

Note from the Seminar on Corruption and Health

London, 2 February 2006

Purpose and participants

The seminar was held following the launch of the 2006 Global Corruption Report (GCR) produced by **Transparency International**¹. The report has a special focus on Corruption and Health. The seminar was jointly organised by Transparency International and **HLSP Institute**². Its purpose was to discuss the main messages of the GCR and, where appropriate, draw conclusions about the implications for development agencies.

Participants at the seminar included health and governance specialists from the UK Department for International Development; staff from the NHS Counter Fraud and Security Management Service; representatives from NGOs, the academic community, and staff of HLSP Institute and the DFID Health Resource Centre.

The nature of corruption in the health sector

The seminar started with an introduction by **David Nussbaum**, Chief Executive of Transparency International (TI). He explained TI's interest in health – both because of the large scale and far reaching impact of the health and pharmaceutical sectors, and because the issue has not been extensively analysed. The GCR sets out some of the successful efforts to tackle corruption – but it is not clear how far these can be transferred elsewhere.

Bill Savedoff spoke about some of the findings on corruption in the health sector. He quoted an IMF study of 71 countries that showed that countries with higher corruption also have higher infant and child mortality rates. The scale of diversion of resources in health is estimated to be between \$3 and 4 billion per year globally.

Corruption in the health sector varies in nature and scope – it includes major theft, the sale of fake drugs; over-charging for supplies; diversion of public drug supplies to private markets referring patients to private practice and unofficial fees.

Health is vulnerable because of the substantial funds involved (e.g. national health insurance funds) and because it is difficult for consumers or regulators to assess whether treatment given is appropriate - and if not whether inappropriate treatment or fake medicines were given intentionally. In addition professional bodies that are supposed to have a regulatory role can be defensive when problems are detected.

Corruption can be measured and this can be useful for advocacy. Methods include staff surveys and tracking supplies within a hospital; asking the public what happened when they sought medical care; and comparisons of prices paid for specific supplies across countries, health authorities or hospitals.

The UN Convention against Corruption provides a framework for international action on corruption. It includes the potential for asset recovery to address large scale theft.

Action to increase transparency and accountability at country level can also be effective - for example, analysis in Bolivia showed that those Hospital Boards with active community members reduced the prices

¹ <http://www.transparency.org/publications/gcr>

² HLSP Institute provides policy analysis and contributes to debate and learning on international health and development assistance issues. HLSP Institute contributed a section in the GCR 2006 on HIV and Corruption.

paid by 40% and had lower illegal charges. In Argentina, publication of the prices paid by hospitals resulted in a fall in prices paid for supplies by some 12%.

Corruption and HIV and AIDS

Clare Dickinson, HIV and AIDS specialist in HLSP Institute, argued that the nature of corruption related to HIV is similar to that in health generally. If anything the pressures are greater - given the scale of the epidemic in much of Africa; the social stigma which militates against transparency; the high value of the drugs involved, especially anti-retroviral drugs, and their limited supply which encourages faking of drugs, theft and illicit payment for treatment. Furthermore AIDS may encourage corruption in other sectors, as people living with HIV and AIDS try to cater for their family before they die.

In addition the scale and intensity of the international response – which has been growing and is estimated to reach \$10 billion annually by 2007 – creates scope and incentives for large scale corruption. The pressure to disburse the funds and show results in terms of performance indicators could also lead to creative accounting.

The institutions for coordinating and over-seeing allocation of national responses and international support raise issues for transparency. For example, the implications of locating National AIDS Commissions under the Office of the President, or the process for appointing District AIDS Committees and coordination units, may be open to political interference. It may be useful to encourage more political analysis of the structure and governance arrangements when supporting countries to develop and implement AIDS responses.

Discussion centred around the Global Fund to Fight AIDS, TB and Malaria (GF). The GF has made efforts to avoid and discourage corruption, through involving civil society in overseeing and delivering programmes; appointing local finance agents in each country to audit performance; and by suspending grants as soon as corruption is detected. On the other hand, the GF involves large sums and does not encourage use of local systems for accountability and management, nor link into other efforts to strengthen public financial management and accountability. NGOs are involved at country level but may have little influence on decisions on how to deploy grants.

Tackling fake and substandard drug supplies in Nigeria

Professor **Dora Akunyili**, Director General of the Nigerian National Agency for Food and Drug Administration and Control (NAFDAC) spoke about experience in Nigeria.

Fake or counterfeit drugs may have no medicinal content and may even be harmful and can kill people. Sub-standard drugs may have ineffective ingredients or low dosage. They can lead to drug resistance. There are more fakes of expensive and/or very high volume drugs than cheaper ones, as there is more money to be made.

Nigeria used to rank as one of the highest countries in the world for fake drugs – before 2001 it was estimated that 40-80% of drugs were fakes. The system for drug registration was ineffective – in 2001 68% of drugs available in the country were unregistered.

NAFDAC took action to address the problems. Key strategies were:

- public education – through radio, TV, competitions in schools, and publishing showing the differences between fake and genuine drugs in newspapers every 2 weeks. (This was the most effective strategy.)
- identifying the companies that produce fakes and blacklisting them;
- factory inspection by NAFDAC staff before drugs are registered;
- tracking and clearing imports;
- banning drug imports labelled 'For Export Only' as these are typically not registered in their country of origin;
- substantial fines for those caught and owners of warehouses that are used to store unregistered or fake drugs. Fines were found to be more effective in most cases than prosecution, which can be very slow and may not result in conviction. Exposing people in the press was also more effective.
- searching for smuggled drug imports and destroying these;
- surveillance of markets and confiscation of drugs where traders cannot show the source;

- streamlining the registration process;
- moving to require prescriptions for drugs.

As a result the incidence of fake drugs has reduced by 90% since 2001. The number of adverse incidents has fallen and multinational companies are coming back into the country. There were attacks on NAFDAC offices and staff to discourage their efforts.

An international convention on harmonised drug regulation was proposed.

Guitelle Baghdadi from WHO reported on an initiative that WHO has started with selected Asian countries to encourage good governance in pharmaceutical supply. The aim is to improve transparency and accountability in four key elements of the drug supply process: drug registration; getting onto national essential drugs lists; procurement and promotion.

The project started in late 2004. The first stage is a national assessment of transparency and vulnerability to corruption. This surveys perceptions of corruption; it is carried out with standard assessment tools by nationals. The second stage is development of an ethical framework and national campaigns in response to the assessment. This addresses issues such as agreeing principles, codes of conduct, sanctions and controls. The third stage is envisaged to be training and capacity building for implementation of the framework.

Other points raised by participants included:

- the UK counter-fraud service works by deterring and detecting fraud – it estimates that it saved the National Health Service £675 million in 2005.
- Transparency International has found it useful to get various stakeholders to agree they would benefit from change – for example, both research based and generic drug companies would benefit from tackling fake drugs
- Research by the London School of Hygiene and Tropical Medicine has shown the widespread use of informal payments, even where user fees have officially been abolished. This is particularly prevalent in Eastern Europe.
- Civil society can have a role in improving transparency and encouraging rational drug use as services scale up. Patient representatives can play a positive role on hospital boards.
- Public opinion and the press can play a key role in deterring fraud and informing the public.
- There have been successful anti-corruption efforts at sector level, so it is encouraging that there is interest in addressing this in the health sector.

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