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Barriers to access to medication– the role of corruption and poverty

Anne Lugon-Moulin, Deputy Head of Governance Division, Swiss Agency for Development and Cooperation

There are many different factors that determine patients' access to medication. Lack of R&D on affordable compounds that can be used for fighting neglected diseases, lack of training of health staff, weak logistic and administration systems and a lack of demand from the client side due to an absence of appropriate information and education are just some of these factors. This paper highlights two factors, which are known to be essential barriers to access: corruption and poverty.

1. Corruption as a barrier:

The health care sector has multiple actors determining access to medication. Government regulators, suppliers, payers¹, health care providers and patients are key actors with differing interests and an asymmetric information flow among each other. These stakeholders are in themselves heterogeneous and have diverging – sometimes also conflicting - interests. The state of information among these actors can vary widely which leads to uncertainty and might encourage corrupt behaviour. The 2006 Transparency International report highlights three reasons for corruption in the health sector²:

- imbalance of information
- uncertainty in health markets and the
- opaque complex relations within the health system.

Corruption & Bribery (inc. racketeering & extortion) is typically the unlawful use of an official position to gain an advantage on contravention of duty. This can involve the promise of an economic benefit or other favour, the use of intimidation or blackmailing. It can also refer to the acceptance of such inducements

Corruption in the health sector has many faces and is not limited to any particular kind of health system. It can be observed between or within key actors on small and big scale.

Some examples might illustrate the different manifestations of corruption linked to medication

- On the service and treatment side of medication, corruption can occur with doctors and nurses who charge informal payments to patients to supplement their inadequate incomes. It can occur with suppliers who offer bribes, as well as at the level of health ministers and hospital administrators who accept bribes. It can occur with officials who drain money from health budgets or reroute funds that should be spent on building hospitals, buying medicines or employing staff. In Cambodia, health practitioners interviewed for the Global Corruption Report 2006 estimate that more than 5 per cent of the health budget is lost to corruption before it even leaves central government.
- On the product side, medication entering a health system may already be ineffective, of reduced quality or unsafe due to corruption taking place at the production or distribution and storage stage. We can find the whole bandwidth of embezzlement, theft, selling-on and administration of diluted, substituted, recycled, counterfeited/ falsified and expired medicines.
- Also nepotism can be imputed among this phenomenon of corruption in the health sector. Nepotism is the favouring of relatives or personal friends because of their relationship rather than because of their abilities

In any case, corruption represents a serious barrier to access to medication, especially for the poor in societies because they cannot afford bribes or private health care. It deprives people of access to health care and can also lead to wrong or dangerous treatment being administered.

¹ This can be insurance companies as well as donors and funding agencies

² Global Corruption Report 2006, page 7 ff

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1.1. Examples of petty corruption in the delivery of medication

Various forms and related examples of petty corruption are listed below:

Ghost Paper Trail

- Patient registers are invented or falsified in order to get medicaments or to be in line with the stock register
- Staff in the staff list is not existent but salaries are paid out (Ghost workers)
- Working contracts of retired or resigned staff are not cancelled or delayed for a few months in the accounting and the money for salaries is diverted (Ghost workers)
- Doctors continue to bill treatments for patients who are dead
- Doctors and other health workers are paid but do not show up to work – general staff non-attendance (absenteeism)
- Ghost training sessions are held and per diems are paid out

Upcoding

- A doctor performs medical procedures and charges the donor/ patient for another, more profitable one.
- Patients are charged for “free medication” or “free treatment” (informal payments)

Unbundling

- Hospital procurement is split into different items; a wheelchair broken down into its components—a wheel separated from the seat with a separate bill for each, can increase the profit for the supplier (Kick back payments).
- Patients are asked to come back for a second examination in order to charge them twice.

Nepotism

- Relatives and personal friends receive a working contract because of their relationship rather than because of their abilities
- Overseas training is not offered to appropriate health workers but to friends and relatives

Pharmacy Fraud

- The pharmacist dispenses a generic drug rather than a brand-name drug and pockets the difference.
- A pharmacist registers a “free medication”, buys it back from the patient who is eligible for free or discounted medication, then sells it again.
- The pharmacist or the Doctor refers the patients to a private pharmacy due to “stock out” in the public one.

- Doctors employed by a public hospital are telling the patients that the treatment quality is bad and refer them to their private practice.
- The patient gets diluted, substituted, recycled, counterfeited/ falsified or expired medicines.
- Pharmaceutical companies offering doctors additional “jobs”. Under this assignment doctors prescribe patients the particular drug and then prepare a report on how it works.
- The drug business is sponsoring doctors’ participation in expensive “seminars”, usually held in attractive destinations abroad.
- Inventory theft due to weak physical controls

General Fraud

- Overseas training / seminars is misused for private purpose
- Informal payments³ are in many countries an important source of income for health staff. From Tajikistan it is reported that up to 80% of expenditures for health services happen on an informal basis, through non official user or drug fees.
- etc

1.2. Corruption practices in the context of purchasing and procuring medication or services

The purchasing and procuring of medication or services represents a major part in health care expenditures and therefore the risk of corruption and its impact within this field is very high. Never the less, there are possibilities to limit and manage such a risk (see 1.3) as many of the problems are related to procedure controlling and accounting. According to the Global Corruption Report 2006, a study from Argentina showed that the variation across hospitals in prices paid for medical supplies dropped by 50 per cent after the ministry began to disseminate information about how much hospitals were paying for their supplies.

Various forms of related corruption examples are listed below:

- Public Tenders are strongly specified in order to put a designated supplier in favour
- Public Tenders miss to compare relevant requirements of the procured items (e.g. Incoterms⁴, package insert in the wrong language) and put in favour a designated supplier
- Different donors are not aware of the fact that they finance the same project and the same

³ Informal payments can also be goods of any kind; e.g. alcohol in Eastern Europe and the Balkans, sheep or chicken in Africa.

⁴ Incoterms are standard trade definitions most commonly used in international sales contracts. Among the best known Incoterms are EXW (Ex works), FOB (Free on Board), CIF (Cost, Insurance and Freight), DDU (Delivered Duty Unpaid) and CPT (Carriage Paid To)

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- inventory or indicators are shown to different donors
- The procured items are not meeting the required and tendered standards (no follow up provokes kick back payments)
- Grant funded hospitals are managing private polyclinics, funded on unclear principles and utilizing the public hospital's staff and equipment; Public goods are used and sold in the private sector
- Collusion between the ministry of health/state agencies and pharmaceutical business concerning drug registration (very non-transparent process) and drug reimbursement (drugs put on the official state list are reimbursed by the state).
- Grants are converted into local currency with exchange rates which do not reflect actual market rates
- etc

1.3. Existing control mechanisms for prevention and for addressing corruption cases

Even if every case of corruption is different, there are some conditions, which appear in all detected cases:

- **“motivation”** The individual does have an incentive (or cause) to commit fraud⁵
- **“opportunity”** The individual can identify an opportunity to commit fraud
- **“justification”** The individual is able to rationalise the reason for committing fraud

Prevention:

Starting points to the prevention of corruption are given by the 3 key factors (motivation, opportunity and justification). Motivation can be reduced for example by adequate salaries, justification by the implementation of ethical standards, peer pressure and generally agreed code of conduct. To reduce the “opportunity”, a common understanding of clearly defined internal processes is necessary:

- Everybody should be aware of the applied procedures.
- Identification of weak points and risks in every domain of the organisation (personnel & procedures); from the management to the employees as well as external persons.⁶
- Evaluation and appraisal of the risks, their occurrence probability and the possible impact
- Implementation and communication of appropriate control mechanisms in the entire organisation

⁵ Fraud is the intentional use of deceit to deprive another of money, property or a legal right.

⁶ e.g. high volumes or high risks as well as areas of high complexity

- Create awareness to warning signals and open a possibility to report concerns, rumours, observations etc. to an independent entity (e.g. board of directors, audit committee, Internal audit, Board of management, internal or external legal counsel, fraud hotline).

In general there is a correlation between a higher number of controls and a higher chance of detecting fraud and corruption. A higher risk to be detected decreases the “opportunity” and has consequently a preventive impact.

Control measures & mechanisms:

The most common instituted control measures are

- External audits⁷
- Internal audits
- Internal Control⁸ mechanisms.

Other thinkable but not that widely incorporated measures are Corporate Security, Whistle-blowing⁹ hotline, regular personnel rotation, specific training on fraud or fraud risk management systems¹⁰. Also codes of conduct, procurement guidelines, transparency, Civil society participation, conflict of interest rules, monitoring procedures and rigorous prosecution are seen as trigger mechanisms to fight corruption.

As a basis of all of these mentioned control measures remain reliable financial statements¹¹ (or financial reports). Projects or organisations/institutions without an independent reliable and transparent accounting can not be considered as “controlled”.

Also the quality of the controller is crucial within a controlling system. It is mandatory that the controlling agency, which does data evaluation and on site verifications of health care related projects, has to have strong **financial and healthcare** know-how. Without a background on both topics it is not possible to follow up on financial transactions as well as on medical / technical information in detail. A single transaction in a financial statement can reveal important questions within different program dimensions.

¿Are the ordered goods appropriate (e.g. technically, quality, quantity, pricing, in compliance to national treatment protocol, WHO recommended, reasonable

⁷ Audits are the formal examination and review of a company's accounts and /or practices

⁸ e.g. computer security (access, back up), account reconciliations, segregation of duties

⁹ Whistle blowing is the disclosure by an employee of malpractice in the workplace

¹⁰ Systems put in place to assess, identify and respond to risks in the company

¹¹ Financial statements are records of a business' financial flows and levels (eg. Statement of financial position, Profit and loss statement, Statement Cash Flow)

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expiry date) and the financial processes respected (e.g. tendering, supplier selection, terms of payment, Incoterms, exchange rate fluctuations, financial recording)?

In a normal setting, it is impossible for one person to answer all these questions.

- where internal controls are strong, auditors typically rely more on **Substantive Analytical Procedures** (the comparison of sets of financial information, and financial with non-financial information, to see if the numbers 'make sense' and that unexpected movements can be explained)
- where internal controls are weak, auditors typically rely more on **Substantive Tests of Detail** (selecting a sample of items from the major account balances, and finding hard evidence (e.g. invoices, bank statements) for those items)

On the governmental level there have been different initiatives the last few years to prevent corruption. Since 2000 it is illegal for Swiss enterprises to bribe foreign public servants (following the OECD Convention from 1997 to fight the corruption of foreign public servants). SDC and SECO published brochures on this topic¹² and an anti corruption clause is a standard SDC contracts.

The World Bank introduced the 'Voluntary Disclosure Program' (VDP)¹³. It is a proactive anti-corruption investigative tool designed to uncover corrupt and fraudulent schemes and patterns in Bank-financed projects through the voluntary cooperation of participating firms and individuals. The VDP allows entities which have engaged in past fraud and corruption to avoid administrative sanctions if they disclose all prior wrongdoing and satisfy standardized, non-negotiable terms and conditions.

Donor Agencies try to prevent corruption in their funded programs by introducing indicators and a monitoring of the financial and programmatic performance (e.g. Global Fund to Fight AIDS, Malaria and TB, GAVI, bilateral donors etc). In general it is difficult for these agencies to introduce, build up and maintain a high and rigid control of their programs as donors expect a maximum of funds to be spent on project operations and a minimum of funds to be spent

¹² Korruptionsbekämpfung, Leitlinien DEZA 1998, EDMZ Nr. 43227 / Broschüre; Korruption vermeiden, Hinweise für im Ausland tätige Schweizer Unternehmen, Staatssekretariat für Wirtschaft SECO / Richtlinie für die Vergabe von Aufträgen im Rahmen von Infrastrukturfinanzierung des seco mit Transitions- und Entwicklungsländern, Staatssekretariat für Wirtschaft SECO, Juni 2003

¹³ Please refer to the link list or consult <http://www.worldbank.org/vdp>

on administration. The necessity of control instruments is not easy to communicate and always leaves a taste of mistrust and "colonial" behaviour.

2. Poverty as a barrier

An estimated 30 percent of the world's population lacks reliable access to required medicines¹⁴. In the poorest parts of Africa and Asia, the figure rises to over 50 percent.

The price of medicines and therefore poverty plays an essential role in access to medicines. The following examples show this relation between poverty and access to medicines clearly.

The price of a course of treatment for peptic ulcer, put in relation to a wage gives a feeling about the local market price. The brand version of Ranitidine costs (for one month's treatment):

- the equivalent of 13 days wages in the Philippines private sector
- nearly 19 days wages in Armenia
- and 50.5 days of pay in Cameroon – almost two month's pay.¹⁵

This shows how a medicine bill can easily consume the entire income of a person. It might be possible for the patient to get a generic equivalent from public sector sources at a lower price but in two of the three countries mentioned (Armenia and Cameroon) the generic is not available. In the Philippines, the price difference between the generic and the brand drug from the public sector is minimal- (generic price is one day less than for the brand drug from the public sector).

Unaffordable drug prices are the major cause for non compliance with hypertension medication in Ghana¹⁶

Furthermore, in some countries people also have to pay user fees to obtain the services that provide treatment. This is for example, the case with public health facilities in Kenya where people reportedly paid between USD 0.7 and USD 7 to gain access to the service providing treatment. In Thailand, ART is provided under the 30 Baht scheme (0.8 dollar): this is the user fee for visits to health facilities for the essential health services provided by the government. These costs may not seem high, but since they are recurrent they can still pose a significant financial problem to ART users.¹⁷

In many countries, people have to pay for HIV and CD4 tests (around USD 6 on average) themselves, even though ART is generally free. This amount

¹⁴ World Medicines Situation 2004, p.61

¹⁵ WHO, Essential Drugs Monitor No 33, page 13

¹⁶ Please refer to the link list or <http://www.msh.org>

¹⁷ HIV/AIDS Access by 2010, 10 challenges on the way, page 12

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restricts access to treatment for the poor, especially when the prescribing physicians request that other tests be done. In Peru, half the ART users interviewed reported that they had to pay around USD 30 for testing before their treatment had even started.¹⁸

In Vietnam, respondents reported the following additional costs

Items	Cost USD
Consultation per visit	0.3
Elisa test	3
CD4 testing using flow cytometry	12
CD4 testing using dynabeads technique	4
Liver function	2
Chest X ray	1.5
Sputum smear (x3)	3
Other Costs: Counselling, psychological support; transportation, food per month	30
Total USD:	55.8

Table: Treatment related costs reported by the respondents in Vietnam

In general, medicines are less affordable in African countries because of low wages and higher prices. In Indian states, where wages are also low, the low prices make most products affordable. In Tajikistan the very low wages make many medicines unaffordable, in spite of their low prices.¹⁹

2.1. How poverty impedes access to medication: facts and figures, mechanisms

The percentage of the population in the developing world with regular access to essential medicines is low, particularly for countries in Africa where over 80 percent of the population are in the "very low" and "low to medium" access groups.

WHO Region	Percentage of Population with Regular Access to Essential Medicines				Total Countries
	Very Low Access (<50%)	Low to Medium Access (50%-80%)	Medium to High Access (81%-95%)	Very High Access (>95%)	
	Number of Countries	Number of Countries	Number of Countries	Number of Countries	
Africa	14	23	5	3	45
Americas	7	14	7	7	35
Eastern Mediterranean	2	7	5	8	22
European	3	12	6	25	46
South-East Asian	2	4	3	0	9
Western Pacific	1	8	8	9	26
Total Countries	29	68	34	52	183

Table: Range of access to essential medicines by WHO region, 1999¹

¹⁸ HIV/AIDS Access by 2010, 10 challenges on the way, page 10.

¹⁹ Price, availability and affordability, An international comparison of chronic disease medicines, Background Report December 2005, page 48

About 30% of the world's population, or between 1.3 and 2.1 billion people, are estimated not to have access to the essential medicines they need. In India, an estimated 499-649 million people (50% to 65% of the population) do not have regular access to essential medicines. Throughout Africa, a further 267 million people also lack access. Classifying access to countries level of income shows a clear relationship between economic level and access to medicines.²⁰

Country income group	Median reported access level (%)	Minimum reported %	Maximum reported %
Low-income	60	10	93
Middle-income	85	30	100
High-income	100	98	100

Table: Country income level and access to essential medicines

The percentage of the population estimated to lack adequate access to essential medicines is less than 1% in high-income countries, 39% in low-income countries and 24% in middle-income countries. The 1.3 billion people in low-income countries estimated to lack access account for almost 80% of the total number of people in the world who lack essential medicines.²¹

²⁰ World Medicines Situation 2004, p.63

²¹ World Medicines Situation 2004, p.63

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Country income group	Number of countries	Population	Population without access to essential medicines		
		Number (million)	Number (million)	As % of country income group	As % of global total without access
Low-income	63	3548	1369	38.6	79.4
Middle-income	86	1447	350	24.2	20.3
High-income	34	859	5	0.6	0.3
Total countries and population	183	5854	1724	n.a	100

Table: People without access to essential medicines, by countries' level of income

In addition, it is well known that inequitable access within countries is also strongly linked to poverty. The poorer and more vulnerable population segments as well as rural populations are confronted with great access problems to medication as compared to wealthier groups.

Taking together that the fact that poverty as well as corruption represent a barrier to access to medication, the poorer population is penalised twice. Not only the poverty builds a barrier for the poor but on top of the poverty comes the inability to pay bribes in order to get access to medication.

Contacts

Swiss Agency for Development and Cooperation

Franziska Freiburghaus
 franziska.freiburghaus@deza.admin.ch
 Anne Lugon-Moulin
 Anne.Lugon-Moulin@deza.admin.ch

Swiss Centre for International Health

Swiss Tropical Institute
 Marcel Braun
 marcel.braun@unibas.ch,

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13. HIV/ AIDS Universal Access by 2010, 10 challenges on the way, Health Action International
14. Price, availability and affordability, An international comparison of chronic disease medicines, Background Report December 2005, WHO, Health Action International

Links:

- **World Bank Voluntary Disclosure Program** <http://www.worldbank.org/vdp>.
The Voluntary Disclosure Program (VDP) is managed by the World Bank's Department of Institutional Integrity (INT). Under the VDP, participants commit to cease paying bribes or engaging in fraud, corruption, collusion or coercion. They must disclose to the World Bank all such past misconduct in Bank-supported projects or contracts, implement a robust and monitored compliance program, and pay the bulk of the costs associated with participation in the VDP. Participants can be firms or other entities, such as NGOs or individuals. Those under active investigation by the World Bank are not eligible to enter the program. In exchange for full cooperation, VDP participants avoid public debarment for disclosed past misconduct, and benefit from the Bank's assurances of confidentiality.
- **Global Forum on Pharmaceutical Anti Counterfeiting** <http://www.pharma-anticounterfeiting.info/>
The Global Forum on Pharmaceutical Anti Counterfeiting is a interface between the principal stakeholders in pharmaceutical protection (drug regulators, healthcare professionals, manufacturers and anti-counterfeiting technology and service providers) from both developing and industrialised countries to discuss and implement practical solutions to the endemic problems of counterfeit, diverted and substandard medicines.
- **Partnership for Safe Medicines** <http://www.safemedicines.org/>
The Partnership for Safe Medicines is a coalition of patient, physician, pharmacist, university, industry and professional organizations concerned about consumer safety threats posed by the purchase and use of unapproved, counterfeit, substandard, mishandled or otherwise unsafe medicines. The Partnership's website includes a clearinghouse of initiatives, reports, and policy statements on anti-counterfeiting activities worldwide.
- **Campaign for access to essential medicines** <http://www.accessmed-msf.org/>
- **Management Sciences for Health** <http://www.msh.org>
- **Health Action International** <http://www.haiweb.org>