
Yes	11
To some extent	7
Not	8
Do not know	3

As can be seen in the Figure below, two-thirds of the stakeholders living in Eastern Europe were of the opinion that prescribing generics helps to fight healthcare bribery. This result is in line with the findings of the fact-finding missions and the previous study, which also show that in these countries several policies focus on the mandatory prescription of generics instead of branded pharmaceuticals.

In the other two regions, the views held by stakeholders are more or less similar. Around 60% believe that this measure will, at least to some extent, contribute to the fight, while 30% do not believe prescription of generics will help in combatting healthcare bribery.

**Figure 4.12 Geographical spread conclusion #8 (n=29)**



The number of respondents in each group: n= 7 (group 1), n= 12 (group 2), n= 10 (group 3).



### Fact finding missions

**Greece:** Some respondents indicated that this measure would have a positive effect, while others doubt it. They indicated that several attempts have already been made by the Greek government, but that the results have been minimal so far.

**Croatia:** Most Croatian stakeholders argued that prescribing generic drugs does not have a positive effect on reducing healthcare bribery – indeed; it was argued they could lead to more bribery as patients prefer to have the branded drug. Only representatives of the Ministry of Health argued it was beneficial.

**Lithuania:** It was noted that this statement is not applicable to Lithuania because physicians have to prescribe the active substance rather than a specific pharmaceutical product.

**Hungary:** Hungarian stakeholders disagreed with the statement that generic drugs reduce healthcare bribery.

**Poland:** In Poland, lists of generic medicines exist and physicians are obliged to prescribe patients generics instead of branded pharmaceutical products. Despite the existence of the list, several physicians still prescribe branded pharmaceuticals. As a result, it is difficult to keep prices for pharmaceuticals low. While the current list and policy on the prescription of generics is not working satisfactorily, most stakeholders indicated that the prescription of generics will have a positive effect on the healthcare system and public healthcare expenditure.

**Romania:** Stakeholders did not agree with this statement. In Romania, only medicines included on the national list of medicines, adopted by the Ministry of Health and the National House of Insurance, are (partially) reimbursed. Part of this list refers only to generics and active substances. Although reimbursement is based on a prescribed substance and not on a particular brand, multiple opportunities are found for bribery. According to some stakeholders, bribing for introducing substances onto the subsisted medicines list is one of the main forms of corruption.

### EU-level interviews

The AIM and ASSPRO representatives both mentioned that the prescription of generics only reduces healthcare bribery to some extent – as long as there is a large amount of money involved, corruption risks will persist.

#### 4.2.9. Conclusion 9: Self-regulation between the industry and healthcare providers is needed to fight corruption in healthcare

#### Survey results

75% of all stakeholders (29 in total) agreed with the conclusion that self-regulation between the industry and healthcare providers is needed to fight corruption in the healthcare sector. Only two respondents (7%) believe that self-regulation will not contribute to the fight against corruption. The remaining 17% does not know whether or not this measure will help.

**Table 4.10 Answers to statement #9 (n=29)**

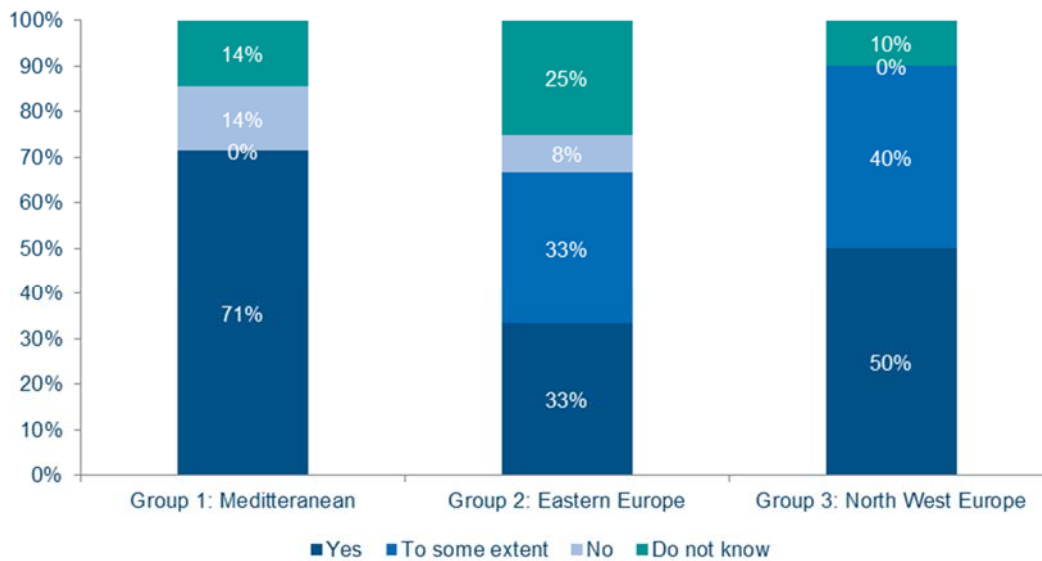
Self-regulation between the industry and healthcare providers is needed to fight corruption in healthcare (n=29)	
Yes	14
To some extent	8
Not	2
Do not know	5

The views on whether self-regulation will have a positive effect on the fight against corruption differed substantially between the three regions. In the Mediterranean area 71% of the respondents indicated that they fully believe that self-regulation is important.

In North West Europe 90% of the respondents indicated that self-regulation would, at least to some extent, contribute to reducing corruption in health care. None of the respondents in this region indicated that self-regulation would not be beneficial.

Respondents in Eastern Europe seem to be the most sceptical, as a total of 66% indicated that self-regulation is, at least to some extent, needed. Of all the respondents giving a clear 'yes' as an answer, the share of respondents in Eastern Europe is the lowest (33% compared to 50% in North West Europe and 71% in the Mediterranean).

**Figure 4.13 Geographical spread conclusion #9 (n=29)**



The number of respondents in each group: n= 7 (group 1), n= 12 (group 2), n= 10 (group 3).

**Fact finding missions**

**Greece:** Not all stakeholders agreed that self-regulation is needed in the fight against corruption. The ones that were of the opinion that self-regulation is important also indicated that incentives for cooperation are needed. Without incentives, they assume that self-regulation would not have the desired effect.

**Croatia:** Croatian stakeholders were in agreement about the importance of self-regulation between industry and healthcare providers.

**Lithuania:** Most stakeholders agreed that self-regulation between the industry and healthcare providers is needed to fight corruption in healthcare. It was noted that when the initiatives between the industry and healthcare providers are embedded into legislation, this helps enforcement. For example, response rates of the healthcare professionals in the transparency register are likely to increase in that case. Although there is not yet self-regulation in place between industry and providers in Lithuania, the pharmaceutical sector and the medical societies are taking steps to work together, e.g. they are working on a joint white paper on interaction and collaboration which is expected to be published in the first quarter of 2017.

**Hungary:** Hungarian stakeholders held that self-regulation can help, but is not sufficient by itself.

**Poland:** Polish stakeholders agreed that self-regulation between the industry and healthcare providers is needed to fight corruption. However, they also indicate that some aspects of the self-regulation should be included in Polish law as well, in order to be able to better enforce the behavioural rules. Currently, physicians can easily evade the self-regulation rules as there is no legal obligation to comply with the ethical codes and transparency codes adopted by the industry.

**Romania:** Stakeholders partially agreed to the above statement. However, most of them also indicated that currently no clear initiatives are taken to impose any form of self-regulation. Corruption is deeply embedded in the Romanian healthcare system and no clear incentives exist to combat this phenomenon.

### EU-level interviews

The representative from ASSPRO did not agree that self-regulation between players is needed to fight corruption. On the other hand, both MedTech Europe and AIM representatives stated that it is important.

#### 4.2.10. Conclusion 10: Self-regulation among players (such as within the pharmaceutical industry or among physicians) is needed to fight corruption in healthcare

##### Survey results

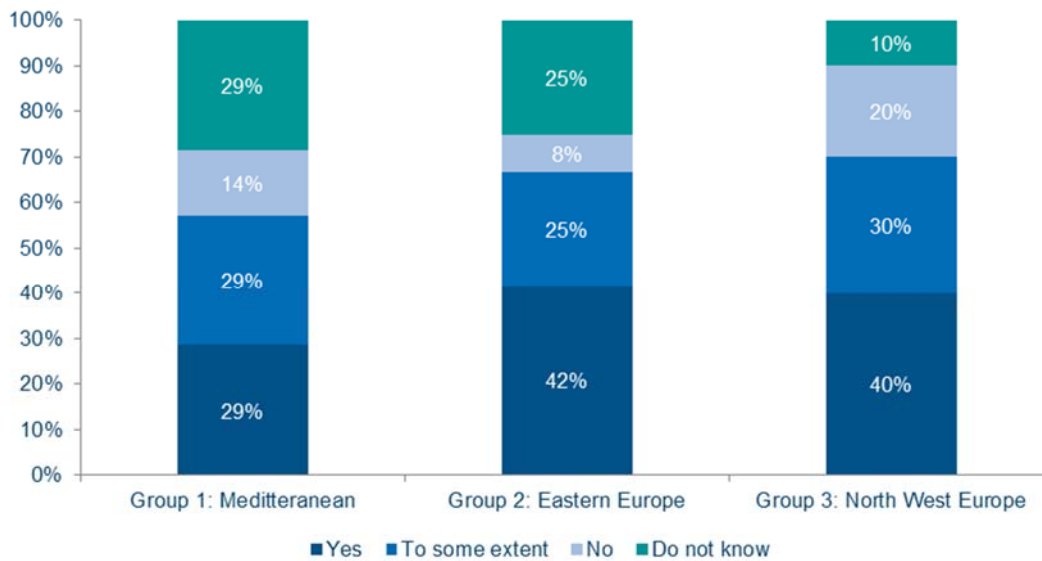
Two-thirds of the total number of stakeholders agreed with the conclusion that self-regulation among players is needed in the fight against healthcare related corruption. About 20% of the respondents said they did not know whether self-regulation is needed. Four respondents indicated that self-regulation among players is not required.

**Table 4.11 Answers to statement #10 (n=29)**

Self-regulation among players (such as the pharmaceutical industry or doctors) is needed to fight corruption in healthcare (n=29)	
Yes	11
To some extent	8
Not	4
Do not know	6

When the answers given to this question are analysed in relation to the geographical regions where the respondents came from, the analysis presented above is more or less confirmed. In all three regions, around two-thirds of the respondents were of the opinion that self-regulation among players is necessary. The share of respondents indicating that self-regulation is not required to combat corruption is highest in North West Europe (20%). In the other two regions, this percentage is lower: 14% in the Mediterranean and 8% in Eastern Europe.

Figure 4.14 Geographical spread conclusion #10 (n=29)



The number of respondents in each group: n= 7 (group 1), n= 12 (group 2), n= 10 (group 3).

### Fact finding missions

**Greece:** Not all stakeholders agreed that self-regulation is needed in the fight against corruption. The ones that were of the opinion that self-regulation is important also indicate that incentives for cooperation are needed. Without incentives, they assume that self-regulation will not have the desired effect.

**Croatia:** Croatian stakeholders were in agreement about the importance of self-regulation between industry and healthcare providers.

**Lithuania:** Lithuanian stakeholders agreed that self-regulation within for example the pharmaceutical industry or among physicians, can help to combat corruption. There are already initiatives in place for the pharmaceutical companies, but not yet among physicians or between different groups of stakeholders.

**Hungary:** As in Croatia, Hungarian stakeholders held that self-regulation can help, but is not sufficient in itself.

**Poland:** Polish stakeholders agreed that self-regulation within for example the pharmaceutical industry or among physicians, can help to combat corruption. Comparable to Lithuania, there are initiatives in place for pharmaceutical companies.

**Romania:** Stakeholders partially agreed to this statement. However, most of them also indicated that currently no clear initiatives are taken to impose any form of self-regulation.

### EU-level interviews

The representative from ASSPRO did not agree that self-regulation among players is needed to fight corruption. On the other hand, both MedTech Europe and AIM representatives stated that it is important. The representative from AIM however also noted that, to date, it has been impossible to reach consensus among payers on the need for self-regulation.

#### No consensus on the need of self-regulation among payers - statutory health insurance

Both within and across countries there is a lack of consensus on the need for corporate compliance in statutory health insurance. Views on the matter differ substantially, ranging from the zero-tolerance principle to the acceptance of some form(s) of misuse because of other interests (e.g. ensuring a contract with a specific

provider). These different interests are problematic – there are incentives to move in opposite directions, and this makes it impossible to have a voluntary code of conduct amongst payers.

**4.2.11. Conclusion 11: Awareness raising campaigns and fraud and corruption reporting hotlines are an effective instrument to fight corruption in healthcare**

**Survey results**

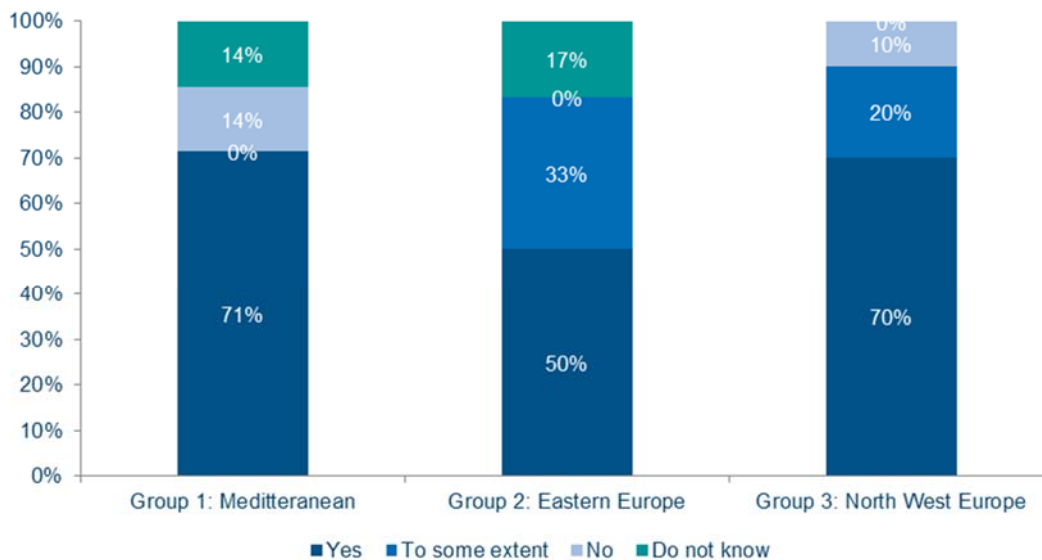
The majority of the stakeholders responded positively to the question. As can be seen in the Table below, more than 80% (24 out of the 29 respondents) indicated that they were of the opinion that campaigns and hotlines are, at least to some extent, effective instruments. Only two respondents indicated that they did not agree that the measures are effective, while three respondents answered that they did not know.

**Table 4.12 Answers to statement #11 (n=29)**

Awareness raising campaigns as well as fraud and corruption reporting hotlines are effective instruments to fight corruption in healthcare (n=29)	
Yes	18
To some extent	6
Not	2
Do not know	3

In all three regions, the majority of the respondents agreed with the SHC1 conclusion that awareness campaigns and reporting hotlines are effective. In North West Europe, all respondents had a clear opinion, while in the other two regions several stakeholders were not able to answer the question.

**Figure 4.15 Geographical spread conclusion #11 (n=29)**



The number of respondents in each group: n= 7 (group 1), n= 12 (group 2), n= 10 (group 3).

**Fact finding missions**

**Greece:** Although all stakeholders agreed that awareness campaigns are needed in combatting corruption, some stakeholders indicated that campaigns are not the best measure.

**Croatia:** Croatian stakeholders agreed that awareness raising campaigns and reporting hotlines can be an effective additional instrument to fight corruption. However, it was noted that citizens often do not report corruption, and the Ministry of Justice stressed the citizens would not usually use hotlines for this purpose.

**Lithuania:** Lithuanian stakeholders agreed that awareness raising campaigns and reporting hotlines are important instruments to fight corruption. Lithuania recently introduced various awareness raising campaigns and set up two hotlines. These are perceived to be effective instruments by several stakeholders.

**Hungary:** Hungarian stakeholders held the opinion that awareness raising campaigns and hotlines are an important instrument, but cannot be effective in reducing corruption by themselves.

**Poland:** Several stakeholders actually started awareness raising campaigns and they indicated that their own instruments were effective. It should be noted that these instruments are strongly internally focussed and do not involve the general public. As a result, within public administrations and industry associations, awareness campaigns are seen as valuable instruments, but it is doubtful whether the Polish citizens are aware of all actions taken. Also, the perception of the patients regarding what constitutes corrupt behaviour is rather unclear. Corrupt practices regarding privileged access, for instance, are seen as perfectly normal.

**Romania:** Stakeholders partially agreed with the statement. Although they were of the opinion that awareness campaigns and hotlines are important, they also remarked that results of such initiatives are limited. The government, especially the Integrity Department of the Ministry of Health, introduced several initiatives for the public to report on corruption. An example of this is a website where patients can report on bribes paid, bad care received and other malpractices. However, the number of complaints and reports received is low. It seems that patients are not willing to share their experiences with governmental agencies.

#### EU-level interviews

The ASSPRO representative noted that awareness raising campaigns and hotlines help to some extent in fighting corruption. AIM representatives attached greater significance to the positive effect of these instruments.

#### 4.2.12. Conclusion 12: The government should play a (more) active role in creating transparency in the relations between the industry and healthcare providers

##### Survey results

24 out of the 29 stakeholders (equalling 82%) indicated that the government should play a role in creating transparency in the relations between industry and healthcare providers. Three respondents (10%) indicated that there is no desire for a larger role for the government, while the two remaining stakeholders answered that they did not know.

**Table 4.13 Answers to statement #12 (n=29)**

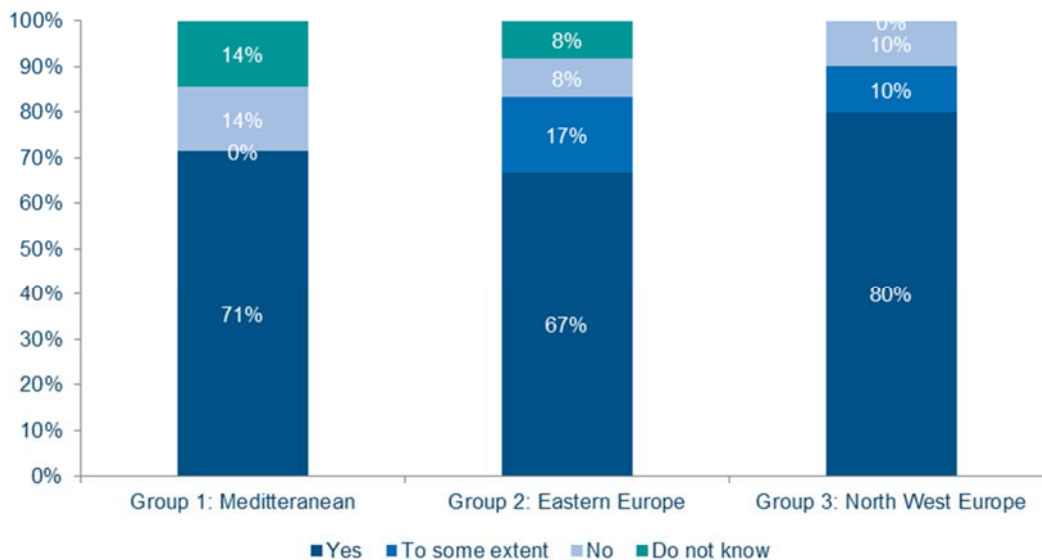
The government should play a (more) active role in creating transparency in the relations between the industry and healthcare providers (n=29)	
Yes	21
To some extent	3
Not	3
Do not know	2

As can be seen in the Figure below, the perception about the role the government could play in increasing transparency differs between the regions:

- In the Mediterranean region, 71% indicated that the government should play a role.
- In Eastern Europe, 84% indicated that the government could, at least to some extent, play a role. 67% indicated that they see a clear role, while the other 17% see some role for the government.
- In North West Europe, 90% of the respondents see a role for the government. 80% see a clear role, while 10% see some role.

Overall, one can conclude that the respondents in North West Europe are the most positive about the role the government could play in increasing transparency between industry and healthcare providers.

**Figure 4.16 Geographical spread conclusion #12 (n=29)**



The number of respondents in each group: n= 7 (group 1), n= 12 (group 2), n= 10 (group 3).

### Fact finding missions

**Greece:** All Greek stakeholders indicated that the government should play an active role in creating more transparency in the relations between industry and healthcare providers. However, the current Greek laws still allow for certain favours, e.g. direct sponsorship is a valid activity. This will make it more difficult to create more transparency. Whether or not a political willingness exists to increase transparency is unknown.

**Croatia:** Croatian stakeholders were divided with regard to this statement: whereas the Croatian Medical Chamber argued that the government had no role, the pharmaceutical association argued it could be helpful if the government put this issue on the agenda. The patient organisation argued that a governmental role is more necessary for physicians, as the industry has already introduced self-regulation. The Ministry of Health and Justice both saw a role for government to create more transparency.

**Lithuania:** All stakeholders agreed that the government should play a (more) active role in creating transparency in the relations between the industry and healthcare providers. Initiatives for increasing transparency have been introduced, and the Ministry of Health would like to take a more active role in this, for example by exploring the possibilities for embedding initiatives in the sector into law. A working group has been set-up for this purpose.

**Hungary:** Hungarian stakeholders were split about the role government should play in creating transparency. Whereas the academic respondent and Transparency International argued that the government should step up to the plate, the patient association was wary of a greater government role.

**Poland:** The Polish stakeholders partially agreed with the statement. Several stakeholders would like to see the government playing a bigger role in creating transparency. However, currently no initiatives are taken that focus on creating more transparency in the healthcare sector. The transparency-related measures taken thus far focus on the internal processes of the government.

**Romania:** Although stakeholders agreed with the statement, most of them are also sceptical about the role of the government. Several signals were received that the newly elected government (in place since mid-December 2016), is particularly unwilling to actively combat corruption. A good example is the recent proposal for a law to decriminalise all corruption cases of less than EUR 45,000. As a result, these would count as non-corrupt payments.

### EU-level interviews

The representative from AIM stated that the government should only have an active role in increasing transparency to some extent, because it might lead others to 'game' the regulations and self-regulation is a necessary element as well. ASSPRO representatives stated that the government should have an active role without reservations.

#### 4.2.13. **Conclusion 13: Active – independent – media involvement and pressure from 'civil society' watchdogs are essential to fight corruption in healthcare.**

### Survey results

The importance of active media involvement and pressure from civil society watchdogs was seen as at least to some extent relevant by 82% of the survey respondents. Two respondents indicated they did not see a role for media and watchdogs, while three respondents answered that they did not know.

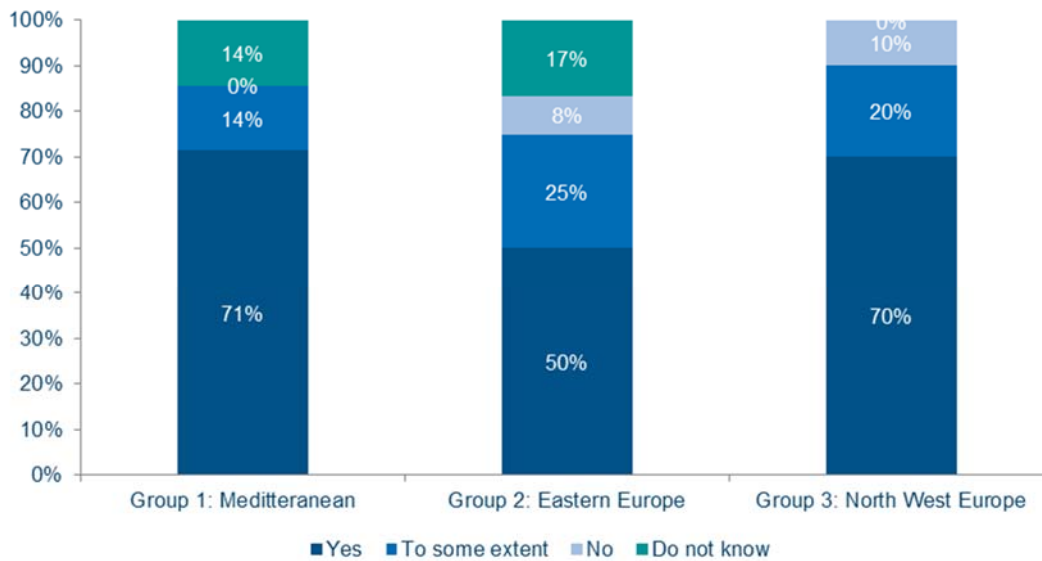
**Table 4.14 Answers to statement #13 (n=29)**

The importance of active – independent – media involvement and pressure from 'civil society' watchdogs is essential to fight corruption in healthcare (n=29)	
Yes	18
To some extent	6
Not	2
Do not know	3

Based on the geographical distinction, one can observe that 75% of respondents in Eastern Europe are of the opinion that the involvement of media and watchdogs is, at least to some extent, essential to fight corruption. In the Mediterranean region this is 85% of the respondents, while in North West Europe it is 90%.



**Figure 4.17 Geographical spread conclusion #13 (n=29)**



The number of respondents in each group: n= 7 (group 1), n= 12 (group 2), n= 10 (group 3).

**Fact finding missions**

**Greece:** All stakeholders agreed, at least to some extent, that more media involvement and civil pressure are needed. However, stakeholders also indicated that civil society watchdogs are hardly present. For example, Transparency International Greece is not active in the field of healthcare corruption. Also, websites where cases of corruption can be reported are rarely used. There is still a long way to go, according to some stakeholders.

**Croatia:** Whereas all Croatian stakeholders we spoke with agreed that active and independent media involvement is important, the Medical Chamber and pharmaceutical association had concerns regarding the independence and partisanship of the Croatian media.

**Lithuania:** The Lithuanian stakeholders all agreed that active and independent media involvement is important. One example in this context is the active role of Transparency International in Lithuania, where they are playing an important role in creating awareness (both with regard to best practice and recent cases) and enabling discussions between different actors in the healthcare sector on these topics through social design.

In 2016, TI Lithuania conducted a research study in Lazdynai Outpatient Clinic using social design methods. In this research, they changed the environment of the clinic and tried to understand how and whether such change indirectly affects the behaviour of patients, physicians and other staff; and how it can influence their attitude towards the clinic, increase transparency and reduce bribery.

The results of the research show that:

- The initiatives helped to improve the patient-physician relationship.
  - Patients, who believe that gifts and informal payments do not help to get better services, were more likely to recommend the clinic to others. Thus, corruption perception levels can be directly related to the willingness to recommend the institution to others.
  - Patients, who took part in the Vitamin Lab, evaluated the clinic better and were less likely to think that informal gifts or material rewards could help them receive better services in that clinic
  - Patients who took part in the Vitamin Lab were more likely to recommend the clinic to others.
- For more information, see <https://www.youtube.com/watch?v=G31HLtVdqyo>.

**Hungary:** Hungarian stakeholders agreed that active, independent media involvement and civil society watchdogs are essential to fight corruption in healthcare.

**Poland:** Polish stakeholders agreed that active – independent – media involvement and pressure from ‘civil society’ watchdogs is essential to fight corruption in healthcare. At the

same time, stakeholders indicated that not many initiatives have been taken. An initiative that was started around 2002 was stopped several years ago as it was not perceived to be valuable, even by physicians who are openly against bribery.

**Romania:** All stakeholders fully agreed that investigative journalism is important in the discussions about corruption. Since 2013, discussing corruption in the healthcare system has become more common, and the public is speaking up against the current bad practices. Several stakeholders indicated that investigative journalism is an important factor in the discussion about combatting corruption. The journalists fuel the current discussions and contribute to the non-acceptance of corruption in all Romanian sectors.

### **EU-level interviews**

Representatives from both AIM and ASSPRO indicated that active independent media involvement and pressure from civil society watchdogs is essential to fighting corruption in healthcare.

### **4.3. Thematic deepening**

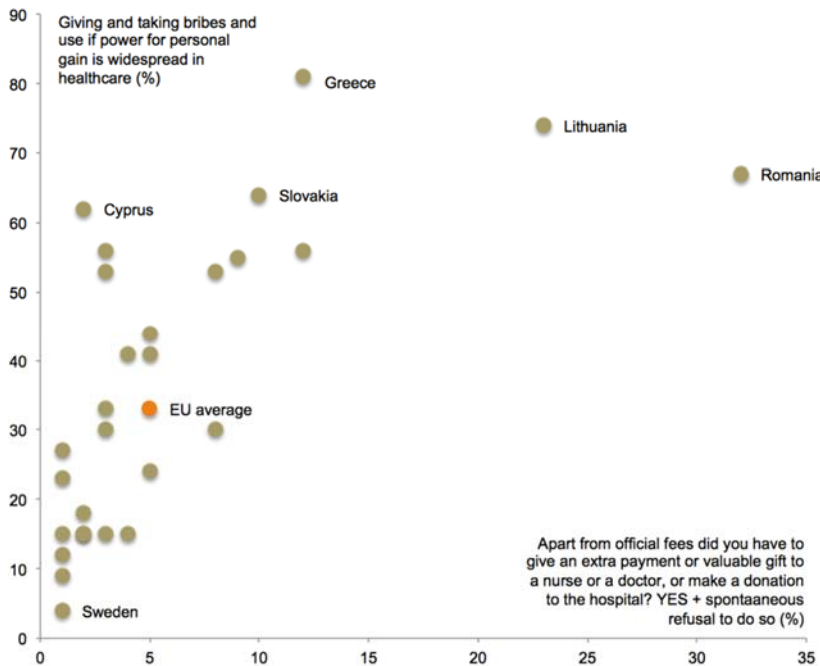
This section describes and analyses the developments in relation to the thematic areas of focus for this study, namely:

- Privileged access to medical services (including informal payments and the use of privileged information and information peddling);
- Improper marketing by pharmaceutical companies and medical device producers (at national and/or EU level, including for market authorisation and reimbursement approval);
- Potential risks involving double practice in public and private clinics.

#### **4.3.1. Theme 1: Privileged access**

Closer analysis of the Special Eurobarometer 397 on corruption in healthcare perceptions reveals that the [perceptions may be influenced by general perceptions of corruption in society, but also by one specific type of corruption in healthcare: bribery in medical service delivery](#). A conclusion from Figure 4.18 may be that there is a correlation between perceptions of corruption in healthcare and experiences in actually giving fees, an extra payment or a valuable gift to a nurse or a physician, or a donation to the hospital. However, corruption in the healthcare sector may cover more types of corruption than bribery in medical service delivery.

**Figure 4.18 Correlation between perceptions of corruption in healthcare and experiences with bribery in medical service delivery**



Source: Ecorys 2016, derived from Special Eurobarometer 397, 2014 (fieldwork February - March 2013), Table QB7 and QB2 (yes + refusal).

The Special Eurobarometer provides more detail on different ways that the situation of giving an extra payment, gift or hospital donation may have arisen. Patients may have **felt that they had to give** an extra payment or valuable gift and did so **before** and / or **after** care was given. They may also have been **requested to provide** an extra payment or valuable gift in advance and / or following the treatment. Countries that score high on general corruption (in healthcare) perceptions generally score high on these sub-indicators.

### Survey results

A total of 28 respondents answered the question regarding whether or not privileged access to medical services occurs frequently in their country. 25% (7 respondents in total) indicated that privileged access does happen often or all the time. 43% (12 respondents in total) indicated that privileged access does happen sometimes or occasionally. Two respondents (equalling 7%) indicate privileged access never happens. The remaining seven respondents did not know the answer.

**Table 4.15 Answers given to statement on privileged access (n=28)**

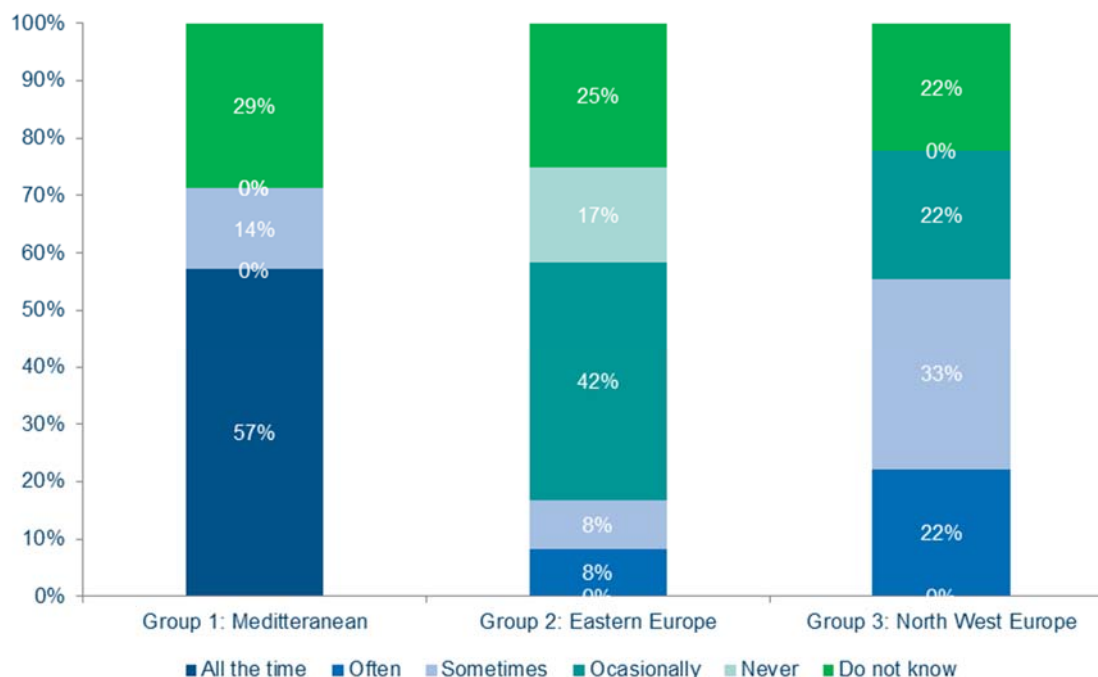
Does privileged access to medical services frequently occur in your country? (n=28)	Total
5 All the time	4
4 Often	3
3 Sometimes	5
2 Occasionally	7
1 Never	2
- Do not know	7

In the Figure below, the geographical spread of the answers for each of the three defined regions is presented. As can be seen, in the Mediterranean region privileged access seems the most common, as 57% of the respondents indicated that privileged access happens all

the time, compared to 8% in Eastern Europe (often) and 22% in North West Europe (often).

Also interesting to note is that Eastern Europe is the only region where some of the respondents indicated that privileged access never happens. It is not clear why this should be the case.

**Figure 4.19 Geographical spread for privileged access (n=28)**



The number of respondents in each group: n= 7 (group 1), n= 12 (group 2), n= 9 (group 3).

In response to the question regarding whether or not the respondent is aware of specific policies and practices aimed at preventing and controlling privileged access, 39% indicated that they were aware of specific policies, while the remaining 61% indicated that they were not familiar with any such policies.

**Table 4.16 Answers to the question regarding awareness of specific policies and practices to prevent and control privileged access**

Are you aware of specific policies and practices to prevent and control privileged access to medical services in your country? (n=28)	Total
Yes	11
No	17

### Fact finding missions

In [Greece](#) the topic of privileged access is closely linked to double practice. Patients mainly use the availability of double practice to obtain privileged access to public hospitals. The patient first visits the physician in his/her private clinic and pays the physician with both private insurance as well as under-the-table payments (i.e. double payment). Once the physician is paid, the patient is admitted directly to the public hospital and he/she is placed higher on the waiting list. By visiting the physician in a private clinic, waiting lists in public hospitals are bypassed.

In [Croatia](#), gifts to physicians are becoming less common but still exist to some extent. The culture is, however, changing, in part because attention is now paid to the risk of

corruption during medical education. In addition, it is now regulated through the Conflict of Interest Act. This cultural change has taken place in society over the last 15 years.

In [Lithuania](#) the healthcare sector is very informal and it is generally accepted by society to pay small bribes to physicians in the form of gifts or money, either to gain access or to show gratitude. The mind-set is changing however, with the shift in generations; younger physicians and patients do not necessarily consider it common practice. Not only informal payments, but also informal relations can play an important role in gaining access to treatment or to a physician. This holds for all types of healthcare; from family doctor visits to tertiary hospital services. The importance of informal relations creates risks for unequal, and privileged, access to healthcare.

In [Hungary](#), informal payments are ubiquitous. A law prohibits informal payments before treatment, but they are allowed when given after treatment has taken place. There is a separate clause in the labour law prohibiting 'gratitude' payments, but this can be (legally) overruled by the director of a hospital, whose formal approval removes the prohibition. The distribution of informal payments is very skewed as it is mostly the head physicians who receive these payments. About 60% of all informal payments go to 5% of all physicians. The younger generation receives less informal payments, and is also less willing to rely on them. As a consequence, younger healthcare professionals often go work abroad. This is particularly relevant for nurses, whose wages are low and who do not benefit from the informal payments at all.

Privileged access is a serious problem in [Poland](#). In this country the waiting lists are long, and it is often not clear to patients what their position is on a waiting list. In addition, most employed Poles are both publicly and privately insured. In order to move to a higher position on the waiting list, the patient first goes to a private hospital. Here, he or she receives a first consultation and makes sure that a referral to the public hospital is provided. Patients who follow this route, are placed higher on the waiting lists of public hospitals. As a consequence, they are able to bypass fellow patients who are not following the private healthcare route. Patients using their double insurance facilities obtain privileged access over patients that cannot or will not follow this route. Most stakeholders confirmed that this is common practice in Poland.

Examples exist in [Romania](#) where patients use their private insurance to obtain preferred access to a public hospital. Often a patient visits a physician in a private clinic and pays him or her an additional fee to get earlier access to treatment, e.g. surgery, in a public hospital. As a result, patients that are not able to afford private care are confronted with longer waiting times, and face the risk of being excluded from the healthcare system.

In addition to these findings, two initiatives in other EU countries are worth mentioning:

**New anti-corruption in healthcare law in Germany**

In April 2016, a new anti-corruption in healthcare law was adopted in Germany. One of the elements in this law, which is called "the fight against fraud and corruption in the healthcare sector", concerns the prosecution of independent physicians. Before the new law came into force, independent working physicians could not be punished for bribery or corruption as a result of a verdict of the High Court. Since April 2016, these physicians can be prosecuted and punished for corruption. Another element of the new law concerns an increased reporting obligation for notified bodies, such as the health insurance organisations.

**Privileged access and informal payments in Bulgaria**

According to the Bulgarian patients' organisation, young physicians are pressured by older physicians to ask patients for informal payments. This is widespread in Bulgaria. Politicians and their relatives are not subject to pressures for informal payments as they have privileged access to the governmental hospital, which has the best equipment and is funded with public money. Physicians themselves are also sometimes driven to make informal payments to get access to a specialisation track for further education, or to ensure that they pass exams. The latter appears to happen primarily with foreign medical students, and may have deleterious effects on the quality of healthcare professionals.

## EU-level interviews

DG SANTE noted that waiting lists themselves may create the conditions for the imposition of bribes to help certain patients to circumvent the waiting lists or to be placed higher on the list. In general there are no comparable data available, which complicates transparency with regard to access to health care. DG SANTE further noted that Commission recommendations in the field of curbing informal payments focus on four countries: Latvia, Hungary, Bulgaria, and Romania. In the case of Romania, the European Commission is also directly working together with the national government to monitor the developments with regard to informal payments.

The [European Hospital and Healthcare Federation \(HOPE\)](#) noted that a shift in types of corruption happened when 10 new Member States acceded to the European Union in 2004. At that time, most of the attention was directed to informal payments. This amounted to a big culture shift compared to what the patient federation was used to in terms of their experiences in Western Europe. Nowadays, the focus is more on corruption in the general sense: influence of pharmaceutical companies, public procurement, etc.

[Transparency International](#) stated its position that societies cannot accept out of pocket (informal) payments by patients for (access to) healthcare. Governments need to be in a position to properly pay for service delivery, much like is the case for education or other social services.

### 4.3.2. Theme 2: Improper marketing

The special Eurobarometer does not give any information on the occurrence of improper marketing by pharmaceutical companies and medical device producers.

In several countries, this topic is researched at the Member State level. For example, in the Netherlands, a study on the effect of sponsoring by pharmaceutical companies on the prescription behaviour of physicians was recently picked up by the media.

#### Study on the effect of sponsoring by pharmaceutical companies on the prescription behaviour of physicians in the Netherlands

## Arts kiest vaker pillen sponsorende farmaceut

Tom Kreling, Remy Koenen  
Elien de Visser  
Amsterdam

Medisch specialisten schrijven vaker en meer dure medicijnen voor van de farmaceutische bedrijven die hen sponsorged betaalen. Dat blijkt uit onderzoek van de Volkskrant en zorgverzekeraar VGZ naar het voorschrijfgedrag van vier nieuwe geneesmiddelen.

Veel buitenlandse studies hebben de afgelopen jaren een verband vastgesteld tussen sponsoring en voorschrijfgedrag. Dat onderzoek kon in Nederland niet worden gedaan omdat de voorschrijfgedrag niet openbaar zijn.

VGZ, de op een na grootste zorgverzekeraar (ruim vier miljoen verzekeren), zette van vier nieuwe, dure geneesmiddelen op een rij hoeveel recepten internisten daarvoor uitschrijven. Die informatie werd op verzoek van de Volkskrant gekoppeld aan de sponsorbedragen van de farmaceutische industrie, voor bijvoorbeeld

#### BANDEN MET FARMACIE

Percentage internisten dat medicijn voorschrijft

■ artsen **met** band met farmaceut

■ artsen **zonder** band met farmaceut

Medicijn: Toujeo (diabetes)

Farmaceut: Sanofi

19,7

53,2

Medicijn: Repatha (cholesterol)

Farmaceut: Amgen

3,8

14,3

Medicijn: Praluent (cholesterol)

Farmaceut: Sanofi

11,2

9,4

221216 © de Volkskrant - fb. Bron: VGZ

Hoewel de cijfers statistisch significant zijn, levert het verband tussen sponsoring en voorschrijfgedrag niet

op een duidelijk beeld van het

kenhuizen. Artsen uit die ziekenhuizen zouden dan boven aan de lijst met voorschrijvers moeten staan. Dat blijkt nauwelijks het geval.

Volgens Nefarma, de koepel van farmaceutische bedrijven, hebben artsen een voorkeur voor bepaalde geneesmiddelen op basis van hun professionele inzicht. 'Als ziekenhuizen en zorgverzekeraars afwijkend voorschrijfgedrag zien, kunnen ze artsen vragen of daar een verklaring voor is', aldus een woordvoerder.

De Amsterdamse wetenschapsfilosoof en psychiater Berend Verhoeff noemt het verband logisch: 'Met geld bind je mensen. Als je iets krijgt, ben je de gever bewust of onbewust iets verschuldigd. De farmaceutische industrie weet dat feilloos uit te buiten.'

Geld heeft altijd invloed, zegt ook emeritus-hoogleraar gezondheids-economie Guus Schrijvers. 'Artsen hebben dat lang niet altijd in de gaten.'

Schrijvers spreekt van een 'sleutel-gastuudie'. 'We zien slechts een deel van de kamer maar we hebben wel in de ga-

On 22 December 2016, the Dutch newspaper Volkskrant published an article entitled "Physicians more often choose drugs from sponsoring pharmaceutical companies". The article outlines the results of a study that was conducted by the newspaper in cooperation with a health insurance company. The study looked into the prescribing behaviour of medical specialists for four new and expensive drugs, and sponsoring by pharmaceutical companies. The results show a statistically significant

relationship between sponsoring and prescription behaviour but, as the article also notes, this is not hard evidence for improper influencing by the industry; there may be other factors in play that were not included in the study (e.g. differences in case mix between specialists). The results indicate that further research into this topic is warranted.

In the context of improper marketing it is also important to consider the risks associated with [lobbying](#). While lobbying is not necessarily a bad thing, it may create risks if conducted improperly. In 2015, Transparency International published a report about lobbying

practices in 19 countries and three EU institutions. The results show that in only seven out of the 19 countries in the study there is dedicated lobbying regulation. In addition, the study reveals that 58% of EU citizens believe that “their country’s government is to a large extent or entirely controlled by a few big interests”. Some of the other key findings of the study are that, in Europe<sup>131</sup>:

- The lobbying landscape is diverse and (increasingly) complex;
- Hidden and informal influences persist;
- Lobbying regulation seems to be inadequate, despite the risk factors – the average score on the quality of the lobbying regulation is 31%. The average scores on the three dimensions of a comprehensive lobbying regulation system are:
  - 26% on transparency;
  - 33% on integrity;
  - 33% on equality of access.

### Survey results

In the survey, stakeholders were asked if improper marketing often occurs in their country. Four respondents (equalling 15%) indicated that improper marketing happens often or all the time. 11 respondents (equalling 42%) indicated that improper marketing happens occasionally or sometimes. Only one respondent indicated that improper marketing does not occur. It should be noticed that 10 respondents (38%) were not able to answer this question.

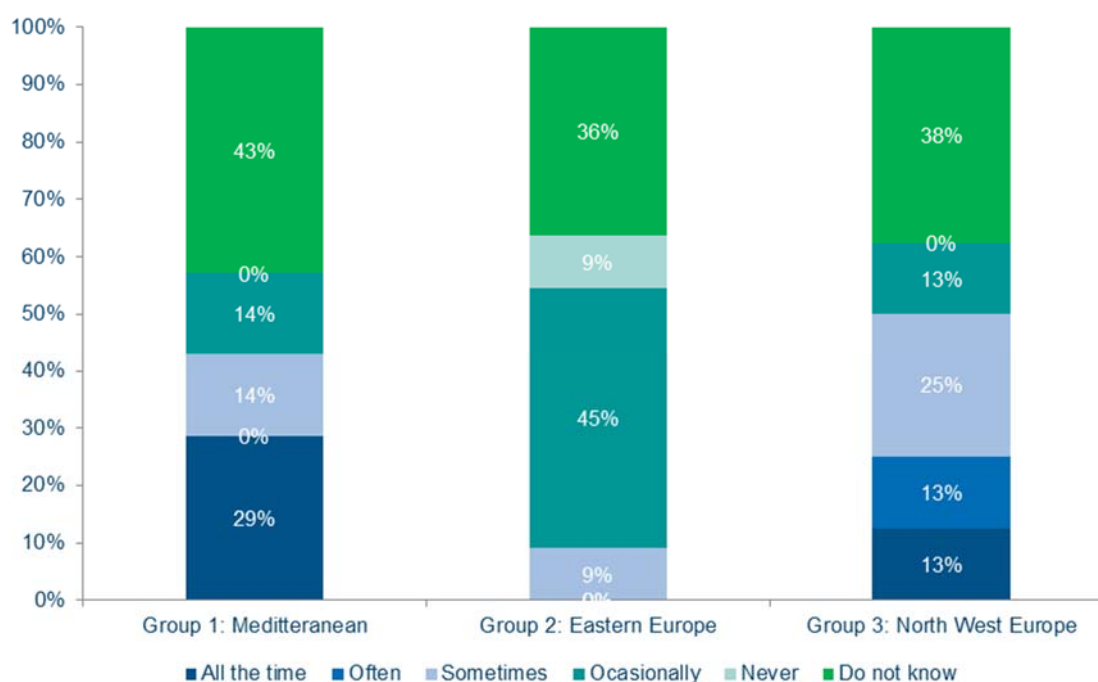
**Table 4.17** Answers given to statement on improper marketing (n=26)

Does improper marketing frequently occur in your country? (n=26)	Total
5 All the time	3
4 Often	1
3 Sometimes	4
2 Occasionally	7
1 Never	1
- Do not know	10

As illustrated in the Figure below, none of the respondents in Eastern Europe indicated that improper marketing occurs often or all the time, while in the other two regions, the answers are more or less equal (i.e. 29% in the Mediterranean region compared to 26% in North West Europe). Eastern Europe is also the only region where stakeholders indicated that improper marketing does not happen.

<sup>131</sup> Transparency International (2015). Lobbying in Europe. Hidden Influence, Privileged Access. [https://www.transparency.org/whatwedo/publication/lobbying\\_in\\_europe](https://www.transparency.org/whatwedo/publication/lobbying_in_europe), page 7.

**Figure 4.20 Geographical spread for improper marketing (n=26)**



The number of respondents in each group: n= 7 (group 1), n= 11 (group 2), n= 8 (group 3).

To the question asking whether or not the respondent is aware of specific policies and practices aimed at preventing and controlling improper marketing, 46% indicated that they were aware of specific policies, while the remaining 54% indicated that they were not familiar with any such policy.

**Table 4.18 Answers to the question regarding awareness of specific policies and practices to prevent and control improper marketing**

Are you aware of specific policies and practices to prevent and control improper marketing in your country? (n=26)	Total
Yes	12
No	14

### Fact finding missions

Direct sponsorship is allowed under [Greek](#) law. Many medical equipment providers are willing to pay a physician in order to ensure sales of their products. Physicians are also keen to accept additional payments or other extras from providers, as it enables them to increase their income, which is rather low. Several of the larger multinational companies (which are members of MedTech Europe) have already adopted the new MedTech Code – which phases out direct sponsorship - and will likely also apply this to their distributors. In addition, SEIV (the national trade association for medical equipment and devices companies) has already translated the newly adopted MedTech Code and in June 2017, during the General Assembly, SEIV members will be asked to adopt the Greek translation. However, even when all SEIV members have adopted the Code, only a small proportion of the market will be bound by it, as many, particularly smaller, companies are not members of the SEIV. This may create problems in the implementation of the Code, and particularly the phasing out of direct sponsorship.

In [Lithuania](#) several measures were introduced to regulate improper marketing. For example, in 2014, the Ministry of Health introduced a ban on gifts from pharmaceutical sales representatives to physicians, for things that are not related to the professional



activities of the physician. In addition, the pharmaceutical industry associations IFPA and VGA jointly introduced the Disclosure Code, according to which pharmaceutical companies have to disclose their payments for scientific events to physicians. The code is followed by 40 companies, and the industry associations estimate that the percentage of personal disclosure is 75%. While the Disclosure Code is currently a self-regulation measure, the Ministry of Health is looking into the possibility of introducing legislation on this. This is encouraged by the pharmaceutical sector in Lithuania. With regard to lobbying, on December 9th 2016, the new Minister of Health talked in his speech about the issue of illegal lobbying practices. Currently there is a lack of relevant legislation in this area, which creates risks for corrupt behaviour. The Ministry of Health is aware that there is still a lot of work to be done on this topic.

Improper marketing, and in particular sponsorship of healthcare professionals, is a topic of debate in [Poland](#). Both the pharmaceutical industry and medical equipment providers aim to reduce (direct) sponsorship. The relevant associations have adopted codes of conduct, which aim to regulate which costs can and cannot be reimbursed when inviting physicians to conferences and other events. Such codes of conducts rely on self-regulation and are not compulsory by law. In addition to the codes adopted by the industry, governmental organisations, e.g. the Ministry of Health and NFZ (the sole payer), also have codes of ethics, which indicate under which circumstances costs incurred by civil servants can be reimbursed by the industry. The stakeholders interviewed indicated that such codes are effective and provide useful guidance to combat improper marketing.

In [Romania](#), examples of improper marketing were encountered in the relation between physicians and the pharmaceutical industry. Once a pharmaceutical company has its medicine included on the list of the Ministry, the company tends to approach physicians and offer them additional payments if they prescribe the listed medication. Examples were mentioned where physicians prescribe medication for diseases for which the medication is not intended, in order to increase their income.

During the fact-finding missions to [Croatia](#) and [Hungary](#) the EFPIA Code of Conduct (see below) was referenced multiple times. However, no additional relevant information regarding this theme was collected.

### **EU-level interviews**

An important development since the last study is the merger of Eucomed, EDMA and MedTech Europe at the end of 2016. This merger resulted in the [trade association MedTech Europe](#), which represents the entire industry from diagnosis to cure. Before the merger (in 2014), MedTech Europe decided that one of the first things they needed was a new common code of conduct that contains stringent rules on how industry should interact with healthcare professionals and healthcare organisations. This code came into effect on 1 January 2017, outlining a new approach to the funding of healthcare professionals and the research community (academics).<sup>132</sup> If implemented, it effectively puts a stop to the direct funding of individuals. The guideline has been adopted by the vast majority of MedTech members and represents a significant change in conduct.

The code has a double [monitoring](#) system. On the one hand, MedTech Europe is monitoring what their members are doing and has given them until end of this year to phase out direct sponsorship. The reason for giving them time to achieve this is that in some countries it is not evident. On the other hand, MedTech Europe set up an independent compliance panel at the European level. Patients, physicians, and also competitors, can complain about an alleged infringement at this panel. It is expected that particularly the (potential) complaints by competitors will regulate the industry. If the assessment of the panel shows that there

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<sup>132</sup> This presentation can be found here: <http://www.medtecheurope.org/industry-themes/topic/122>.

is an infringement, there is a list of sanctions that the panel can choose to impose on member companies.

Several other initiatives found through desk research are also worth mentioning:<sup>133</sup>

#### **EFPIA self-regulation**

The European Federation of Pharmaceutical Industries and Associations (EFPIA) is the overarching association of national pharma industry associations. It has several self-regulation initiatives, such as the HCP Code and the PO Code. Recently, it adopted a 'Disclosure Code' to supplement these two. The latest self-regulation initiative demands that its members disclose, on their websites, the transfers of value given to healthcare professionals and healthcare officers<sup>134</sup> Its stated aim is to 'secure the integrity of the decision and encourage a consistent disclosure approach'. It is applicable to all EU member states as well as Switzerland, Turkey, Norway, Russia, Serbia and Ukraine; enforcement of the Codes is discharged by the member associations.

#### **Self-regulation in Germany**

In Germany, there is an interesting development where self-regulation has turned into regulation. Healthcare professionals are no longer allowed to receive kickbacks when referring patients from the GP to the hospital. It was acknowledged that this is a problem, even at the Parliamentary level, where many physicians are represented. The legislation was also approved by them, which shows that the culture and perception in Germany has changed over the past few years. The new law, which added a criminal offence to Sec. 299a and Sec. 299b of the Criminal Code ("Strafgesetzbuch" – StGB) came into force a few months ago.<sup>135</sup>

#### **Conference vetting system**

The discussions on the appropriateness of direct sponsorship of healthcare professionals has been ongoing for many years. In 2010/2011, after questions and comments from companies, the industry started thinking about a system for assessing whether conferences are professional or mainly leisure (and hence not appropriate for sponsorship). In that context, the conference vetting system was developed and introduced in 2012. This system assesses, for the entire industry, which European and global conferences can be supported and which cannot. The system changed the conference landscape; the organisation of conferences has become more professional. To a certain extent, there was already an ongoing move towards that, but it seems that the conference vetting system, as well as the EFPIA system (similar system), helped to create a professional standard of what is an appropriate conference for sponsorship. Now, with the phasing out of direct sponsorship in the MedTech industry, using the conference vetting system remains a requirement for determining for which conferences an educational grant is provided.

### **4.3.3. Theme 3: Double practice**

As is illustrated in Figure 4.21, countries where patients are asked to go for a private consultation in order to be treated in a public hospital are, in particular: Malta (67%), Ireland (36%), Spain (31%), Austria (28%), Denmark (23%), France (20%) and Romania (19%), while the EU27 average is 12%.<sup>136</sup>

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<sup>133</sup> The study team was, notwithstanding several requests to EFPIA, unable to arrange an interview with EFPIA.

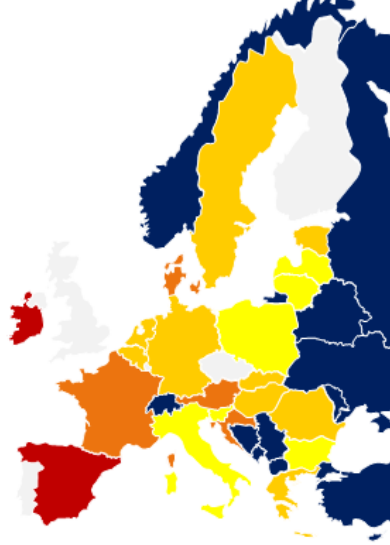
<sup>134</sup> The Disclosure Code and other EFPIA self-regulation can be found here: <http://transparency.efpia.eu/the-efpia-code-2>.

<sup>135</sup> See for example <https://www.taylorwessing.com/synapse/ti-new-anti-bribery-law-german-healthcare-sector.html> for more information.

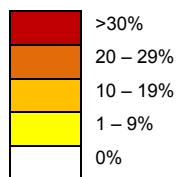
<sup>136</sup> Special Eurobarometer 397, 2014, p.92.

**Figure 4.21 Double practice**

*You were asked to go for a private consultation in order to be treated in a public hospital?*



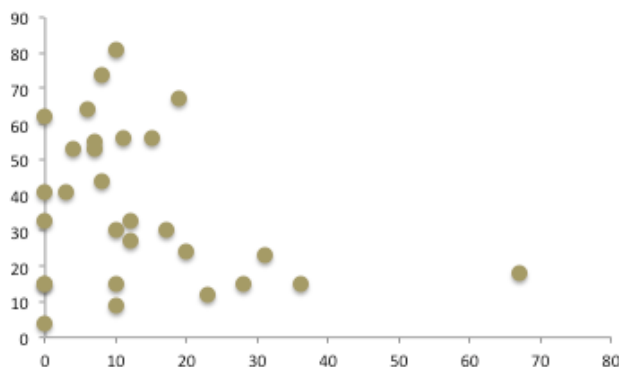
Source: Special Eurobarometer 397, 2014, QB3, T5



These results suggest that the problem of double practice is not isolated to Member States, with a high perception of corruption (in healthcare); as Figure 4.22 shows, there is no clear correlation of experiences with double practice with general perceptions of corruption in the healthcare sector.

**Figure 4.22 No (clear) correlation between perceptions of corruption in healthcare and experiences with double practice**

*Y-axis: % of respondents that think that the giving and taking of bribes and the abuse of power for personal gain are widespread in healthcare; X-axis: % of respondents that has been asked to go for a private consultation in order to be treated in a public hospital.*



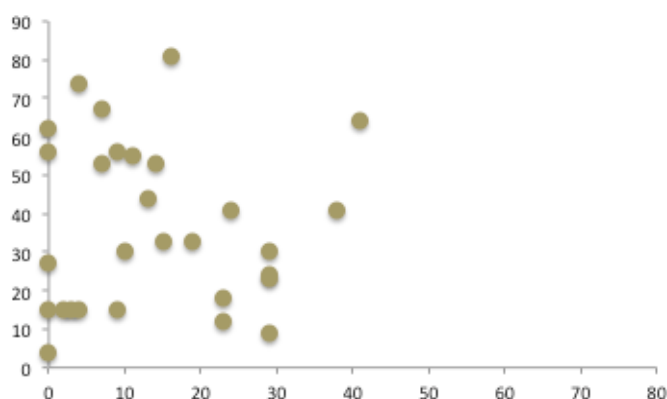
Source: Ecorys 2016, derived from Special Eurobarometer 397, 2014 (fieldwork February - March 2013), Table QB7 and QB3 (You were asked to go for a private consultation in order to be treated in a public hospital)

Countries where patients have most frequent experiences [paying for privileged treatment](#) are: Slovakia (41%), Slovenia (38%) and Germany, Spain, France and Sweden (all 29%),

while the EU average stands at 19%.<sup>137</sup> As the Figure below shows, there is no clear correlation with general perceptions of corruption in the healthcare sector.

**Figure 4.23 No (clear) correlation between perceptions of corruption in healthcare and experiences with bribery for preferred treatment**

*Y-axis: % of respondents that think that the giving and taking of bribes and the abuse of power for personal gain are widespread in healthcare; X-axis: % of respondents that have been asked to pay for a privileged treatment.*



Source: Ecorys 2016, derived from Special Eurobarometer 397, 2014 (fieldwork February - March 2013), Table QB7 and QB3 (You were asked to pay for a privileged treatment).

### Survey results

44% of the survey respondents (11 in total) indicated that double practice occurs often or all the time in their country. 40% (10 in total) indicated that double practice happens sometimes or occasionally, while only one respondent indicated that double practice never happens. Three respondents were not able to answer the question.

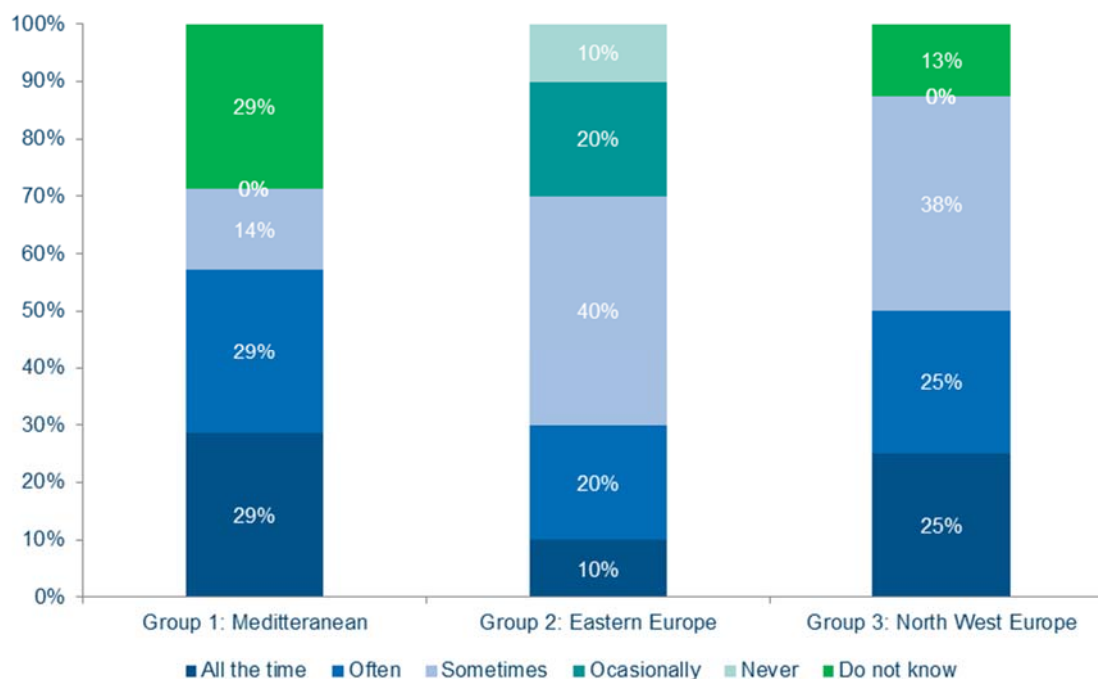
**Table 4.19 Answers given to statement on double practice (n=25)**

Does double practice in public and private clinics frequently occur in your country? (n=25)	Total
5 All the time	5
4 Often	6
3 Sometimes	8
2 Occasionally	2
1 Never	1
- Do not know	3

As presented in the Figure below, double practice seem to be most common in both the Mediterranean region (58%) and North West Europe (50%), while in Eastern Europe double practice only occurs often (as opposed to all the time), according to 30% of the respondents. Eastern Europe is the only region where respondents indicate that double practice never occurs.

<sup>137</sup> Special Eurobarometer 397, 2014, p.92.

**Figure 4.24 Geographical spread for double practice (n=25)**



The number of respondents in each group: n= 7 (group 1), n= 10 (group 2), n= 8 (group 3).

The majority of the stakeholders, 76%, are not aware of specific policies and practices to prevent and control double practice in their country. The remaining 23% indicated that they are aware of such policies and practices.

Are you aware of specific policies and practices to prevent and control double practice in your country? (n=26)	Total
Yes	6
No	19

### Fact finding missions

The problem of double practice is a relatively new problem in Greece. Until some years ago physicians in hospitals used to be employed fully as civil servants. As a consequence, they were not allowed to work in the private sector as well. Currently, some physicians have other types of contracts, which allow them to work, under conditions, in both the public and private sector. Moreover, some public physicians (still being civil servants) are also illegally active in the private sector.

In **Croatia**, it is not possible for physicians to hold a private practice in public hospitals, but physicians can work in both public and private hospitals. Double practice is considered a problem, because the physicians working in private clinics do not have enough energy to perform their work properly at the public hospitals. People prefer private hospitals because they are quicker and more efficient. This may be problematic with regard to equal access. Stakeholders, however, support the combination of public and private healthcare, and some even argued that having private practice could lower waiting lists in public hospitals.

In **Lithuania** it is actually very common, and legal, for physicians to have multiple positions in the public and private sector. It is difficult to estimate the effect that this has on the healthcare sector. In an effort to further look into this, the Ministry of Health undertook to determine how many physicians had dual positions (in 2015). This was done by comparing

data from the tax authorities with data declared on the basis of the 2014 Law on Private Interest (which states that all physicians had to declare their interests in 2015 to the Chief Official Ethics Commission). This comparison revealed that a large number of physicians had not declared all their interests, which made it impossible to accurately estimate the size of the problem, and again confirmed the need to further investigate the issue of double/ multiple practices..

In [Hungary](#) double practice is allowed and most physicians engage in it. Although no update has been made since the 2013 study's data, it is known that 50% of patients make an informal payment for hospitalisation (with an average worth of 100 EUR), and 20% of patients make an informal payment worth 15 EUR for physician visits.<sup>138</sup>

Working at the same time in a public and private hospital – double practice - is allowed under [Polish](#) law. Stakeholders indicated that allowing physicians to work in both sectors helped to combat informal payments, as physicians have the opportunity to increase their income in a legal way. Nevertheless, stakeholders also indicated that double practice could contribute to forms of corruption, especially to privileged access. In such cases, the physician admits patients from his private clinic to his public hospital, helping them to bypass the long waiting lists.

Double practice does occur in [Romania](#). The main reason given for the existence of double practice is the low salaries of physicians. By working at both private and public hospitals, physicians have the opportunity to increase their salary with additional income. Some stakeholders interviewed reported that private facilities are often used as recovery centres, while the actual treatment, e.g. surgery, takes place in the public hospital. As described in the country report on Romania, the Romanian government initiated a law that aimed to legalise double practice. This initiative encountered much opposition as it would only benefit a minority of physicians, the ones with the highest salaries.

### **EU-level interviews**

[DG SANTE](#) stated that double practice is an important issue as it relates to conflict of interest issues, but is not acknowledged as being a problem by many Member States.

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<sup>138</sup> See Baji P., Pavlova M., Gulácsi L., Farkas M., Groot W. (2014), The link between past informal payments and willingness of the Hungarian population to pay formal fees for health care services: results from a contingent valuation study. In *European Journal of Health Economics* 15(8): 853:67.

## 5. CONCLUSIONS

The objectives of this study were:

- To analyse and report on relevant developments in the areas of medical service delivery, procurement and certification of medical devices, and procurement and authorisation of pharmaceuticals since the publication of our initial study on corruption in the healthcare sector (SCH1, October 2013);
- To provide an in-depth analysis of selected issues, including:
  - Privileged access to medical services (including not only informal payments but also the use of privileged information and information peddling);
  - Potential risks involving double practice in public and private clinics.
  - Improper marketing by pharmaceutical companies and medical device producers (at national and/or EU level, including for market authorisation and reimbursement approval);

The study covers all EU-28 Member States with specific focus on Greece, Croatia, Hungary, Lithuania, Poland, and Romania. These are countries where the EU Anti-Corruption Report highlights healthcare as an issue. Below, we highlight the main findings and conclusions per main part of the study.

### 5.1. Revisiting the general conclusions of SCH1

In the initial study on Corruption in the Healthcare Sector (SCH1), 13 general conclusions were drawn. In the current study, stakeholders were asked, during the survey, fact-finding missions and interviews, whether they believe these conclusions are still relevant. The consulted stakeholders added the following nuances to the conclusions on the phenomena of corruption in healthcare in itself and avenues to combat it:

**Conclusion 1: Convictions of (high-profile) corruption cases have a deterrent and norm-setting effect.**

The majority of the stakeholders confirmed that this conclusion is still valid. However, in some countries hardly any cases are brought to court and this weakens the norm-setting effect. In addition, stakeholders mentioned that a norm-setting effect is only effective when it is followed up by sustained political action.

**Conclusion 2: Centralisation of procurement is a method to lower the risks of corruption.**

The majority of the stakeholders consulted agreed (either fully or to some extent) that central procurement is a good method to lower the risks for corruption. Agreement with this conclusion is stronger in Eastern and North West Europe than in the Mediterranean countries.

It was noted that it may also be important to have public registries in place and to introduce transparency increasing measures, otherwise centralised procurement may actually face more risks (also see "conclusion 3").

**Conclusion 3: Central procurement systems can become vulnerable as targets for lobbyists and more politically inspired types of corruption.**

The majority of the stakeholders agreed with this statement, though it was noted that decentralised systems may also be prone to lobbying and politically inspired corruption. As with conclusion 2, for conclusion 3 we observed regional differences in the stakeholder responses in the survey: the outcomes indicate that the risks on lobbying and politically inspired types of corruption are perceived to be higher in the Mediterranean and Eastern Europe area compared to North West Europe.

**Conclusion 4: Bribery in medical service delivery cannot be contested with only targeted policies against the phenomenon as such, but need to be supplemented with a variety of accompanying (structural) measures.**

In regions where bribery in medical service delivery is still common, the majority of stakeholders agreed that both targeted policies and structural measures are required to fight the problem. Interviewees indicated a wide variety of necessary accompanying measures, including: strengthening the judicial system, changes in the healthcare system, and changes in attitudes towards corrupt practices. In North West Europe, where this form of corruption is less common, only a minority of stakeholders expressed the need for more structural changes alongside targeted policies.

**Conclusion 5: Raising salaries does not have a significant preventive effect on reducing bribery in medical service delivery.**

Low salaries are indeed a problem according to the majority of the stakeholders. However, the majority of respondents in all regions agreed that raising salaries cannot be a standalone measure. For example, it was mentioned that active prosecution and public awareness of the unethical aspects are also needed.

**Conclusion 6: There is more than one root cause of corruption in healthcare.**

Survey results showed that the most frequently mentioned root causes are: a general acceptance of corruption, ineffective managerial structures, inappropriate financing mechanisms, and unequal allocation of resources. Respondents also mentioned insufficient healthcare capacity, and insufficient funding for independent medical research as causes for corruption.

**Conclusion 7: The introduction of transparent waiting lists has a positive effect on reducing healthcare bribery.**

Most stakeholders agreed that introducing transparent waiting lists would have a positive effect on healthcare bribery. However, recent attempts to reduce such lists have not been successful in all countries, due, for example, to the fact that the lists were not frequently updated which resulted in outdated information being supplied to patients.

**Conclusion 8: Prescription of generics instead of branded pharmaceutical products has a positive effect on reducing healthcare bribery.**

The majority of respondents are of the opinion that the prescription of generics instead of branded pharmaceutical has, at least to some extent, a positive effect on reducing healthcare bribery. Particularly in Eastern Europe, where several countries have introduced this type of policy, the majority of people agree to the statement. However, our research has shown that in practice, this measure has had a minimal impact so far, or only reduces bribery to some extent.

**Conclusion 9: Self-regulation between the industry and healthcare providers is needed to fight corruption in healthcare.**

The vast majority of stakeholders agreed that self-regulation is an instrument to fight corruption. Looking at the different regions, it stands out that stakeholders in Eastern European countries appear to be the most sceptical, and only expect self-regulation to be effective to 'some extent'. Many stakeholders noted that self-regulation is important, but not sufficient, and that it would be beneficial if initiatives between the industry and the healthcare provider are embedded in legislation, for example, to strengthen enforcement mechanisms.

**Conclusion 10: Self-regulation among players (such as within the pharmaceutical industry or among physicians) is needed to fight corruption in healthcare.**

The majority of the stakeholders agreed that self-regulation among players is important. Compared to 'conclusion 9' there is relatively little geographical variation in the responses of stakeholders. As with self-regulation between the industry and healthcare providers (conclusion 9), stakeholders note that it is not sufficient by itself and that incentives for cooperation are important for self-regulation to be effective.



**Conclusion 11: Awareness raising campaigns and fraud and corruption reporting hotlines are an effective instrument to fight corruption in healthcare.**

Most stakeholders agreed that awareness campaigns and reporting hotlines are effective instruments in the fight against corruption. Nevertheless, some interviewees stressed that many patients do not report to such hotlines, and therefore many cases might remain unknown. Also, reporting hotlines alone cannot be effective in reducing corruption; they need to be combined with other measures and legislation to fight corruption.

**Conclusion 12: The government should play a (more) active role in creating transparency in the relations between the industry and healthcare providers.**

According to the vast majority of the stakeholders, the government should play a (more) active role in creating transparency in the relations between industry and healthcare providers. The respondents in North West Europe are the most positive about the role the government could play in this. In our research, we encountered incidental scepticism regarding the role of the government when governments do not show sufficient willingness to fight corruption in general.

**Conclusion 13: The importance of active – independent – media involvement and pressure from 'civil society' watchdogs is essential to fight corruption in healthcare.**

Media involvement and civil pressure are generally considered as essential to fight corruption, also by the stakeholders involved in this study: the vast majority agreed with the statement at least to some extent. Though it is considered an important tool in the fight against corruption, our research shows that there is a difference between countries regarding the countervailing power of these 'watchdogs'.

## **5.2. Relevant developments since SCH1**

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

Bribery in medical service delivery - also referred to as 'petty corruption', 'under-the-table payments', or 'informal payments' - was one of the main typologies identified in SCH1; and one of the most prevalent and visible forms of corruption, especially in Eastern and Southern European Member States.

The results of the current study reveal that **bribery in medical service delivery remains one of the main challenges**, especially in many Eastern and Southern European Member States. **Root causes mentioned for most countries include general acceptance of bribery, low wages for health professionals, including physicians, ineffective managerial structures, and ineffective control mechanisms.**

When considering possible ways to fight bribery in medical service delivery, both the survey results as the results from the interviews indicate that raising salaries of health professionals will not be sufficient in itself. The majority of consulted stakeholders also agree that **petty corruption cannot be combatted by policies targeted at the phenomenon as such, but needs to be combined, or preceded, by structural measures in the healthcare system**, including transparency enhancing measures (e.g. transparency of waiting lists). In addition, (media coverage of) **prosecution of cases can have a deterrent and norm-setting effect**. The vast majority of survey respondents and interviewees - both during the fact finding missions and at EU-level - acknowledged the importance of this norm-setting effect. An important precondition is the existence of proper checks and balances; in many Member States the disciplinary board overseeing control currently consists of only physicians and this is considered rather ineffective.

Common developments in the six focus countries include an increase in awareness raising campaigns and the fact the prosecution of physicians for bribery in medical service delivery has, over the last few years, become more common. There are, however, **significant differences between Member States in terms of their efforts, as well as successes, in**

**fighting petty corruption.** For example, much progress was made in Poland: bribery in medical service delivery is currently less accepted by society. This is expected to be the result of a combination of awareness raising campaigns, active prosecution of physicians, and media coverage of these cases. In Greece, on the other hand, the situation has worsened as a result of the economic downturn. Increasing demand for public healthcare (as patients can no longer afford private care) in combination with decreasing salaries for physicians, leads to a situation in which more informal payments are requested. In other Member States the situation appears to have stayed more or less the same in terms of occurrence, despite efforts to fight bribery in medical service delivery.

A promising, though slow moving, development that is observed in the countries visited for this study is that younger generations – both physicians and patients – no longer accept bribery in medical service delivery as common practice. The countries show a **generational shift in terms of mentality towards informal payments**; this mentality is generally acknowledged to be one of the most difficult causes to fight petty corruption.

### ***Corruption in procurement of medical devices and pharmaceuticals***

In our initial study we concluded that corruption in procurement often takes place during the early stages of the process, most commonly by tailoring the tender specifications and/or the tender phase to one (preferred) supplier. One of the proposed solutions to mitigate the risks for this type of corruption is **centralisation of procurement processes**. An important precondition for this measure to be effective is transparency in the central procurement body: “*transparency...is corruption's natural enemy*<sup>139</sup>”. Without transparency, increasing pressure from, for example, lobbyists and conflicts of interest, may actually increase the risks for corruption.

In this study we found that stakeholders differ in their view on whether or not centralising procurement will reduce corruption risk. More than half of the survey respondents believe that centralisation is indeed an effective method for lowering the risk for corruption in procurement, but over 70% of the respondents also indicate that centralisation comes with risks. Hence, the effectiveness will depend on the way in which the system is implemented. The system in Hungary is an example of why combining centralised procurement with transparency is essential for success; to date no transparency enhancing measures have been introduced in Hungary and hence stakeholders believe that the situation has actually worsened compared to the former (decentralised) system. There are also countries facing challenges in a decentralised system: individual physicians are made responsible for their own procurement without having the knowledge to do this (efficiently). This information asymmetry between healthcare providers and industry create risks for corruption.

We also found that **several Member States have implemented other measures to reduce the risk of corruption in the procurement of medical devices and pharmaceuticals**. One example is the online publication of procurement data in Croatia and Lithuania. In Lithuania, the Ministry of Health is also encouraging hospitals to collaborate in order to enable larger procurements and to reduce the bargaining power of the industry. In Romania and Greece, anti-corruption bureaus/directorates have been set-up to look into this type of corruption. Finally, we mention the price observatory for medical supplies in Greece as an example: this list indicates the maximum prices that can be charged to hospitals.

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<sup>139</sup> <https://www.neweurope.eu/article/transparency-corruptions-natural-enemy/>

### ***Privileged access & double practice***

Gaining privileged access to healthcare services is not only achieved through informal payments, but also through informal relations or information peddling. The fact-finding mission in Lithuania, for example, revealed that informal relations play an important role in gaining access to healthcare; from family doctor visits to tertiary hospital services. As there is no comparable data on the topic available, transparency with regard to the level of access to healthcare services is further complicated.

Double practice, i.e. physicians working both in the public and private sector, also creates risks for corruption. In some countries misuse of double practice goes hand in hand with privileged access. For example, in Greece, Romania and Poland stakeholders described the following link between double practice and privileged access. A patient first visits the physician in his/her private clinic and pays him/her through private insurance as well as via under-the-table payment (i.e. double payment). Once the physician is paid, the patient is admitted directly to the public hospital and he/she is placed higher on the waiting list. Hence, by visiting the physician in a private clinic, waiting lists in public hospitals are bypassed.

Compared to bribery in medical service delivery, [corruption related to granting privileged access to healthcare or potential risks involving double practice occur much more randomly and are not \(clearly\) correlated with general perceptions of corruption \(in the healthcare sector\)](#).

Survey results indicate that over 75% of the respondents is not aware of any specific policies or practices to control double practice in their country. Moreover, the fact-finding missions revealed that in [many of the countries studied in more depth, double practice is not illegal](#), and sometimes even considered a good thing as it may reduce informal payments and/or decrease waiting lists in the public sector. [Nevertheless, the risk of double practice is acknowledged and some countries are looking into how to mitigate these risks](#), without prohibiting physicians from working in both the public and the private sector (e.g. Romania).

### ***Improper marketing***

Relationships between physicians and the industry are necessary and beneficial in the context of product development and monitoring the use of medicines in practice. In addition, industry supports continuous medical education of healthcare professionals through sponsorship. Important to note is that these relationships also create risks for improper and corrupt practices, such as influencing prescribing behaviour. Such practices can lead to inefficient allocation of resources or even healthcare risks when certain medicines or devices are prescribed or used for reasons other than proven medical indications.

In our initial study, improper marketing – in both the pharmaceutical and medical devices sectors - was identified as one of the main corruption in healthcare typologies, even though it was not one of the focus areas of that study. The initial study also revealed that both at the Member State and the EU level different measures were implemented to prevent and control this form of corruption. For example, through transparency enhancing initiatives and self-regulation codes of conduct. The current study shows that [improper marketing remains a major problem area and often occurs in many countries](#). Only one survey respondent indicated that improper marketing does not occur in his/her country.

To prevent improper marketing, [several \(self-\)regulation initiatives have been introduced](#). At the EU-level, the trade associations EFPIA (pharmaceuticals) and MedTech Europe (medical devices) have both introduced a new code since the publication of our initial study in October 2013. EFPIA introduced the 'Disclosure Code', which supplements the codes

already in place. This code states that EFPIA members should disclose, on their websites, the transfers of value given to healthcare professionals and healthcare officers. Enforcement of the Code is discharged by the member associations. MedTech Europe introduced the Code of Ethical Business practices, which came into effect on 1 January 2017. One of the main points in this Code is the phasing out of direct sponsorship. Many of the multinational members of the association have already implemented the Code, and the national organisations are currently in the process of transposing it.

Both the EFPIA and MedTech Europe Code were mentioned in the interviews that took place as part of the fact finding missions. The transposition of the codes by national organisations was sometimes mentioned to be challenging, for example because direct sponsorship is allowed and/or transparency is not required under national law. In addition, there are some countries where the legislation is stricter than the self-regulation codes, or ambiguous with regard to specific aspects of the code, which makes it difficult to determine how the two can coexist.

In addition to the transposition of the EFPIA and MedTech Europe Code, there are also [other initiatives at the national level to prevent improper marketing](#). In many countries, the national associations have introduced a code of conduct or ethics or transparency enhancing initiatives. Self-regulation appears to play an important role in the fight against improper marketing. Over two-thirds of the survey respondents agreed that self-regulation among players is needed. Moreover, over 80% of these respondents also indicated that the [government should play a \(more\) active role in creating transparency, especially with regard to combining self-regulation measures with formal legislation](#).

As stated above, it is also important to consider the risks associated with lobbying when talking about improper marketing. While lobbying is in itself not a bad thing, it may create risks if conducted improperly. In 2015, Transparency International published a report about lobbying practices in 19 countries and three EU institutions. The results show that in only seven out of the 19 countries included in the study there is dedicated lobbying regulation. In addition, the study reveals that 58% of EU citizens believe that “their country’s government is to a large extent or entirely controlled by a few big interests”. The [importance of legislation on lobbying practices](#) was acknowledged during the fact finding missions. For example, in Lithuania the Minister of Health recently expressed concern about the lack of regulation on this issue as it creates big risks for corruption. In Poland, there is self-regulation by governmental organisations, specifying for which costs civil servants can be reimbursed by the industry to mitigate the corruption risks.

An example of a policy that was implemented by several national governments is the [policy that physicians can only prescribe active substances, not branded medication](#). Stakeholders are not unanimous in their opinion as to whether or not this policy will help to prevent improper marketing. In the survey, 60% of the respondents indicated that this policy will help to reduce corruption risks, at least to some extent. This was acknowledged by several EU-level interviewees, who in turn also stressed that [this policy alone will not be enough](#). The fact-finding missions confirmed this notion. For example, in Greece, Croatia, Poland and Romania, stakeholders mentioned that although the policy has potential, and seems to have some effect; physicians sometimes still find ways to prescribe branded products, and industry can shift their influencing efforts from physicians to the officials responsible for determining the reimbursement list.

## Annex I: Interview guide

### Study on corruption in the healthcare sector II – INTERVIEW GUIDE

This interview guide is part of an independent research of Ecorys Nederland B.V. (project leader: Dr. Brigitte Slot) on corruption in the healthcare sector. The project is commissioned by the European Commission, Directorate General Migration and Home Affairs (DG Home).

The fight against corruption is one of the key priorities for the EC. Corruption is defined as “*the abuse of power for private gain*” – this is a wide definition that also encompasses aspects that go beyond the criminal law aspects, including situations such as conflict of interest, favouritism, etc.

The current study aims to:

- Update the results of the previous study;
- Collect information on selected thematic issues
  - Informal payments in medical service delivery;
  - Certification and procurement of medical devices;
  - Authorisation and procurement of pharmaceuticals;
  - Privileged access to medical services (including not only informal payments but also the use of privileged information and information peddling);
  - Improper marketing by pharmaceutical companies and medical device producers (at national and/or EU level, including for market authorisation and reimbursement approval);
  - Potential risks involving double practice in public and private clinics.
- Focus on selected countries: Croatia, Greece, Hungary, Lithuania, Poland and Romania.

### Purpose of the interview

The purpose of the interview is to get detailed insights into the current situation regarding the extent, nature and impact of corrupt practices as well as legal and policy mechanisms to prevent and combat corruption at EU and/or MS level.

The information provided during the interview will be treated confidentially. The interview report, summarising the main points discussed, will be sent back to the interviewees for validation. These interview reports will serve as an input for the final report, but will not be published in the report. Quotes that will be included in the report will not be traceable to individual interviewees. The final report will provide an overview of all the interviews conducted. This overview will contain the following information:

- Member State (if applicable);
- Date of the interview;
- Stakeholder category (e.g. patients, payers, industry, providers, regulators, civil society organization, anti-corruption agency);
- Interviewees will not be named personally;
- The name of the organisation the interviewee represents will only be named if the interviewee explicitly gives consent for this.

## QUESTIONS

### **A. Introduction and general questions**

- Can you give a brief introduction on your organisation and your role within the organisation?

Please note that corruption is much broader than paying or receiving bribes, transferring kickbacks or diverting (health care) 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 or 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 health care.

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 practice (systematic corruption).

- What are the most prevailing types of corruption in the healthcare sector?
- What are the causes and/or risks of corruption in general, and specifically for the healthcare sector?
- What is the impact of corruption in the healthcare sector?

**In the following sections we focus on:**

- Questions that are related to the recent cases of corruption in the healthcare sector (section B)

- Questions that are related to legislation, specific policies and practices to prevent and control corruption (section C)

- Questions that are related to the general conclusions of the 2013 Corruption in the Healthcare study<sup>140</sup> (section D)

### **B. Recent cases.....**

- Are you aware of any recent cases of corruption in the healthcare sector (since 2013)?
- Are these related to any of the following issues:
  - Informal payments in medical service delivery;
  - Certification and procurement of medical devices;
  - Authorisation and procurement of pharmaceuticals;
  - Privileged access to medical services (including not only informal payments but also the use of privileged information and information peddling);

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<sup>140</sup> [http://ec.europa.eu/dgs/home-affairs/what-is-new/news/news/docs/20131219\\_study\\_on\\_corruption\\_in\\_the\\_healthcare\\_sector\\_en.pdf](http://ec.europa.eu/dgs/home-affairs/what-is-new/news/news/docs/20131219_study_on_corruption_in_the_healthcare_sector_en.pdf).

- Improper marketing by pharmaceutical companies and medical device producers (at national and/or EU level, including for market authorisation and reimbursement approval);
- Potential risks involving double practice in public and private clinics.
  - Could you provide details on the cases (including e.g. main actors, whether or not it was proven in a court or rather a suspicion of fraud)?

**C. Policies and practices to prevent and control corruption .....**

- Which specific policies and practices and/or legislation to prevent and control corruption are in place (since 2013) at EU and/or Member State level?
  - generic anti-corruption policies and practices;
  - generic health care policies and practices;
  - corruption-in-health policies:
    - Are these related to any of the following issues:
      - Informal payments in medical service delivery;
      - Certification and procurement of medical devices;
      - Authorisation and procurement of pharmaceuticals;
      - Privileged access to medical services (including not only informal payments but also the use of privileged information and information peddling);
      - Improper marketing by pharmaceutical companies and medical device producers (at national and/or EU level, including for market authorisation and reimbursement approval);
      - Potential risks involving double practice in public and private clinics.
- Are there any examples of good practices (e.g. government actions, legal initiatives, policy changes, regulation, self-regulation etc.) at EU and/or Member State level to prevent and/or combat corruption (regarding the issues mentioned above) (since 2013)?

**D. General conclusions of the 2013 report**

- Below we provide the general conclusions of the 2013 Corruption in the Healthcare study. Please could you indicate for each statement to what extent this is (still) applicable and why.

	Yes	To some extent	No	Don't know
Convictions of (high-profile) corruption cases have a deterrent and norm-setting effect.				
Centralisation of procurement is a method to lower the risks of corruption.				
Central procurement systems can become vulnerable as target for lobbyist and more political inspired types of corruption.				
Bribery in medical service delivery cannot be contested with only targeted policies against the phenomenon as such, but need to be supplemented with accompanying (structural) measures.				
Raising salaries does not have significant preventive effect on reducing bribery in medical service delivery.				
The root causes of corruption in healthcare are related to: <ul style="list-style-type: none"> <li>• Ineffective managerial structures;</li> <li>• Inappropriate financing mechanisms;</li> <li>• Insufficient healthcare capacity;</li> <li>• Insufficient funding for independent medical research;</li> <li>• Unequal allocation of resources;</li> <li>• A general acceptance of corruption in society;</li> <li>• Other root causes, please clarify.</li> </ul>				
The introduction of transparent waiting lists has a positive effect on reducing healthcare bribery.				

	Yes	To some extent	No	Don't know
Prescription of generics instead of branded pharmaceutical products has a positive effect on reducing healthcare bribery. Self-regulation between the industry and healthcare providers is needed to fight corruption in healthcare.				
Self-regulation among players (such as within the pharmaceutical industry or among doctors) is needed to fight corruption in healthcare.				
Awareness raising campaigns and fraud and corruption reporting hotlines are an effective instrument to fight corruption in healthcare.				
The government should play a (more) active role in creating transparency in the relations between the industry and healthcare providers.				
The importance of active – independent – media involvement and pressure from 'civil society' watchdogs is essential to fight corruption in healthcare.				

- Do you have any final remarks or suggestions for our study?

Thank you!



## Annex II: Overview of survey stakeholders

Table AII.1 Overview of survey stakeholders

Stakeholder category	Country	Organisation category	Organisation
Industry	Austria	National associations that are a member of EUCOMED or EDMA – medical devices and in vitro diagnostics industry	austromed
Industry	Austria	National associations that are a member of EUCOMED or EDMA – medical devices and in vitro diagnostics industry	ODGH
Industry	Austria	National associations that are a member of EFPIA	Fachverband der Chemischen Industrie Österreichs (FCIO)
Industry	Austria	National associations that are a member of the European Generic and Biosimilar Medicines Association	OeGV (Austria)
Industry	Belgium	National associations that are a member of EUCOMED or EDMA – medical devices and in vitro diagnostics industry	UNAMEC
Industry	Belgium	National associations that are a member of EFPIA	pharma.be (Association Générale de l'industrie du Médicament)
Industry	Belgium	National associations that are a member of the European Generic and Biosimilar Medicines Association	FeBelGen (Belgium)
Industry	Bulgaria	National associations that are a member of EUCOMED or EDMA – medical devices and in vitro diagnostics industry	BAMDE
Industry	Bulgaria	National associations that are a member of the European Generic and Biosimilar Medicines Association	BGPharma (Bulgaria)
Industry	Czech Republic	National associations that are a member of EUCOMED or EDMA – medical devices and in vitro diagnostics industry	CzechMed
Industry	Czech Republic	National associations that are a member of the European Generic and Biosimilar Medicines Association	CAFF (Czech Republic)
Industry	Czech Republic	National associations that are a member of EUCOMED or EDMA – medical devices and in vitro diagnostics industry	CZEDMA
Industry	Denmark	National associations that are a member of EUCOMED or EDMA – medical devices and in vitro diagnostics industry	DiaLab Denmark
Industry	Denmark	National associations that are a member of EUCOMED or EDMA – medical devices and in vitro diagnostics industry	Medicoindustrien
Industry	Denmark	National associations that are a member of EFPIA	Laegemiddelindustriforeningen The Danish Association of the Pharmaceutical Industry (LIF)
Industry	Denmark	National associations that are a member of the European Generic and Biosimilar Medicines Association	IGL (Denmark)

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Stakeholder category	Country	Organisation category	Organisation
Industry	Finland	National associations that are a member of EUCOMED or EDMA – medical devices and in vitro diagnostics industry	Sialab
Industry	Finland	National associations that are a member of COCIR	FiHTA
Industry	Finland	National associations that are a member of EFPIA	Lääketeollisuus ry / Pharma Industry Finland (PIF)
Industry	Finland	National associations that are a member of the European Generic and Biosimilar Medicines Association	FGA (Finland)
Industry	France	National associations that are a member of EUCOMED or EDMA – medical devices and in vitro diagnostics industry	SNITEM
Industry	France	National associations that are a member of the European Generic and Biosimilar Medicines Association	GEMME (France)
Industry	Germany	National associations that are a member of EUCOMED or EDMA – medical devices and in vitro diagnostics industry	BVMed
Industry	Germany	National associations that are a member of EUCOMED or EDMA – medical devices and in vitro diagnostics industry	SPECTARIS
Industry	Germany	National associations that are a member of EUCOMED or EDMA – medical devices and in vitro diagnostics industry	VDGH
Industry	Germany	National associations that are a member of COCIR	bvitg
Industry	Germany	National associations that are a member of COCIR	ZVEI
Industry	Germany	National associations that are a member of the European Generic and Biosimilar Medicines Association	Progenerika (Germany)
Industry	Ireland	National associations that are a member of EUCOMED or EDMA – medical devices and in vitro diagnostics industry	IMDA
Industry	Ireland	National associations that are a member of EFPIA	Irish Pharmaceutical Healthcare Association (IPHA)
Industry	Italy	National associations that are a member of EFPIA	Associazione delle imprese del farmaco (Farmindustria)
Industry	Italy	National associations that are a member of EUCOMED or EDMA – medical devices and in vitro diagnostics industry	Assobiomedica
Industry	Italy	National associations that are a member of the European Generic and Biosimilar Medicines Association	AssoGenerici (Italy)
Industry	Netherlands	National associations that are a member of EUCOMED or EDMA – medical devices and in vitro diagnostics industry	DIAGNED
Industry	Netherlands	National associations that are a member of EUCOMED or EDMA – medical devices and in vitro diagnostics industry	FHI
Industry	Netherlands	National associations that are a member of EUCOMED or EDMA – medical devices and in vitro diagnostics industry	Nefemed
Industry	Netherlands	National associations that are a member of COCIR	Holland Health Tech

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Stakeholder category	Country	Organisation category	Organisation
Industry	Netherlands	National associations that are a member of EFPIA	Vereniging Innovatieve Geneesmiddelen Nederland (Nefarma)
Industry	Netherlands	National associations that are a member of the European Generic and Biosimilar Medicines Association	BOGIN (Netherlands)
Industry	Portugal	National associations that are a member of EUCOMED or EDMA – medical devices and in vitro diagnostics industry	APIFARMA
Industry	Portugal	National associations that are a member of EUCOMED or EDMA – medical devices and in vitro diagnostics industry	APORMED
Industry	Portugal	National associations that are a member of the European Generic and Biosimilar Medicines Association	APOGEN (Portugal)
Industry	Romania	National associations that are a member of EUCOMED or EDMA – medical devices and in vitro diagnostics industry	AFPM
Industry	Slovakia	National associations that are a member of EUCOMED or EDMA – medical devices and in vitro diagnostics industry	SEDMA
Industry	Slovakia	National associations that are a member of EUCOMED or EDMA – medical devices and in vitro diagnostics industry	SK-MED
Industry	Slovenia	National associations that are a member of EUCOMED or EDMA – medical devices and in vitro diagnostics industry	SLO-MED
Industry	Spain	National associations that are a member of EUCOMED or EDMA – medical devices and in vitro diagnostics industry	FENIN
Industry	Spain	National associations that are a member of EFPIA	Asociación Nacional Empresarial de la Industria Farmacéutica (Farmaindustria)
Industry	Sweden	National associations that are a member of EUCOMED or EDMA – medical devices and in vitro diagnostics industry	Swedish Labtech
Industry	Sweden	National associations that are a member of EUCOMED or EDMA – medical devices and in vitro diagnostics industry	Swedish Medtech
Industry	Sweden	National associations that are a member of EFPIA	Läkemedelsindustriföreningen / The Swedish Association of the Pharmaceutical Industry (LIF/Sweden)
Industry	Sweden	National associations that are a member of the European Generic and Biosimilar Medicines Association	FGL (Sweden)
Industry	UK	National associations that are a member of EUCOMED or EDMA – medical devices and in vitro diagnostics industry	ABHI
Industry	UK	National associations that are a member of EUCOMED or EDMA – medical devices and in vitro diagnostics industry	BIVDA
Industry	UK	National associations that are a member of COCIR	AXrEM

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Stakeholder category	Country	Organisation category	Organisation
Industry	UK	National associations that are a member of the European Generic and Biosimilar Medicines Association	BGMA (United Kingdom)
Other	Bulgaria	University	Medical University of Varna
Other	Denmark	European Association for Medical devices of Notified Bodies	www.presafe.dk
Other	France	European Association for Medical devices of Notified Bodies	www.gmed.fr
Other	Germany	European Association for Medical devices of Notified Bodies	www.dqs-medizinprodukte.de
Other	Germany	European Association for Medical devices of Notified Bodies	www.med-cert.com
Other	Germany	European Association for Medical devices of Notified Bodies	www.tuev-nord-cert.de
Other	Ireland	European Association for Medical devices of Notified Bodies	www.nsai.ie
Other	Italy	Anti-corruption	Istituto per la Promozione dell'Etica in Sanità (ISPE-Sanita)
Other	Slovenia	European Association for Medical devices of Notified Bodies	www.siq.si
Other	Sweden	European Association for Medical devices of Notified Bodies	www.intertek.se
Other	UK	European Association for Medical devices of Notified Bodies	www.intertek-acsl.com
Other	UK	European Association for Medical devices of Notified Bodies	www.bisgroup.com
Other	UK	European Association for Medical devices of Notified Bodies	www.lrq.com
Patients	Austria	Member of the European Consumer Organisation	Verein Fur konsumenteninformtion - VKI
Patients	Austria	Member of the European Consumer Organisation	Arbeiterkammer
Patients	Belgium	EPF European Patients Forum	VPP - Flemish Patients' Platform
Patients	Belgium	Member of the European Consumer Organisation	Test - Achats
Patients	Bulgaria	EPF European Patients Forum	NPO - National Patients' Organisation of Bulgaria (Bulgaria)
Patients	Bulgaria	EPF European Patients Forum	KZZ - Confederation Health Protections (Bulgaria)
Patients	Bulgaria	EPF European Patients Forum	BAPD - Bulgarian Association for Patients Defence
Patients	Bulgaria	Member of the European Consumer Organisation	Bulgarian national association active consumers - BNAAC
Patients	Cyprus	EPF European Patients Forum	Pancyprian Federation of Patients Associations and Friends (Cyprus)
Patients	Cyprus	Member of the European Consumer Organisation	Cyprus Consumers' Association - CCA
Patients	Czech Republic	Member of the European Consumer Organisation	dTest
Patients	Denmark	Member of the European Consumer Organisation	Forbrugerrådet Tænk
Patients	Estonia	EPF European Patients Forum	EPIK - Estonian Chamber of Disabled People
Patients	Estonia	Member of the European Consumer Organisation	Estonian consumers union - Eesti tarbijakaitse LIIT
Patients	Finland	Member of the European Consumer Organisation	Kuluttajaliitto-Konsumentförbundet ry

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Patients	Finland	Member of the European Consumer Organisation	The Finnish Competition and Consumer Authority (FCCA)
Patients	France	EPF European Patients Forum	CISS - Collectif inter associatif Sur la Santé
Patients	France	Member of the European Consumer Organisation	UFC-Que choisir
Patients	France	Member of the European Consumer Organisation	Consommation, logement et cadre de vie – CLCV
Patients	Germany	Member of the European Consumer Organisation	Stiftung Warentest
Patients	Germany	Member of the European Consumer Organisation	Verbraucherzentrale Bundesverband – vzbv
Patients	Ireland	EPF European Patients Forum	MRCG - Medical Research Charities Group
Patients	Ireland	Member of the European Consumer Organisation	Consumers' Association of Ireland – CAI
Patients	Italy	Member of the European Consumer Organisation	Consumatori Italiani per l'Europa (CIE)
Patients	Italy	Member of the European Consumer Organisation	Altroconsumo
Patients	Latvia	EPF European Patients Forum	SUSTENTO - The Latvian Umbrella Body for Disability Organization
Patients	Latvia	Member of the European Consumer Organisation	Latvian National Association for Consumer Protection - LPIAA
Patients	Lithuania	EPF European Patients Forum	LPOAT - Council of Representatives of Patients' organizations of Lithuania (Lithuania)
Patients	Lithuania	Member of the European Consumer Organisation	Alliance of Lithuanian Consumer Organisations
Patients	Malta	EPF European Patients Forum	MHN - Malta Health Network (Malta)
Patients	Malta	Member of the European Consumer Organisation	Ghaqda Tal-Konsumaturi - CA Malta
Patients	Netherlands	Member of the European Consumer Organisation	Consumentenbond
Patients	Portugal	Member of the European Consumer Organisation	Deco
Patients	Romania	EPF European Patients Forum	COPAC - Coalition of Patients' Organizations with Chronic Diseases
Patients	Romania	Member of the European Consumer Organisation	Association for consumers' protection – APC
Patients	UK	EPF European Patients Forum	The ALLIANCE - Health and Social Care Alliance Scotland
Patients	Slovakia	EPF European Patients Forum	AOPP - Association for the Protection of Patients' Rights
Patients	Slovakia	Member of the European Consumer Organisation	Association of Slovak consumers
Patients	Slovenia	Member of the European Consumer Organisation	Zveza Potrošnikov Slovenije - ZPS
Patients	Spain	EPF European Patients Forum	FEP - Spanish Patients' Forum
Patients	Spain	Member of the European Consumer Organisation	Confederación de consumidores y usuarios – CECU
Patients	Spain	Member of the European Consumer Organisation	Organización de consumidores y usuarios – OCU
Patients	Sweden	Member of the European Consumer Organisation	Sveriges Konsumenter
Patients	UK	EPF European Patients Forum	AMRC - Association of Medical Research Charities

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Stakeholder category	Country	Organisation category	Organisation
Patients	UK	EPF European Patients Forum	National Voices (United Kingdom)
Patients	UK	Member of the European Consumer Organisation	Which?
Payer	Austria	Members of the International Association of Mutual Benefits Societies (AIM)	Sozialversicherungsanstalt der Bauern (SVB)
Payer	Austria	Members of the European Alliance in social insurance (ESIP)	Hauptverband der österreichischen Sozialversicherungsträger, Vienna
Payer	Belgium	Health insurance institute	INAMI/RIZIV Rijksinstituut voor ziekte- en invaliditeitsverzekering
Payer	Belgium	Members of the International Association of Mutual Benefits Societies (AIM)	MUTAS - Centrale d'Alarime Mutualiste
Payer	Belgium	Members of the International Association of Mutual Benefits Societies (AIM)	Union Nationale des Mutualités Libérales
Payer	Belgium	Members of the International Association of Mutual Benefits Societies (AIM)	Union Nationale des Mutualités Neutres (UNMN)
Payer	Belgium	Members of the International Association of Mutual Benefits Societies (AIM)	Union Nationale des Mutualités Socialistes (UNMS)
Payer	Belgium	Members of the European Alliance in social insurance (ESIP)	Office National des Pensions/Rijksdienst voor Pensioenen, Brussels
Payer	Bulgaria	Members of the European Alliance in social insurance (ESIP)	National Social Security Institute, Sofia
Payer	CzechRepublic	Members of the International Association of Mutual Benefits Societies (AIM)	Svaz zdravotních pojišťoven (SZP)
Payer	CzechRepublic	Health insurance	VZP (General Health Insurance Fund of Czech Republic)
Payer	Estonia	Members of the International Association of Mutual Benefits Societies (AIM)	Estonian Health Insurance Fund (EHIF) "Eesti Haigekassa"
Payer	Finland	Members of the European Alliance in social insurance (ESIP)	Eläketurvakeskus, Helsinki
Payer	Finland	Members of the European Alliance in social insurance (ESIP)	FAII Federation of Accident Insurance Institutions, Helsinki
Payer	Finland	Members of the European Alliance in social insurance (ESIP)	TVR Työttömyysvakuutusrahasto, Helsinki
Payer	France	Health insurance	CNAMTS (health insurance)
Payer	France	Members of the International Association of Mutual Benefits Societies (AIM)	Fédération Nationale de la Mutualité Française (FNMF)
Payer	France	Members of the European Alliance in social insurance (ESIP)	Caisse Centrale de la Mutualité Sociale Agricole, Paris
Payer	France	Members of the European Alliance in social insurance (ESIP)	Caisse Nationale des Allocations Familiales, Paris
Payer	France	Members of the European Alliance in social insurance (ESIP)	Caisse Nationale d'Assurance Maladie des Travailleurs Salariés, Paris

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Payer	France	Members of the European Alliance in social insurance (ESIP)	Caisse Nationale d'Assurance Vieillesse, Paris
Payer	France	Members of the European Alliance in social insurance (ESIP)	Fédération Nationale de la Mutualité Française, Paris
Payer	France	Members of the European Alliance in social insurance (ESIP)	Régime Social des Indépendants, La Plaine Saint Denis
Payer	Germany	Members of the International Association of Mutual Benefits Societies (AIM)	BKK Dachverband e.V.
Payer	Germany	Members of the International Association of Mutual Benefits Societies (AIM)	Gemeinsame Vertretung der Innungskrankenkassen (IKK e.V.)
Payer	Germany	Members of the International Association of Mutual Benefits Societies (AIM)	Sozialversicherung für Landwirtschaft, Forsten und Gartenbau (SVLFG)
Payer	Germany	Members of the International Association of Mutual Benefits Societies (AIM)	Verband der Ersatzkassen e. V. (vdek)
Payer	Germany	Members of the European Alliance in social insurance (ESIP)	Arbeitsgemeinschaft Berufsständischer Versorgungseinrichtungen
Payer	Germany	Members of the European Alliance in social insurance (ESIP)	AOK-Bundesverband, Berlin
Payer	Germany	Members of the European Alliance in social insurance (ESIP)	BKK-DV BKK Dachverband, Berlin
Payer	Germany	Members of the European Alliance in social insurance (ESIP)	Gesetzliche Unfallversicherung, Berlin
Payer	Germany	Members of the European Alliance in social insurance (ESIP)	Deutsche Rentenversicherung Bund, Berlin
Payer	Germany	Members of the European Alliance in social insurance (ESIP)	GKV-Spitzenverband
Payer	Germany	Members of the European Alliance in social insurance (ESIP)	Interessenvertretung der Innungskrankenkassen, Berlin
Payer	Germany	Members of the European Alliance in social insurance (ESIP)	Knappschaft Bahn See, Hamburg
Payer	Germany	Members of the European Alliance in social insurance (ESIP)	Sozialversicherung für Landwirtschaft, Forsten und Gartenbau (SVLFG), Kassel
Payer	Germany	Members of the European Alliance in social insurance (ESIP)	Verband der Ersatzkassen e. V., Berlin
Payer	Italy	Members of the International Association of Mutual Benefits Societies (AIM)	Federazione Italiana Mutualità Integrativa Volontaria (FIMIV)
Payer	Italy	Members of the European Alliance in social insurance (ESIP)	INPS Istituto Nazionale della Previdenza Sociale, Rome
Payer	Luxembourg	Health insurance	CNS Luxembourg National Health Fund
Payer	Luxembourg	Members of the International Association of Mutual Benefits Societies (AIM)	Caisse Médico-Chirurgicale Mutualiste
Payer	Luxembourg	Members of the International Association of Mutual Benefits Societies (AIM)	Conseil Supérieur de la Mutualité Luxembourgeoise (CSM)
Payer	Luxembourg	Members of the European Alliance in social insurance (ESIP)	ALOSS Association Luxembourgeoise des Organismes de Sécurité Sociale, Luxembourg
Payer	Netherlands	Health insurance	Zorgverzekeraars Nederland (ZN)

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Payer	Netherlands	Members of the European Alliance in social insurance (ESIP)	SVB Sociale Verzekeringsbank, Amstelveen
Payer	Netherlands	Members of the European Alliance in social insurance (ESIP)	UWV Uitvoeringsinstituut Werknemersverzekeringen
Payer	Netherlands	Members of the European Alliance in social insurance (ESIP)	ZIN Zorginstituut Nederland, Diemen
Payer	Portugal	Members of the International Association of Mutual Benefits Societies (AIM)	União das Mutualidades Portuguesas (UMP)
Payer	Romania	Members of the European Alliance in social insurance (ESIP)	NHIF/CNAS National Health Insurance Fund, Bucharest
Payer	Slovakia	Members of the International Association of Mutual Benefits Societies (AIM)	Všeobecná Zdravotná Pois'ov'a (VZP SR)
Payer	Slovakia	Members of the European Alliance in social insurance (ESIP)	SIA Social Insurance Agency/ Sociálna poisťovňa, Bratislava
Payer	Slovenia	Members of the International Association of Mutual Benefits Societies (AIM)	Vzajemna Zdravstvena Zavarovalnica d.v.z
Payer	UK	Members of the International Association of Mutual Benefits Societies (AIM)	Benenden
Providers	Austria	HOPE European Hospital and Healthcare Federation	Bundesministerium für Gesundheit
Providers	Austria	Members of the Standing Committee of European Doctors	Österreichische Ärztekammer
Providers	Belgium	HOPE European Hospital and Healthcare Federation	Association Belge des Hôpitaux asbl/ Belgische Vereniging der Ziekenhuizen vzw
Providers	Belgium	HOPE European Hospital and Healthcare Federation	Zorgnet-Icuro
Providers	Belgium	HOPE European Hospital and Healthcare Federation	Fédération des Institutions Hospitalières asbl
Providers	Belgium	Members of the European Specialist Nurses Organisations (ESNO) ( <a href="http://www.esno.org/members.php">http://www.esno.org/members.php</a> )	FINE - European Federation of Nurse Educators
Providers	Bulgaria	HOPE European Hospital and Healthcare Federation	Association of Bulgarian Hospitals
Providers	Bulgaria	Members of the Standing Committee of European Doctors	(Bulgarian Medical Association)
Providers	Bulgaria	European Union of General Practitioners / family physicians	Bulgaria - Bulgarian Medical Association
Providers	Croatia	HOPE European Hospital and Healthcare Federation	Ministry of Health Croatia
Providers	Cyprus	HOPE European Hospital and Healthcare Federation	Ministry of Health
Providers	Cyprus	Members of the Standing Committee of European Doctors	Cyprus Medical Association
Providers	CzechRepublic	HOPE European Hospital and Healthcare Federation	ASOCIACE NEMOCNIC ČESKÉ REPUBLIKY (Czech Hospital Association)
Providers	CzechRepublic	Members of the Standing Committee of European Doctors	Czech Medical Chamber
Providers	CzechRepublic	European Union of General Practitioners / family physicians	Associatoin of gernal practitioners of Czech Replublic
Providers	Denmark	HOPE European Hospital and Healthcare Federation	Danske Regioner
Providers	Denmark	Members of the Standing Committee of European Doctors	Lægeforeningen



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Providers	Denmark	European Union of General Practitioners / family physicians	The Danish Medical Association (Den Almindelige Danske)
Providers	Denmark	Members of the European Specialist Nurses Organisations (ESNO) ( <a href="http://www.esno.org/members.php">http://www.esno.org/members.php</a> )	EORNA - European Operating Room Nurses Association
Providers	Estonia	HOPE European Hospital and Healthcare Federation	EESTI HAIGLATE LIIT
Providers	Estonia	Members of the Standing Committee of European Doctors	Estonian Medical Association
Providers	EU	Members of the European Specialist Nurses Organisations (ESNO) ( <a href="http://www.esno.org/members.php">http://www.esno.org/members.php</a> )	ECMH - European Conference on Mental Health
Providers	EU	Members of the European Specialist Nurses Organisations (ESNO) ( <a href="http://www.esno.org/members.php">http://www.esno.org/members.php</a> )	IFNA - International Federation of Nurse Anesthetists
Providers	EU	Members of the European Specialist Nurses Organisations (ESNO) ( <a href="http://www.esno.org/members.php">http://www.esno.org/members.php</a> )	EfCCNa - European federation of Critical Care Nursing associations
Providers	Finland	HOPE European Hospital and Healthcare Federation	Suomen Kuntaliitto Finlands Kommunförbund (The Association of Finnish Local and Regional Authorities)
Providers	Finland	Members of the Standing Committee of European Doctors	Suomen Lääkäriilitto/Finlands Läkarförbund
Providers	Finland	European Union of General Practitioners / family physicians	The Finnish Medical Association
Providers	France	HOPE European Hospital and Healthcare Federation	FHF
Providers	France	HOPE European Hospital and Healthcare Federation	Fédération Hospitalière de France
Providers	France	HOPE European Hospital and Healthcare Federation	UNICANCER
Providers	France	HOPE European Hospital and Healthcare Federation	Fédération Française des Centres de Lutte contre le Cancer
Providers	France	Members of the Standing Committee of European Doctors	Conseil National de l'Ordre des Médecins
Providers	Germany	HOPE European Hospital and Healthcare Federation	Deutsche Krankenhausgesellschaft (DKG)
Providers	Germany	Members of the Standing Committee of European Doctors	Bundesärztekammer
Providers	Germany	European Union of General Practitioners / family physicians	The Finnish Medical Association
Providers	Germany	Members of the European Specialist Nurses Organisations (ESNO) ( <a href="http://www.esno.org/members.php">http://www.esno.org/members.php</a> )	ENDA - European Nurse Directors Association
Providers	Germany	Members of the European Specialist Nurses Organisations (ESNO) ( <a href="http://www.esno.org/members.php">http://www.esno.org/members.php</a> )	ESGENA - European Society of Gastroenterology and Endoscopy Nurses and Associate
Providers	Ireland	HOPE European Hospital and Healthcare Federation	Independent Hospitals Association
Providers	Ireland	Members of the Standing Committee of European Doctors	Irish Medical Organisation (IMO)
Providers	Ireland	European Union of General Practitioners / family physicians	Irish Medical Organisation (IMO)
Providers	Ireland	Members of the European Specialist Nurses Organisations (ESNO) ( <a href="http://www.esno.org/members.php">http://www.esno.org/members.php</a> )	ACENDIO - Association for Common European Nursing Diagnoses, Interventions and Outcomes

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Providers	Italy	HOPE European Hospital and Healthcare Federation	Regione del Veneto
Providers	Italy	European Union of General Practitioners / family physicians	0
Providers	Italy	European Union of General Practitioners / family physicians	0
Providers	Latvia	HOPE European Hospital and Healthcare Federation	LATVIJAS SLIMNĪCU BIEDRĪBA
Providers	Lithuania	HOPE European Hospital and Healthcare Federation	LIETUVOS LIGONINIŲ ASOCIACIJA
Providers	Lithuania	Members of the Standing Committee of European Doctors	Lithuanian Medical Association
Providers	Luxembourg	HOPE European Hospital and Healthcare Federation	Fédération des Hôpitaux Luxembourgeois
Providers	Luxembourg	Members of the Standing Committee of European Doctors	Association des Médecins et Médecins-Dentistes du Grand-Duché de Luxembourg
Providers	Malta	HOPE European Hospital and Healthcare Federation	Ministry of Health, the Elderly and Community Care
Providers	Malta	HOPE European Hospital and Healthcare Federation	Department of Health
Providers	Malta	Members of the Standing Committee of European Doctors	Medical Association of Malta (MAM)
Providers	Malta	European Union of General Practitioners / family physicians	The Malta College of Family Doctors
Providers	Netherlands	Members of the Standing Committee of European Doctors	Koninklijke Nederlandsche Maatschappij tot Bevordering der Geneeskunst – The Royal Dutch Medical Association (KNMG)
Providers	Netherlands	Members of the European Specialist Nurses Organisations (ESNO) ( <a href="http://www.esno.org/members.php">http://www.esno.org/members.php</a> )	EAUN - European Association of Urology Nurses
Providers	Portugal	HOPE European Hospital and Healthcare Federation	Associação Portuguesa para o Desenvolvimento Hospitalar - APDH
Providers	Portugal	Members of the Standing Committee of European Doctors	Ordem dos Médicos (O.M)
Providers	Romania	HOPE European Hospital and Healthcare Federation	Asociația Spitalelor din România
Providers	Romania	European Union of General Practitioners / family physicians	The Romanian College of Physicians: Romania's reference organisation for the medical professions
Providers	Romania	European Union of General Practitioners / family physicians	The Romanian College of Physicians: Romania's reference organisation for the medical professions
Providers	Slovakia	HOPE European Hospital and Healthcare Federation	Asociácia Nemocníc Slovenska
Providers	Slovenia	HOPE European Hospital and Healthcare Federation	Združenje zdravstvenih zavodov Slovenije
Providers	Slovenia	Members of the Standing Committee of European Doctors	Zdravniška zbornica Slovenije
Providers	Spain	HOPE European Hospital and Healthcare Federation	Ministerio de Sanidad, Servicios Sociales e Igualdad
Providers	Sweden	HOPE European Hospital and Healthcare Federation	SVERIGES KOMMUNER OCH LANDSTING
Providers	Sweden	Members of the Standing Committee of European Doctors	Sveriges Läkarförbund
Providers	Sweden	European Union of General Practitioners / family physicians	The Swedish Medical Association

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Stakeholder category	Country	Organisation category	Organisation
Providers	Sweden	Members of the European Specialist Nurses Organisations (ESNO) ( <a href="http://www.esno.org/members.php">http://www.esno.org/members.php</a> )	EDTNA/ERCA - European Dialysis and Transplant Nurses Association / European Renal Care Association
Providers	UK	HOPE European Hospital and Healthcare Federation	NHS Confederation
Providers	UK	Members of the Standing Committee of European Doctors	British Medical Association
Providers	UK	European Union of General Practitioners / family physicians	The British Medical Association
Providers	UK	Members of the European Specialist Nurses Organisations (ESNO) ( <a href="http://www.esno.org/members.php">http://www.esno.org/members.php</a> )	EONS - European Oncology Nursing Society
Providers	UK	Members of the European Specialist Nurses Organisations (ESNO) ( <a href="http://www.esno.org/members.php">http://www.esno.org/members.php</a> )	ERNA - European Respiratory Nurses Association
Providers	UK	Members of the European Specialist Nurses Organisations (ESNO) ( <a href="http://www.esno.org/members.php">http://www.esno.org/members.php</a> )	ESE - European Society of Endocrinology Nurses
Regulators	Austria	National Competent Authorities Medical Devices	Federal Ministry of Health, Dept. Pharmaceuticals and Medical Devices
Regulators	Belgium	EFHCN member	The Inter-mutualistic Agency (NIC/CIN) - IMA/AIM
Regulators	Belgium	National Competent Authorities Medical Devices	0
Regulators	Belgium	National Competent Authorities Medical Devices	IVDMD, Scientific Institute Public Health, Department Quality Medical Laboratories
Regulators	Belgium	European Medicines Agency, National Competent Authorities	Federal Agency for Medicines and Health Products
Regulators	Belgium	National Competent Authorities Medical Devices	MDD AIMDD, Federal Agency for Medicines and Health Products Health Products Division
Regulators	Bulgaria	European Medicines Agency, National Competent Authorities	Bulgarian Drug Agency
Regulators	Bulgaria	National Competent Authorities Medical Devices	0
Regulators	Bulgaria	National Competent Authorities Medical Devices	Bulgarian Drug Agency Department Medical devices
Regulators	Croatia	EFHCN member	Croatian Ministry of Health
Regulators	Croatia	0	Republic Croatia
Regulators	Cyprus	National Competent Authorities Medical Devices	Cyprus Medical Devices Competent Authority
Regulators	Czech Republic	European Medicines Agency, National Competent Authorities	State Institute for Drug Control
Regulators	Czech Republic	National Competent Authorities Medical Devices	Ministry of Health Department of Pharmacy, Medical Devices Unit
Regulators	Denmark	European Medicines Agency, National Competent Authorities	Danish Medicines Agency
Regulators	Denmark	National Competent Authorities Medical Devices	Danish Medicines Agency Pharmacovigilance and Medical Devices
Regulators	Estonia	European Medicines Agency, National Competent Authorities	State Agency of Medicines
Regulators	Estonia	National Competent Authorities Medical Devices	Health Board, Medical Devices Department

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Stakeholder category	Country	Organisation category	Organisation
Regulators	Finland	National Competent Authorities Medical Devices	Valvira - National Supervisory Authority for Welfare and Health
Regulators	France	National Competent Authorities Medical Devices	Agence nationale de sécurité du médicament et des produits de santé (ANSM)
Regulators	Germany	National Competent Authorities Medical Devices	Federal Institute for Drugs and Medical Devices, AIMDD CA
Regulators	Germany	National Competent Authorities Medical Devices	Federal Ministry of Health (AIMDD, MDD, IVDMD Legislation)
Regulators	Germany	National Competent Authorities Medical Devices	Paul Ehrlich Institute, IVDMD CA
Regulators	Germany	European Medicines Agency, National Competent Authorities	Federal Institute for Drugs and Medical Devices
Regulators	Germany	National Competent Authorities Medical Devices	Zentralstelle der Länder für Gesundheitsschutz bei Arzneimitteln und Medizinprodukten (ZLG) (AIMDD, MDD, IVDMD Designating)
Regulators	Hungary	National Competent Authorities Medical Devices	Health Registration and Training Centre, Department of Medical Devices
Regulators	Ireland	European Medicines Agency, National Competent Authorities	Health Products Regulatory Authority (HPRA)
Regulators	Ireland	National Competent Authorities Medical Devices	Health Products Regulatory Authority
Regulators	Italy	National Competent Authorities Medical Devices	Ministry of Health, - Directorate General of Medical Devices and Pharmaceutical Services
Regulators	Italy	National Competent Authorities Medical Devices	Ministry of Health, - Directorate General of Medical Devices and Pharmaceutical Services
Regulators	Latvia	National Competent Authorities Medical Devices	State Agency of Medicines
Regulators	Latvia	European Medicines Agency, National Competent Authorities	State Agency of Medicines
Regulators	Lithuania	EFHCN member	Lithuanian Ministry of Health
Regulators	Lithuania	European Medicines Agency, National Competent Authorities	State Medicines Control Agency
Regulators	Lithuania	Regulator	Ministry of Health
Regulators	Luxembourg	National Competent Authorities Medical Devices	Ministère de la Santé, Direction de la Santé
Regulators	Luxembourg	European Medicines Agency, National Competent Authorities	Ministry of Health
Regulators	Malta	European Medicines Agency, National Competent Authorities	Medicines Authority
Regulators	Malta	National Competent Authorities Medical Devices	Malta Competition and Consumer Affairs Authority
Regulators	Netherlands	National Competent Authorities Medical Devices	CIBG Farmatec-BMC, Front Office
Regulators	Netherlands	National Competent Authorities Medical Devices	Dutch Healthcare Inspectorate
Regulators	Netherlands	EFHCN member	Nederlandse Zorgautoriteit (NZa)

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Stakeholder category	Country	Organisation category	Organisation
Regulators	Portugal	National Competent Authorities Medical Devices	Infarmed - National Authority of Medicines and Health Products, IP
Regulators	Portugal	EFHCN member	IGAS - General Inspectorate of Health
Regulators	Romania	EFHCN member	Romanian Ministry of Health
Regulators	Romania	National Competent Authorities Medical Devices	National Agency for Medicines and Medical Devices
Regulators	Romania	National Competent Authorities Medical Devices	National Agency for Medicines and Medical Devices
Regulators	Romania	Regulator	Municipality Commission on Healthcare and Social Services
Regulators	Romania	Regulator	Ministry of Health
Regulators	Slovakia	National Competent Authorities Medical Devices	State Institute for Drug Control, Medical Devices Section
Regulators	Slovakia	European Medicines Agency, National Competent Authorities	State Institute for Drug Control
Regulators	Slovenia	European Medicines Agency, National Competent Authorities	Agency for Medicinal Products and Medical Devices of the Republic of Slovenia
Regulators	Slovenia	National Competent Authorities Medical Devices	Agency for Medicinal Products and Medical Devices of the Republic of Slovenia
Regulators	Spain	National Competent Authorities Medical Devices	Agencia Española de Medicamentos y Productos Sanitarios
Regulators	Sweden	National Competent Authorities Medical Devices	Medical Products Agency 'Läkemedelsverket' Medical Devices
Regulators	Sweden	European Medicines Agency, National Competent Authorities	Medical Products Agency
Regulators	UK	European Medicines Agency, National Competent Authorities	Medicines and Healthcare Products Regulatory Agency
Regulators	UK	National Competent Authorities Medical Devices	Medicines & Healthcare products Regulatory Agency (MHRA)



## **Annex III: Survey design**

### **Survey - Study on corruption in the health sector II**

Welcome to the survey on corruption in the health sector in the European Union. This survey is part of the update of the study on corruption in the health sector, commissioned by the European Commission Directorate General Migration and Home Affairs (DG Home). Please find the introduction letter from the Commission's DG HOME [here](#).

Corruption is defined as **"the abuse of power for private gain"** – this is a wide definition that also encompasses aspects that go beyond the criminal law aspects, including situations such as conflict of interest, favouritism, etc.

Completion of the survey will take approximately **15 minutes** as most of the questions only require you to tick a box.

### **Confidentiality**

Ecorys Nederland BV adheres to the EU's legislation on the protection of personal data (Regulation (EC) 45/2001). Any data collected through this survey will be managed in line with these requirements and will not be shared with third parties. The survey results will thereto be stored in a confidential manner.

The data collected will be aggregated and presented anonymously in the report. It will be guaranteed that individual answers will not be traceable to the organisations approached.

Please inform us should your organisation policy require additional safeguards with regard to compliance. We would be pleased to cooperate on this matter.

If you have any question related to this survey, please contact us via: [healthsectorstudy@ecorys.com](mailto:healthsectorstudy@ecorys.com).

### Part 1: General information

In what capacity are you completing this questionnaire?

Question	Answer
Name	
Organisation	
Function/position	
Country (countries) representing	
<ul style="list-style-type: none"> <li>• Austria</li> <li>• Belgium</li> <li>• Bulgaria</li> <li>• Croatia</li> <li>• Cyprus</li> <li>• Czech Republic</li> <li>• Denmark</li> <li>• Estonia</li> <li>• Finland</li> <li>• France</li> <li>• Germany</li> <li>• Greece</li> <li>• Hungary</li> <li>• Ireland</li> <li>• Italy</li> </ul>	<ul style="list-style-type: none"> <li>• Latvia</li> <li>• Lithuania</li> <li>• Luxembourg</li> <li>• Malta</li> <li>• Netherlands</li> <li>• Poland</li> <li>• Portugal</li> <li>• Romania</li> <li>• Slovakia</li> <li>• Slovenia</li> <li>• Spain</li> <li>• Sweden</li> <li>• United Kingdom</li> <li>• EU in general</li> </ul>

Please indicate the stakeholder category that you are representing

Sector	Please select one category
Patient	0
Payer	0
Provider	0
Industry – medical devices	0
Industry – pharmaceuticals	0
Regulator – medical devices	0
Regulator – pharmaceuticals	0
Other, please specify:	0



**Part 2: Developments since the publication of the corruption in the healthcare study (2013)**

General conclusions of the 2013 report

**Below we provide the general conclusions of the 2013 Corruption in the Healthcare study. Indicate for each statement to what extent this is (still) applicable to the country or countries you represent.**

Convictions of (high-profile) corruption cases have a deterrent and norm-setting effect

- Yes
- No
- To some extent
- Do not know

Please clarify

Centralisation of procurement is a method to lower the risks of corruption

- Yes
- No
- To some extent
- Do not know

Please clarify

Central procurement systems can become vulnerable as target for lobbyist and more political inspired types of corruption

- Yes
- No
- To some extent
- Do not know

Please clarify

Bribery in medical service delivery cannot be contested with targeted policies against the phenomenon as such

- Yes
- No
- To some extent
- Do not know

Please clarify

Raising salaries do not have significant preventive effect on bribery in medical service delivery

- Yes
- No
- To some extent
- Do not know

Please clarify

The root causes of corruption in healthcare are related to

- Ineffective managerial structures Yes / No / To some extent / Do not know
- Inappropriate financing mechanisms Yes / No / To some extent / Do not know
- Insufficient healthcare capacity Yes / No / To some extent / Do not know
- Insufficient funding for independent medical research Yes / No / To some extent / Do not know
- Unequal allocation of resources Yes / No / To some extent / Do not know
- A general acceptance of corruption in society Yes / No / To some extent / Do not know
- Other root causes, please clarify

The introduction of transparent waiting lists has a positive effect on healthcare bribery

- Yes
- No
- To some extent
- Do not know

Please clarify

Prescription of generics instead of branded pharmaceutical products has a positive effect on healthcare bribery

- Yes
- No
- To some extent
- Do not know

Please clarify

Self-regulation between the industry and healthcare providers is needed to fight corruption in healthcare

- Yes
- No
- To some extent
- Do not know

Please clarify

Self-regulation among players (such as within the pharmaceutical industry or among doctors) is needed to fight corruption in healthcare

- Yes
- No
- To some extent
- Do not know

Please clarify

Awareness raising campaigns and fraud and corruption reporting hotlines are an effective instrument to fight corruption in healthcare

- Yes
- No
- To some extent
- Do not know

Please clarify

The government should play a (more) active role in creating transparency in the relations between the industry and healthcare providers.

- Yes
- No
- To some extent
- Not applicable

Please clarify

The importance of active – independent – media involvement and pressure from 'civil society' watchdogs is essential to fight corruption in healthcare.

- Yes
- No
- To some extent
- Do not know

Please clarify

**Legislative and policy changes since 2013**

Have there been any relevant legislative developments since 2013 that you are aware of in the EU or specific countries?

- Yes
- No
- Do not know

If yes, could you please briefly describe them or provide links to relevant websites/documents?

Have there been any relevant national policy developments (either anti-corruption policies, healthcare sector policies, or anti-corruption-in-healthcare policies) since 2013?

- Yes
- No
- Do not know

If yes, could you please briefly describe them, specifying the country/countries?

**Part 3: Selected issues**

**Issue 1: Informal payments in medical service delivery**

Do 'informal payments' frequently occur in your country?

- All the time;
- Often;
- Sometimes;
- Occasionally;
- Never;
- Do not know.

Has the occurrence of 'informal payments' changed since 2013?

- Yes, it increased;
- Yes, it decreased;
- No, it remained the same;
- Do not know.

Could you please clarify why this is the case?

Are you aware of specific policies and practices to prevent and control regarding 'informal payments' in your country?

- Yes;
- No.

If yes, could you please briefly describe them?

Are you aware of any recent cases of corruption in healthcare in your country?

- Yes;
- No.

If yes, could you please briefly describe them (including e.g. main actors, whether or not it was proven in a court or rather a suspicion of fraud, and links to relevant sources)?

**Issue 2: Corruption in certification and procurement of medical devices**

Does corruption in certification and procurement of medical devices frequently occur in your country?

- All the time;
- Often;
- Sometimes;
- Occasionally;
- Never;
- Do not know.

Has the occurrence of corruption in procurement and certification of medical devices changed since 2013?

- Yes, it increased
- Yes, it decreased
- No, it remained the same
- Do not know

Could you please briefly why this is the case?

Are you aware of specific policies and practices to prevent and control regarding corruption in procurement and certification in medical devices in your country?

- Yes
- No

If yes, could you please briefly describe them?

Are you aware of any recent cases of corruption in healthcare in your country?

- Yes
- No

If yes, could you please briefly describe them (including e.g. main actors, whether or not it was proven in a court or rather a suspicion of fraud, and links to relevant sources)?



**Issue 3: Corruption in authorisation and procurement of pharmaceuticals**

Does corruption in authorisation and procurement of pharmaceuticals frequently occur in your country?

- All the time
- Often
- Sometimes
- Occasionally
- Never
- Do not know

Has the occurrence of corruption in authorisation and procurement of pharmaceuticals changed since 2013?

- Yes, it increased
- Yes, it decreased
- No, it remained the same
- Do not know

Could you please clarify why this is the case?

Are you aware of specific policies and practices to prevent and control regarding corruption in authorisation and procurement of pharmaceuticals in your country?

- Yes
- No

If yes, could you please briefly describe them?

Are you aware of any recent cases of corruption in healthcare in your country?

- Yes
- No

If yes, could you please briefly describe them (including e.g. main actors, whether or not it was proven in a court or rather a suspicion of fraud, and links to relevant sources)?

**Issue 4: Privileged access to medical services (including not only informal payments but also the use of privileged information and information peddling)**

*Privileged access is defined as "If opportunities of access to medical services are skewed in favour of a few privileged persons, which leads to unfair advantage of these persons."*

Does privileged access to medical services frequently occur in your country?

- All the time;
- Often;
- Sometimes;
- Occasionally;
- Never;
- Do not know.

Are you aware of specific policies and practices to prevent and control privileged access to medical services in your country?

- Yes;
- No.

If yes, could you please briefly describe them?

Are you aware of any recent cases of corruption in healthcare in your country?

- Yes;
- No.

If yes, could you please briefly describe them (including e.g. main actors, whether or not it was proven in a court or rather a suspicion of fraud, and links to relevant sources)?

**Issue 5: Improper marketing at pharmaceutical companies and medical device producers (at national and/or EU level, including for market authorisation and reimbursement approval)**

Does improper marketing frequently occur in your country?

- All the time;
- Often;
- Sometimes;
- Occasionally;
- Never;
- Do not know.

Are you aware of specific policies and practices to prevent and control improper marketing in your country?

- Yes;
- No.

If yes, could you please briefly describe them?

Are you aware of any recent cases of corruption in healthcare in your country?

- Yes
- No

If yes, could you please briefly describe them (including e.g. main actors, whether or not it was proven in a court or rather a suspicion of fraud, and links to relevant sources)?

**Issue 6: Potential risks of practising in both public and private clinics (double practice)**

Does double practice in public and private clinics frequently occur in your country?

- All the time;
- Often;
- Sometimes;
- Occasionally;
- Never;
- Do not know.

Are you aware of specific policies and practices to prevent and control double practice in public and private clinics in your country?

- Yes;
- No.

If yes, could you please briefly describe them?

Are you aware of any recent cases of corruption in healthcare in your country?

- Yes
- No

If yes, could you please briefly describe them (including e.g. main actors, whether or not it was proven in a court or rather a suspicion of fraud, and links to relevant sources)?

**Part IV: Thank you**

Do you have any other remarks, wishes or thoughts that you would like to share?

Thank you for your time and contribution to our study.



**Annex IV: Corruption indicators (Special Eurobarometer 397)****Table AIV.1 Corruption indicators from Eurobarometer 397, 2014**

	QB7	QB5	QB5	QB5	QB2	QB3	QB3
	Corruption in health = widespread	Corruption general = very widespread	Corruption general = fairly widespread	Corruption general (TOTAL)	Bribe paid: yes + refusal	Asked for private consultation	Paid for privileged treatment
Austria	15	13	53	66	4	28	2
Belgium	15	19	48	67	2	10	9
Bulgaria	55	41	43	84	9	7	11
Croatia	56	54	40	94	3	15	0
Cyprus	62	29	49	78	2	0	0
Czech Rep	41	61	34	95	5	0	24
Denmark	12	4	16	20	1	23	23
Estonia	30	15	50	65	3	17	10
EU-27	33	35	41	76	5	12	19
Finland	4	2	27	29	1	0	0
France	24	19	49	68	5	20	29
Germany	30	16	43	59	8	10	29
Greece	81	67	32	99	12	10	16
Hungary	56	36	53	89	12	11	9
Ireland	15	40	41	81	3	36	4
Italy	44	58	39	97	5	8	13
Latvia	53	38	45	83	8	7	7
Lithuania	74	58	37	95	23	8	4
Luxembourg	15	9	33	42	2	0	0
Malta	18	44	39	83	2	67	23
Netherlands	27	19	42	61	1	12	0

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	QB7	QB5	QB5	QB5	QB2	QB3	QB3
Poland	53	32	50	82	3	4	14
Portugal	33	55	35	90	3	0	15
Romania	67	54	39	93	32	19	7
Slovakia	64	46	44	90	10	6	41
Slovenia	41	65	26	91	4	3	38
Spain	23	65	30	95	1	31	29
Sweden	9	7	37	44	1	10	29
UK	15	26	38	64	1	0	3



**Table AIV.2 Corruption indicators from Eurobarometer 397, 2014 – questions**

References		
QB5	T11	How widespread do you think the problem of corruption is in (OUR COUNTRY)?
QB7	T18	In (OUR COUNTRY), do you think that the giving and taking of bribes and the abuse of power for personal gain are widespread among any of the following [healthcare]?
QB2	T2	Apart from official fees did you have to give an extra payment or a valuable gift to a nurse or a doctor, or make a donation to the hospital?
QB3	T5	You were asked to go for a private consultation in order to be treated in a public hospital
QB3	T5	You were asked to pay for a privileged treatment

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