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Human Rights, Health Sector Abuse and Corruption

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Human Rights, Health Sector Abuse and Corruption

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ABSTRACT –research indicates that health sectors in both poor and rich nations are vulnerable to abuse and corruption. This paper discusses the character and scope of health sector abuse and corruption. It suggests that human rights law can play an important role in enhancing the transparency and integrity of health systems. Based on the existing human rights framework, some tools are provided and examples are given of how this can be done.

Subsequently, it is argued that some of such abuses can lead to corrupt acts, as identified under international law. It is maintained that there are clear links between such corrupt acts and human rights law, and that some of such acts can be identified as concrete human rights violations.

‘Every euro lost to fraud or corruption means that someone, somewhere is not getting the treatment that they need, (...) They are ill for longer, and in some cases they simply die unnecessarily. Make no mistake -- healthcare fraud is a killer.’¹

1. Introduction

Health systems across the globe are vulnerable to abuse because they are complex in character and because they face many uncertainties. There are countless examples of actions that reveal a lack of transparency and integrity, and that may ultimately be

defined as health sector corruption. Such abuses take place in all the branches of the health sector, varying from health ministries, to hospitals and pharmaceutical companies. To give some examples: ²

- A health minister skims money off a loan from a foreign country;
- A hospital is in danger of being destroyed to free up prime real estate close to a popular tourist attraction;
- A government accepts a bribe in exchange for the construction permit for a large private hospital in the city centre;
- A hospital illegally bills an insurance company for services that were not actually provided;
- A health care provider provides excessive and low-quality medical treatments;
- A health worker embezzles money from the hospital budget, and steals medicine and medical supplies and equipment for personal use;
- A doctor asks for 'informal payments' or 'under-the-table-payments' from his or her patients;
- A nurse consistently works less hours than agreed;
- A doctor makes a patient pay for the same service twice, first in the public hospital, secondly in the private hospital to which the patient has been referred;
- A patient is rejected by a health insurance company for being too 'costly';³
- The drug selection process in a country is replete with kickbacks and payoffs so that the national drugs list does not contain the most appropriate and cost-effective drugs;
- A pharmaceutical company spends excessive sums on marketing of physicians;⁴

- A pharmaceutical company seeks to influence doctors with high honoraria to participate in their speaker's bureaus;
- A manufacturer seeks to influence researchers who have an interest in bringing a tested drug on the market;⁵
- A patient misrepresents his/her enrolment in an insurance plan by using someone else's insurance card.

It is not difficult to see that such acts have a negative impact on the availability and the accessibility of health services.⁶ On a macroeconomic level, fraud and corruption negatively affect the (financial) resources available for healthcare. According to a recent report by the European Healthcare Fraud & Corruption Network, globally every year 180 billion euros are lost to fraud.⁷ But at the level of healthcare provision access to healthcare can also be affected. The patient who has to pay an under-the-table payment runs the risk of not being able to afford the bill, and the doctor who lets himself be influenced by a pharmaceutical company runs the risk of not providing the drug that is most suitable for his patient.

If such acts deprive people of their access to healthcare services, then their human rights, including their rights to health, life and information are potentially compromised and threatened. This paper seeks to establish the links between such abuses in the health sector and human rights law. Links are established between such issues of transparency and integrity, and the tools provided under human rights law, in particular under General Comment 14 on the Right to the Highest Attainable Standard of Health.⁸ A secondary aim of the paper is to identify some abuses in the health sector as acts of corruption, and to demonstrate how such abuses can be identified as

human rights violations. However, the paper does not focus on corruption exclusively, as this would unduly narrow the analysis.

The paper will first describe what is a health system. In relation to this it will identify a number of actors in the health system that potentially bear human rights responsibilities. Subsequently it will introduce the concepts of transparency, integrity and the related concept of corruption. They will be linked to the human rights framework. An attempt is made to identify a number of policy-oriented tools that can prevent health sector abuse. Subsequently the matter is taken a step further and brought into the legal realm, and an attempt is made to identify abuses that lead to concrete human rights violations. The paper will build a bridge between the human rights doctrine and the anti-corruption framework, as developed by, *inter alia*, Transparency International.⁹

The author of this paper is fully aware that the links between human rights and health systems are much broader than merely the enhancement of transparency and combating of corruption.¹⁰ However the aim of this paper is to argue that this particular issue is an important element in the general debate about the links between human rights and health systems.

2. Health systems, their actors and their vulnerabilities

2.1 Health systems and their actors

Before we can embark upon our analysis of human rights and health systems transparency we need to clarify what we are talking about when we use the term

‘health system’. Numerous definitions of health systems can be found in the literature. Most definitions take a broad approach to a health system.¹¹ For example, the World Health Organization (WHO) gives the following definition of a health system:

‘A health system consists of all organizations, people and actions whose *primary intent* is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as more direct health-improving activities. A health system is therefore more than the pyramid of publicly owned facilities that deliver personal health services. It includes, for example, a mother caring for a sick child at home; private providers; behaviour change programmes; vector-control campaigns; health insurance organizations; occupational health and safety legislation. It includes inter-sectoral action by health staff, for example, encouraging the ministry of education to promote female education, a well known determinant of better health.’¹²

This inclusive definition is in line with the broad notion of a ‘right to health’ which not only guarantees a right to healthcare services but also a right to underlying determinants for health, including access to health-related information, environmental health, and occupational health.¹³ While this definition will be taken as a starting point for this paper, the focus in this paper will be primarily on accessing health care services and health-related information, and not on such underlying conditions as environmental health, access to safe drinking water, and occupational health.¹⁴ Yet taking a broad approach to health sectors implies that we will not be focusing solely on health care delivery, but more generally on the aggregate of organizations, persons and activities that have been installed to provide healthcare. We will do so by roughly identifying the responsible actors in the health sector. For if we want to embark upon a human rights analysis of health systems, we need to identify who are responsible for maintaining the health of the population. Transparency International identifies the following set of actors in the health sector:

- *regulators* (governments, health ministries, parliaments, supervisory commissions, accrediting and licensing bodies);
- *payers* (social security organizations, public and private insurers, financial intermediaries, and public and private donors);
- *providers* (hospitals, doctors and medical associations, pharmacists);
- *suppliers* (commercial suppliers of medical and health care goods and services, including pharmaceutical companies and biotechnology companies as well as producers of medical equipment and medical device companies).¹⁵
- *consumers* (patients and patient support groups and disease-related advocacy groups);

In addition to this, the following actors play an important role in the health sector:

- *medical ‘educators’ and researchers* (institutions, organizations and groups that engage in educating medical personnel and in medical and health care research, including medical schools and their parent universities, medical journals, as well as medical education companies).¹⁶

As will be discussed below, all these actors potentially bear responsibilities under human rights law for ensuring that health service delivery is transparent and not characterized by a lack of integrity.

2.2 *Health sector vulnerabilities*

As mentioned in the introduction, health sectors are generally uncertain and complex systems which are very vulnerable to abuse and corruption. Savedoff and Hussmann explain this very clearly in Transparency International’s 2006 ‘Global Corruption Report’.¹⁷ They mention three reasons why health systems are so prone to corruption:

1. There is a lot of *uncertainty* in the health sector, meaning that there is uncertainty regarding who will fall ill, when illness will occur, and what kinds of illnesses people get.¹⁸ As a result, it is difficult to adequately allocate resources and for healthcare ‘consumers’ it is difficult to make adequate choices between available ‘products’. Health sectors are therefore vulnerable to inefficiency, which creates opportunities for corruption.

2. The health sector is characterized by *asymmetric information*, meaning that information is not shared equally among the health sector actors that were identified above. Healthcare providers know more about the medical services they deliver than their patients; pharmaceutical companies know more about their products than healthcare providers; health insurers may know more about the health status of their clients than healthcare providers and patients themselves; and finally, patients may have certain information about their health status that they may not share with healthcare providers and insurers.
3. In the health sector, a *large number of actors* engage with each other in multiple ways (see above). This may hamper the adequate generation and spread of information, and the promotion of transparency.¹⁹

There is some research indicating that health sector corruption is more likely to occur in poorer countries. IshØy and Sampson indicate that high levels of corruption are associated with middle to low levels of development and with unequal distribution of income and consumption.²⁰ However, we should not turn a blind eye to abuse and corruption in high-income countries. There is for example growing amount of documentation on health sector corruption in the United States.²¹ Its two largest public health care programs, Medicare and Medicaid, estimate that 5–10 per cent of their budget is lost to ‘overpayment’.²² In line with the global anti-corruption approach health sector abuse and corruption should therefore be addressed as a global phenomena and a flexible and broad human rights approach should be defined that meets this global trend.

Furthermore, it is important to note that health sector abuse and corruption may vary according to the way the health system is financed and controlled. A sophisticated table has been developed within the framework of the World Health Organization (WHO), which connects different forms of financing with the risks of corruption. A distinction is made between tax-based, social insurance, private insurance, out-of-pocket expenditure, and community financing.²³ For example, the table makes it clear that a tax-based system is vulnerable to large-scale diversions of public funds at ministerial level, a high risk of informal or illegal payments, corruption in procurement, and abuses that undermine the quality of services. Social and private insurance systems, on the other hand, are vulnerable to excessive medical treatment, fraud in billing, and diverting funds.²⁴

As mentioned, this table also refers to out-of-pocket expenditure, i.e. patients paying for their health services themselves. According to the WHO table this system creates a high risk of over-charging and inappropriate prescribing of services. There is also a risk of employees pocketing official fees collected from patients, and no guarantee that all health services are of value to those buying them.²⁵ Mackintosh and Koivusalo indicate that in many low and middle income countries over 40 percent of health care spending is out of pocket.²⁶ They point out that where this is a predominant means of access to health care it affects the poor most heavily.²⁷ Altogether as patients are often not able to afford the payment required for the needed service, this form of privatization has a direct negative effect on the affordability requirement under the right to health.

At the level of health service delivery, it is important to make a distinction between publicly and privately provided healthcare services. Research reveals that abuses are widespread in both settings. To start with the public sector, IshØy and Sampson explain how in many countries there is an under-financed, inefficient and often corrupt public health sector. However, as people are poor, they cannot obtain the needed services privately.²⁸ Transparency International refers to a 2002 survey of households in Central Europe which singled out public hospitals as one of the most corrupt government institutions. More than 80% of the persons consulted reported the need to offer gifts to hospital doctors in order to obtain services to which they were legally entitled for free.²⁹

Yet privatization of health services can equally pose a risk to the transparency and integrity of a health system. The privatization of public services implies a move away from public services and can as such negatively affect the quality of health services, the accessibility, and the accountability for such failures.³⁰ If private healthcare providers are poorly regulated and monitored, there is no guarantee that they will treat patients fairly. They may for example over-prescribe drugs and ask for high charges.³¹ Health sector privatization may also blur a clear-cut separation between public and private practice. For example, patients may find themselves paying for a service twice, first in the public hospital and then in the private clinic where the same doctor is employed.³²

Finally, it is important to look at the devolution of public and centrally organized health services to local authorities. It is important for the central government to ensure that local health authorities are not corrupt once they attain more power over health

care provision. The decentralization of health care services should always include a strategy to prevent corruption at the local government level. Some interesting suggestions are made to the Nigerian government and local authorities in a report by Human Rights Watch, including: 'subject the discretionary spending of governments and local chairpersons to greater oversight', and 'require that the actual use of funds allocated to discretionary budget lines be reported and made public in detail'.³³

3. Health sector abuse and corruption

This section distinguishes between two layers of abuse in the health sector: the wide range of acts that can be described as 'abuses' due to a lack of transparency and integrity, and a narrower range of acts within this wider range of abuses that can be identified as corrupt acts. A number of terms are introduced in this section that are not commonly used in human rights language: transparency, integrity, and corruption. This author is fully aware that human rights language already has a full and rich vocabulary and that we do not necessarily need to add more. But rather than introducing new terms into human rights language, the purpose of this introduction is to link these with the existing human rights discourse. It is argued that strong connections exist between human rights law and these concepts.

Transparency

Transparency is about decisions being taken in a clear and visible fashion. The term is frequently used by organizations that seek to address this matter in all branches of society. The organization Transparency International describes the principle of transparency as follows:

“Transparency” can be defined as a principle that allows those affected by administrative decisions, business transactions or charitable work to know not only the basic facts and figures but also the mechanisms and processes. It is the duty of civil servants, managers and trustees to act visibly, predictably and understandably.³⁴

‘Transparency’ is not a human rights notion. But as will be discussed below, it has strong links with the principles of ‘information accessibility’, ‘participation’ and ‘accountability’ that frequently appear in the human rights doctrine.

Moral integrity

Barbosa da Silva describes the concept of ‘integrity’ as ‘the condition of being whole, entire or undiminished’.³⁵ He identifies between four types of integrity: physical integrity; mental or psychic integrity and spiritual integrity; personal integrity (including privacy and self-determination); and moral integrity or integrity of character and conscience.³⁶ Physical, mental and personal integrity are different from moral integrity. While physical, mental and personal integrity are important principles for the identification of the values attached to individuals or patients in health and human rights law and in medical ethics, ‘moral integrity’ is not a principle that goes in defense of the rights of the individual.³⁷ Yet perhaps confusingly it is this understanding of ‘integrity’ that together with the principle of ‘transparency’ stands at the core of our analysis of human rights and health sectors. With ‘integrity’ we refer here to morally ‘good’ or ‘proper’ behavior by all the actors in the health sector, including government officials, doctors, pharmacists and patients. As such it refers to the obligation of the duty-holder to behave in an honest and truthful way, in light of its obligations under human rights law. A lack of integrity of an actor in the health

sector may compromise human rights. To give one example: a doctor who does not inform the patient properly about the risks of a certain drug or medical treatment potentially violates the patients' right to health care and the principle of 'information accessibility' and 'informed consent' under human rights law. His/her behavior lacks 'moral integrity'.

Situations where the moral integrity of healthcare providers and other actors in the health sector are particularly threatened are situations where the interests of the patient have to be weighed against the interest of other actors. Such situations are often indicated with the term 'conflict of interest' or 'dual loyalty'. While the term 'conflict of interest' is usually applied to indicate conflicts in the area of research, education and healthcare practice more generally,³⁸ the term 'dual loyalty' is usually applied when referring to the individual patient-doctor-relationship.³⁹ Where such conflicts of interest or dual loyalties exist out of seeking private gain, as defined below, they can be described as forms of health sector abuse and/or corruption.

Corruption

To take it one step further, both transparency and integrity are linked with the notion of corruption. A lack of transparency and integrity can lead to acts of corruption, either within the health sector or in other sectors of society. As will be elucidated below in section 8, the UN anti-corruption Convention and other international conventions specify a number of concrete corrupt acts.

As mentioned above, focusing exclusively on corruption per se would unduly narrow the analysis. Not every abuse is a corrupt act, and we also need to recognize that

corruption and health sector corruption are not clear-cut notions. While in some countries an informal payment is considered an essential part of the culture's country and society, in others it clearly constitutes an act of corruption. A clear example in the health sector concerns the informal payments that doctors ask their patients. While this is common practice in many (developing) countries, in many (developed) countries this is considered to be an unacceptable practice. A definition of what constitutes 'corruption' may therefore vary from the one society to the other. In 1966, Bayley pointed at the beneficial effects of corruption in developing nations, including: it may be a supplemental allocative mechanism compatible with the goals of development; it may serve to increase the quality of public servants; and it provides those disaffected as a result of exclusion from power a stake in the system.⁴⁰ In a similar vein some have argued that corruption is a Western notion in the way it is currently defined.⁴¹ While conscious of these different interpretations this paper will use Transparency International's well-established definition of corruption:

'the misuse of entrusted power for private gain'.⁴²

An important feature of this definition is that contrary to other definitions it not only focuses on State abuse, but that it focuses more generally on the 'misuse of entrusted power'.⁴³ As was elucidated above, this is important for the purposes of addressing health sector abuse corruption, as all the actors can potentially be involved in the abuse. The definition is also broader than national and international legal definitions of corruption in the sense that it also covers forms of abuse that are not strictly speaking a violation of the anti-corruption law. As a result, it can cover a wider range of abuses.

Furthermore, some institutions distinguish between petty and grand corruption. U4 (Anti-Corruption Resource Centre) describes petty or 'low level' corruption as the 'everyday corruption', where modest sums of money usually involved, which people can experience more or less daily.⁴⁴ Examples of such forms of corruption in the health sector are health workers requesting informal payments above the normal cost service, theft from the hospital budget, absenteeism of hospital personnel, and patients using other people's insurance cards. 'Grand' or political corruption involves political decision-makers and is defined as a 'transaction between private and public sector actors through which collective goods are illegitimately converted into private-regarding payoffs.' According to U4, it leads to the misallocation of resources, but it also perverts the manner in which decisions are made.⁴⁵

While this is a useful distinction, the disadvantage of this classification is that 'grand' corruption is linked to acts by political decision-makers. This approach may unduly downsize certain serious abuses to the level of petty corruption: corrupt acts that engage two private actors (eg an insurance company and a pharmaceutical company) are not covered by this definition, yet they can be very serious in nature and should be addressed according to their size and impact.

Therefore this paper a distinction is made between two types of abuse: all abuses are characterized by a 'lack of transparency and/or integrity', while larger abuses are defined as acts of corruption. Both categories embrace State and non-state actors in the health sector. Starting point for all the abuses so defined is Transparency International's definition of a corrupt act, 'the abuse of entrusted power for private

gain’. So it is argued that this definition covers the wide spectrum of abuses that this article covers. We could represent this as follows in a diagram:

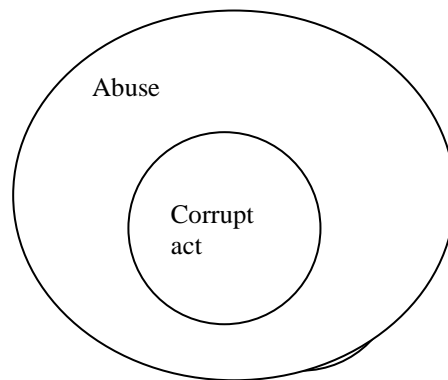


Table 1. ‘The misuse of entrusted power for private gain’

4. Establishing the links with human rights law

Subsequently, we need to establish the links between the above-mentioned definition of abuse and corruption and human rights law. More recently some research has been

carried out to establish such links.⁴⁶ Some authors, however, have been critical of such connections. Goodwin and Rose-Sender, for example, have argued that corruption is not capable of being enforced as a human right. They argue that ‘tackling corruption’ fails to tell one anything about what action should be taken.⁴⁷

This author, however, argues that the above-mentioned definition clearly establishes a link between corruption and human rights. On the basis of human rights, States and/or non-state actors have to respect the powers bestowed upon them (the ‘entrusted power’). For example, on the basis of human rights governments are to respect people’s physical integrity or their access to safe and clean drinking water. An abuse or act of corruption, or more generally ‘the abuse of entrusted power for private gain’, disrespects this responsibility and may as such lead to a violation of human rights. The aggregate of human rights law provides some useful tools for clarifying States’ duties in relation to (health sector) corruption, and that it has mechanisms for holding states accountable for such abuses.

5. Human rights and health sectors

Subsequently we need to identify the rights that are relevant for addressing health sector abuses and corruption. Rather than defining a new ‘anti-corruption right’, it is argued that human rights law as a system can offer protection against such abuses. While all human rights are potentially relevant and can potentially play a role in this, the core right for addressing this issue is the ‘right to the highest attainable standard of health’, as set forth in several international human rights treaties.⁴⁸ The most important provision is Article 12 of the UN International Covenant on Economic,

Social and Cultural Rights (ICESCR). Related to this, General Comment 14 of the Committee on Economic, Social and Cultural Rights (CESCR) describes the meaning and implications of the right to health in Article 12 ICESCR.⁴⁹ Although strictly speaking not a legally binding document, it gives a clear and useful overview of the scope and contents of the right to health. It has the potential to be used as a reference document by courts and quasi-legal bodies that seek to adjudicate (corruption) cases on the basis of the right to health. As will be demonstrated below, it can also be used a tool for policy-makers who seek to implement the right to health.

While the right to health lies at the core of our analysis on corruption in the health sector, the other rights support and reinforce this right. As the General Comment explains, the right to health is closely related to and dependent upon the realization of other human rights.⁵⁰ Relevant to our analysis are, in particular, the right to life, the principle of non-discrimination, the right to a remedy, freedom of expression and the right to information, and the right to political participation.⁵¹ For example, a right to a remedy is essential for guaranteeing access to a remedy after one has been affected by corruption. Furthermore, freedom of expression and the right to information reinforce the right to health the right to health in the sense that they embrace the notion of expressing and accessing health-related information, which is of crucial importance when it comes to combating health sector corruption. For example, on some occasions the corrupt act leads to an attempt to cover up this act, and as such to a violation of freedom of expression and the right to information.

6. A framework for enhancing health sector transparency and integrity

‘AAAQ-AP’

The General Comment on the Right to Health identifies a set of principles that apply at all levels of the health sector and that are also important in relation to the problem of corruption (the so-called ‘AAAQ’). States are required to guarantee the availability, accessibility, acceptability and quality of health facilities.⁵² One finds similar principles in the UN General Comments on the substantive rights in the ICESCR, as well as in a national health law context.⁵³

In addition, two additional principles are relevant to an anti-corruption context: accountability and (political) participation.⁵⁴ Although not part of the ‘AAAQ’ and not elaborately discussed in the General Comment,⁵⁵ they are increasingly referred to in the health and human rights literature as important principles underpinning the right to health.⁵⁶

Accountability, or ‘answerability’ means that responsible actors have the obligation to address questions regarding decisions and/or actions.⁵⁷ Potts explains it as a broad process comprising the following essential elements: monitoring, accountability mechanisms, remedies, and participation.⁵⁸ As such, the principle of accountability is closely related to the States’ ‘obligation to protect’ that will be discussed below. But additionally, the other actors in the health sector are also required to hold themselves accountable for their actions (see also section 7.2).

Participation means that the public has a say in important decisions concerning the health sector, for example, the decision to privatize or decentralize (parts of) the health sector. States should ensure political participation throughout the decision-

making process on the organization of the health sector. Political participation is not only realized through a democratic system of elections, but also for example by providing for public inquiries regarding planned health sector reform.⁵⁹

Altogether this author asserts that these principles are part and parcel of the core framework underlying the right to health. In conclusion, the following principles ('AAAQ-AP') are important tools for enhancing and strengthening the integrity and transparency in the health sector:

- Availability - health facilities, goods and services, as well as programs, are available in sufficient quantity;
- Accessibility - health facilities, goods and services are accessible to all persons without discrimination;
 1. Non-discrimination - health facilities, goods and services are within safe physical reach of all sections of society, especially vulnerable or marginalized groups;
 2. Physical accessibility: health facilities, goods and services be within safe physical reach of all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations;
 3. Affordability: health facilities, goods and services should be affordable to all, whether publicly or privately provided;
 4. Information accessibility: patients and the public as a whole have the right to seek, receive and impart information and ideas;

- Acceptability - health facilities must be respectful of medical ethics and they must be culturally appropriate. Among other things, health facilities must be designed to respect confidentiality and improve the health status of those concerned;
- Quality - health facilities must be scientifically and medically appropriate and of good quality;

And:

- Accountability – the availability of possibilities to address questions regarding the health sector through monitoring, accountability mechanisms, and remedies;
- Participation – participation of the public in the health-decision making process.

This author maintains that States and all the other actors in the health sector must take the AAAQ-AP as a frame of reference for all their actions and they must ensure that the AAAQ-AP is not compromised. For example, when deciding between investing in a new adventure park and a set of community health centers across the country, the principles of availability and physical accessibility of health care services can be decisive for deciding in favor of building the health centers. When it comes to doctors, deciding in favor of a drug that comes with a bonus may compromise the quality and acceptability of medical services. Furthermore, the researcher who lets him or herself be influenced by a manufacturer who has an interest in bringing a certain drug on the market compromises the acceptability and quality of healthcare. Altogether, all actors in the health sector can use the ‘AAAQ-AP’ as a frame of reference for enhancing the transparency and (moral) integrity of health systems.

As such, we have now connected the concepts of ‘moral integrity’ and ‘transparency’ with the ‘AAAQ-AP’:

Availability
Accessibility <i>non-discrimination</i> <i>physical accessibility</i> <i>affordability</i> <i>information accessibility</i>
Acceptability
Quality
Accountability
Participation

Table 2: ‘enhancing integrity and transparency in the health sector’

A lack of integrity or dishonesty by one of the actors in the health sector is very much connected to and can compromise the availability, accessibility, accessibility and quality of health sectors. For example, when private health insurers refuse customers based on their financial situation or health status, the accessibility and affordability of health services is of these individuals is potentially threatened. Or when the drug selection process is characterized by kickbacks and payoffs and as such does not represent the most appropriate drugs, the quality and acceptability of healthcare services is endangered.

Secondly, transparency is very much connected and translates into information accessibility, accountability and participation in the health sector. For a health sector to be transparent it must ensure information accessibility, while accountability and participatory mechanisms must be in place to guarantee that decisions are taken in a fair and transparent manner.

7. Policy-oriented tools for improving health sector transparency and integrity

7.1 State level

Human rights impact assessments

Increasingly States are recommended to undertake ‘human rights impact assessments’ in order to identify the possible human rights consequences of, for example, health sector decentralization and health care commercialization bills and planned policies.

A human rights impact assessment is a tool which enables States and international and national organizations to assess the possible human rights implications of a certain policy, program, project, trend or development. There is an increasing call on governments to do human rights impact assessments prior to the introduction of, for example, privatization of public services, new business plans, and trade agreements.⁶⁰

As part of such a ‘human rights impact assessment’ States can review whether the introduction of health sector reforms will increase health sector corruption. As was described above, certain reforms (eg privatization and decentralization) imply certain risks.

Returning to the ‘AAAQ-AP’, here are some examples of questions that could be raised as part of a human rights impact assessment:

- **Availability:** what will happen to the availability of health services after the proposed changes? For example, will the proposed privatization of the health sector enhance the general availability of health services?
- **Accessibility:**
 - *non-discrimination* – to what extent will health care be accessible on a non-discriminatory basis after the proposed changes? For example, are mechanisms in place to ensure that health insurers cannot refuse customers based on their financial or health status?
 - *physical accessibility* – what happens to the physical or geographic accessibility after the proposed change (eg reorganization of hospital sector)? Will health care services remain geographically accessible to everyone, also to persons living in remote areas?
 - *affordability* – to what extent does the current or proposed health setting ensure that health services are affordable? Do doctors receive adequate wages, so that they do not have to ask for informal payments? Is health insurance affordable, so that customers or patients will receive sufficient coverage for the necessary care?
 - *information accessibility* – is the public informed about the proposed changes? To what extent are mechanisms in place to oversee and guarantee the information accessibility in the doctor-patient relationship?
- **Acceptability** – is legislation in place that ensures that medical data from patients are treated confidentially by health care providers? To what extent are

healthcare providers required under the law to secure the acceptability of drugs, eg prescribing the drug that is in the best interest of the patient?

- Quality – what happens to the quality of health care services after the proposed change? Are quality control mechanisms in place to oversee all the actors in the health sector? For example, to what extent do the health workers in the private health centers receive the same training as the ones that work in the public health center?
- Accountability – are mechanisms in place to oversee all the actors in the health sector, eg when public health sector actors are turned into private ones (see also the definition of the ‘obligation to protect’ in section 8.1)? Do patients have access to a remedy once they become the victim of an abuse in the health sector?
- Participation – does the public have a say in the proposed reforms, eg through the democratic process, a public enquiry or local health boards?⁶¹

7.2 Level of health sector actors

The actors in the health sector can commit themselves to transparency and integrity by adopting ethical codes of conduct. For example, when it comes to physicians, the International Medical Code of the World Medical Association (WMA) contains several references to integrity and non-corrupt behavior. It states, *inter alia*, that a physician shall:

- ‘always exercise his/her independent professional judgment and maintain the highest standards of professional conduct’;
 - ‘not allow his/her judgment to be influenced by personal profit or unfair discrimination’;
- and

- 'not receive any financial benefits or other incentives solely for referring patients or prescribing specific products'.⁶²

These principles are important starting points for the further elaboration of the responsibilities of health workers in relation to the prevention of corrupt behavior. IshØy and Sampson suggest that the WMA could become a key player in fighting corruption in the health sector.⁶³ Another example concerns the new Physician Charter on Medical Professionalism, which was adopted in 2001 by three professional organizations covering the US and Europe, and which contains many implicit references to the prevention of corruption.⁶⁴ For the pharmaceutical industry in the US, there is now the new PhRMA Code, a Code on Interactions with healthcare professionals.⁶⁵

This author asserts that such codes could be strengthened with the insertion of clear references to human rights law. They could indicate that if a doctor's judgment is influenced by personal profit, the right to health care of the patient is potentially threatened. Explicit references could be made to the 'AAAQ-AP', for example by indicating that certain behavior may compromise the quality and the acceptability of the services by patients. Such references will make it clear that abuse and corruption compromise the rights of patients and they couple the ethical and anti-corruption framework with legal accountability under human rights law. In connection to this, it is of the utmost importance that the organizations all have internal enforcement policies to hold themselves and their staff accountable for breaches of their ethical codes.

8. Identifying health sector corruption as human rights violations

8.1 *Anti-corruption framework*

Having defined the notion of corruption, the question arises: which acts exactly lead to corruption? And subsequently: which corruption acts lead to a human rights violation? While these questions are not easy to answer, the first step is to look at the international anti-corruption legislation. At an international and regional level several anti-corruption treaties have been adopted that seek to address the issue of corruption in several sectors of society and in relation to various areas of the law.⁶⁶ While it goes beyond the scope of this paper to discuss these treaties elaborately, these instruments can be important tools in addressing health sector corruption. They can also help to further identify the links between health sector corruption and human rights.

The United Nations Convention Against Corruption (UNCAC) entered into force in 2005.⁶⁷ It does not contain a general definition of corruption.⁶⁸ It first enumerates a number of preventative measures that Member States are required to take in order to prevent corruption from occurring (see below).⁶⁹ Subsequently, in its chapter on ‘Criminalization and Law Enforcement’ it identifies and defines five acts of corruption as criminal acts:

- the *bribery* of national and foreign public officials and bribery in the private sector (the promise, solicitation or acceptance of an undue advantage);⁷⁰
- *embezzlement, misappropriation* or other diversion of property by a public official (of any property or any other things of value entrusted to the public official by virtue of his or her position);⁷¹

- *trading in influence* (the promise, solicitation or acceptance of an undue advantage with a view to obtaining an undue advantage from the public official);⁷²
- *abuse of functions* (the performance or failure to perform an act, in the discharge of his or her functions, with the purpose of obtaining an undue advantage);⁷³
- *illicit enrichment* (a significant increase in the assets of a public official that he or she cannot reasonably explain in relation to his or her lawful income).⁷⁴

It was explained above that when it comes to health sector corruption, it is of crucial importance to address non-state actors, including hospitals, insurance companies and commercial suppliers of medical health care goods and services. As a treaty under international law, UNCAC is directed primarily at Member States and not at non-state actors. The UNCAC descriptions of the corrupt acts that are mentioned above focus on the behavior of ‘public officials’. The Convention nonetheless involves society as a whole and the private sector more particularly by urging Member States to prevent corruption involving the private sector and to promote the active participation of private actors in the fight against corruption and to raise public awareness of the matter.⁷⁵ As such, Member States have so-called ‘obligations to protect’ individuals against the corrupt acts of third parties, including health care providers of goods and services.

The definition of the ‘obligation to protect’ harks back to the tripartite typology of State obligations, which is defined under human rights law. This typology, which will be discussed more elaborately below, makes a distinction between State obligations to respect, protect and fulfil human rights. The legal obligation to protect comes into play when the State is to protect the health of individuals in relation to the acts of

third parties, such as healthcare providers, pharmaceutical companies, and health insurers. As such, it is very much connected to the principle of ‘accountability’ which was defined above.

8.2 *Towards the definition of human rights violations*

The starting point for a definition of a violation under human rights law is the definition of a human rights obligation.⁷⁶ As mentioned above, human rights law distinguishes between so-called State obligations to ‘respect’, to ‘protect’ and to ‘fulfil’ the right to health. This so-called ‘tri-partite typology of State obligations’ was first introduced by Henry Shue, and later refined by several other scholars and subsequently introduced into the UN human rights regime.⁷⁷ It is generally considered to be a useful tool for analyzing positive as well as negative obligations inherent in all rights, and as such for underlining the equality and interdependence of all human rights.⁷⁸ The obligation to respect the right to health is a negative obligation to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to protect requires States to take legislative and other measures that prevent third parties including private insurers, private health care providers, and suppliers from interfering with the guarantees under the right to health. Finally, the obligation to fulfil requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health.⁷⁹ Increasingly, it is argued that such obligations can also be defined for non-State actors, including (private) hospitals and pharmaceutical companies.⁸⁰

Based on the tri-partite typology of State obligations we can now attempt to define concrete human rights violations. In other words, the starting point for the definition of a human rights violation is always (the breach of) an obligation. And since we are primarily focusing on the socio-economic right to health, it is useful to look at the definition of violations under economic, social and cultural rights. The ‘Maastricht Guidelines on Violations of Economic, Social and Cultural Rights’, which were adopted by a group of experts in 1997, define a violation of economic, social and cultural rights as follows: ⁸¹

‘A violation of economic social and cultural rights occurs when **a State** pursues, by **action or omission**, a policy or practice which **deliberately** contravenes or ignores obligations of the Covenant, or fails to achieve the required standard of conduct or result. (...)’. [emphasis added]⁸²

As suggested above, not every abuse or corrupt act can be identified as a human rights violation. Based on this definition this author asserts that there is a sliding scale where some corrupt acts can be more readily be identified as violations than others. Firstly, the Maastricht definition focuses on violations of *States*. As States are the primary responsible actors under international human rights law, we may indeed first want to focus on States, after which we can gradually identify other responsible actors in the health sector. Secondly, the above definition makes a distinction between violations through acts of *commission* and through *omission*.⁸³ This author suggest that we can draw a parallel here with violations of the obligation to respect (violations through acts of commission) and violations of the obligations to protect and to fulfil (violations through an act of omission). While the Maastricht Guidelines do not value such acts differently, this author asserts that failures to realize an obligation to ‘respect’ are more straightforward and serious in nature than a failure to realize an

obligation to protect or fulfil. For example, while stealing from the health budget by a government official (an act of commission) can be identified as a straightforward human rights violation, a failure by the government to protect individuals from being refused by health insurance companies (an act of omission) is more difficult to identify as a human rights violation. When positive obligations to ‘protect’ and to ‘fulfil’ are at stake we may want to focus on corrupt acts that occur in a structural or consistent fashion rather than on smaller incidents. As such, states and other actors can be held to violate the right to health where they *structurally* disrespect the obligations to protect and fulfil that right. There is a correlation here with the distinction between ‘grand corruption’ and ‘petty corruption’.⁸⁴ Thirdly, the Maastricht Guidelines point out that the acts should *deliberately* contravene or ignore the obligations of the Covenant. In this regard the Maastricht Guidelines suggest that the act is more serious when it concerns an *unwillingness* to comply than in case of an *inability* to comply.⁸⁵ We can speak of ‘inability’ where the doctor who is not receiving a proper wage is asking for an informal payment; while ‘unwillingness’ will be at stake when a manufacturer exerts pressure on a healthcare provider to use a certain drug.

Altogether, the most serious violations are deliberate failures of governments to ‘respect’ human rights. Governments violate this obligation when they commit one of the acts identified in the UNCAC: the *bribery* of national and foreign public officials and bribery in the private sector; the promise, the *embezzlement*, *misappropriation* or other diversion of property by a public official; and by *trading of influence* and *abuse of functions*, and *illicit enrichment*. For example, the health minister or other public

official who embezzles money from the health budget or from a foreign donation engages the State in a violation of the obligation to 'respect' the right to health.

Subsequently, we can attempt to identify human rights violations by the other actors in the health sector. Based on the above analysis, the most serious violations of non-state actors in the health sector are deliberate violations of the obligation to respect the right to health. Although the links are not as clear-cut, we can again establish a link with the corrupt acts identified in the UNCAC. Non-state actors may violate human rights law, for example, when they pay bribes to get public contracts in the health sector, steal or embezzle medicine and medical supplies or equipment for personal use, illegally bill other actors in the health sector (insurance companies, governments, patients), or try to influence health care providers to have their drugs or medical equipment selected, or steal or import counterfeit drugs.⁸⁶

9. Conclusions

This paper has sought to demonstrate that abuses in the health sector are widespread across all the actors in the health sector. Although poor nations are probably more vulnerable to such abuses, it is a global phenomenon, affecting also middle and high income countries. The abuses come in different shapes and the patterns of abuse may be affected by the type of health sector (eg tax-based versus insurance-based) and the character of health service delivery (eg public versus private). While some forms of abuse may be characterized as corrupt acts as defined under international law, other abuses do not fall under this category. Yet, all the abuses have a potential impact on the realization of the right to health and other human rights. For example, the

healthcare provider who consistently provides low-quality treatment compromises the affordability requirement under the right to health, while the pharmaceutical company who exerts pressure on a doctor to prescribe a certain drug threatens the quality and acceptability requirement as set forth in the right to health framework.

The main point that this paper has attempted to bring forward is that we need to start addressing the wide range of abuses as human rights issues. A framework was presented for addressing such abuses. It was suggested that States can assess the human rights consequences of their bills and planned reforms through human rights impact assessments prior to the introduction of such changes. The other actors in the health sector can adopt their own ethical codes of conduct and enforcement mechanisms to hold themselves accountable; and in addition to that, it is essential that governments establish accountability mechanisms to oversee all the actors in the health sector.

On other occasions, we may want to use the human rights framework to address abuses that can be identified as acts of corruption and as clear human rights violations. Addressing such violations before judicial and quasi-judicial bodies remains very challenging. Take the paying of a bribe by a private healthcare provider to get a public contract in the health sector. To start with, it is very likely that this corrupt act will be covered up. It will therefore be very difficult to prove that there has been corruption. It will also be difficult to prove that one has been the victim of this corrupt act, for example when the health insurer has refused the complainant as a patient. For it will be difficult to demonstrate that the damage suffered was caused by

the bribe. Furthermore, the fact that human rights violations of non-state actors are often at issue complicates the enforceability of the human rights violation.

Altogether a number of problematic issues remain when it comes to the legal enforcement of health sector corruption under human rights law. Yet here it should be taken into account that the enforceability of human rights law is a flexible process which is evolving gradually. For example, while this was considered problematic previously, we now have enforcement mechanisms for economic, social and cultural rights. In a similar vein it is not impossible that in the near future acts of corruption will be enforceable under the existing human rights mechanisms.

Keywords

Health sector abuse and corruption

Access to healthcare

Health rights

Biography

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This paper builds on two book chapters in which the focus was exclusively on the links between corruption and human rights: see Brigit Toebes, ‘Human Rights and Health Sector Corruption’, in J. Harrington and M. Stuttford (eds.), *Global Health and Human Rights: Legal and Philosophical Perspectives*, Routledge, 2010 (1), pp. 102-135 and Brigit Toebes, ‘Health sector corruption and human rights - a case study’, in H. Nelen & M. Boersma (eds.), *Corruption and Human Rights: Interdisciplinary Perspectives*, Antwerp: Intersentia, 2010 (2), pp. 91-125.

¹ Paul Vincke, president of the European Healthcare Fraud and Corruption Network (EHFCN), see Reuters, <http://www.reuters.com/article/idUSTRE60H01620100118>, accessed May 2010. For the report see the European Healthcare Fraud and Corruption Network (EHFCN) and the Center for Counter Fraud Services (CCFS) at Britain's Portsmouth University, *The Financial Cost of Healthcare fraud*, available at <http://www.ehfcn.org/media/documents/The-Financial-Cost-of-Healthcare-Fraud---Final-%282%29.pdf> (2009), accessed May 2010.

² For a more elaborate case study see Toebes, 2010 (2), see biography. Some of the examples were derived from Transparency International, *Global Corruption Report 2006, Special Focus – Corruption and Health*, London: Pluto Press, available at <http://www.transparency.org>, accessed May 2010.

³ For an example see Reuters, *Exclusive: Wellpoint routinely targets breast cancer patients*, April 22, 2010, available at http://news.yahoo.com/s/nm/20100422/bs_nm/us_wellpoint_cancer accessed May 2010.

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⁵ For examples see US Institute of Medicine of the National Academies (IOM), *Conflict of Interest in Medical Research, Education and Practice*, April 2009, see <http://www.iom.edu/Reports/2009/Conflict-of-Interest-in-Medical-Research-Education-and-Practice.aspx>, accessed June 2010.

⁶ See also Transparency International, *Corruption and health webpage*, available at http://www.transparency.org/global_priorities/other_thematic_issues/health, accessed May 2010.

⁷ European Healthcare Fraud & Corruption Network, *The financial cost of Healthcare fraud*,

⁸ UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment 14 on the Right to the Highest Attainable Standard of Health, UN Doc. E/C.12/2000/4, August 11, 2000.

⁹ Global Civil Society Organization leading the fight against corruption, see <http://www.transparency.org/>, accessed June 2010.

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- ¹¹ See also Hunt and Backman, see note 11, p. 8.
- ¹² WHO, 'Everybody's Business: Strengthening Health Systems to Improve Health Outcomes', 2007, p. 2, available at http://www.searo.who.int/LinkFiles/Health_Systems_EverybodyBusinessHSS.pdf accessed May 2010. See also, for example, M. Mackintosh, and M. Koivusalo, 'Health Systems and Commercialization: In Search of Good Sense', *Commercialization of Health Care: Global and Local Dynamics and Policy Responses*, Palgrave Macmillan, Hampshire/New York, 2005, pp. 3-21, at pp. 5-6.
- ¹³ General Comment 14, see note 9.
- ¹⁴ For corruption in accessing safe drinking water see Transparency International's *Global Corruption Report 2008*, 'Corruption in the Water Sector', available at <http://www.transparency.org/publications/gcr>, accessed May 2010.
- ¹⁵ William Savedoff and Karen Hussmann, 'Why are health systems so prone to corruption?', in Transparency International, see note 3, pp. 4-7, pp. 8-10, For an overview of how these actors interact see Savedoff, *Transparency and Corruption in the Health Sector: A Conceptual Framework and Ideas for Action in Latin American and the Caribbean*, Health Technical Note 03/2007, May 2007 (Inter-American Development Bank, Washington, D.C), available at <http://idbdocs.iadb.org/wsdocs/getdocument.aspx?docnum=1481625>, accessed May 2010, p. 3.
- ¹⁶ Usually, their issues are addressed in terms of 'conflicts of interest'. See IOM, see note 6.
- ¹⁷ Transparency International, see note 3.
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- ¹⁹ Savedoff Hussmann, see note 16, pp. 4-7.
- ²⁰ Torben IshØy and Steven Sampson, *Corruption in Hospital Care Systems: Findings of an International Survey* (unpublished paper), 2010 (the authors are members of the Danish chapter of TI), p. 4. They draw a comparison between the scores on the Corruption Perception Index and rankings on the Human Development Index.
- ²¹ Michael S. Sparrow, 'Corruption in health care systems: the US experience', in TI, see note 2, pp. 16-22 and the Health Care Renewal Blogspot, at <http://hcrenewal.blogspot.com:80/>, accessed February 2010.
- ²² Transparency International, see http://www.transparency.org/global_priorities/other_thematic_issues/health, accessed May 2010.
- ²³ Table derived from Macroeconomics and Health: Investing in Health for Economic Development - Report of Working Group 3, 2002, World Health Organization Commission on Macroeconomics. See the webpage of U4, Anti-corruption resource centre, at <http://www.u4.no/themes/health/causesandconsequences.cfm>, accessed May 2010.
- ²⁴ WHO Table, note 25.
- ²⁵ WHO table, see note 24.
- ²⁶ Mackintosh and Koivusalo, see note 13, p. 8.
- ²⁷ Mackintosh and Koivusalo, see note 13, p. 8.
- ²⁸ IshØy and Sampson, see note 21.
- ²⁹ Transparency International, at http://www.transparency.org/global_priorities/other_thematic_issues/health/health_systems (accessed May 2010).
- ³⁰ Brigit Toebes, 'The Right to Health and the Privatization of National Health Systems: A Case Study of the Netherlands', *Health and Human Rights*, Vol. 9, No. 1, 2006, p. 114-11, at p. 105, and Brigit Toebes, 'Taking a human rights Approach to Healthcare Commercialization', in Patricia A. Cholewka and Mitra M. Motlagh (eds.), *Health Capital and Sustainable Socioeconomic Development*, Taylor & Francis, 2008, at pp. 441-459.
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- ³² International Federation for Human Rights (FIDH), *Serbia: discrimination and corruption, the flaws in the health care system*, No. 416/2, April 2005, p. 24.
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- ³⁴ See the Transparently international website at http://www.transparency.org/news_room/faq/corruption_faq (accessed May 2010).

³⁵ António Barbosa da Silva, 'Autonomy, Dignity and Integrity in Health Care Ethics – A Moral Philosophical Perspective', in Sinding Aasen, Henriette, Rune Halvorsen, António Barbosa da Silva (ed.), *Human Rights, Dignity and Autonomy in Health Care and Social Services : Nordic Perspectives*, Antwerp: Intersentia, 2009, pp. 13-68, at p. 32, referring to M. Andersson, *Integritet som begrep och princip: en studie av ett vårdetiskt ideal I utveckling* [Integrity as a concept and principle: a study of an ideal of health care in development] (Åbo Academic Press, 1994), pp. 32-37.

³⁶ Barbosa da Silva, see note 35, p. 20. Based on Ronald Dworkin, *The Theory and Practice of Autonomy*, Cambridge University Press, 1988, p. 102.

³⁷ Barbosa da Silva, see note 35, p. 32.

³⁸ See IOM, see note 6.

³⁹ For an excellent report on dual loyalty see Physicians for Human Rights, *Dual Loyalty and Human Rights in Health Professional Practice: Proposed Guidelines and Institutional Mechanisms*, USA: 2002, available at <http://physiciansforhumanrights.org/library/report-dualloyalty-2006.html>, accessed June 2010.

⁴⁰ David H. Bayley, 'The effects of corruption in a developing nation', *Political Research Quarterly*, 19 (4), 1966, pp. 719-732, at pp. 727-730 (nine reasons in total are presented as to why corruption could be beneficial in developing nations).

⁴¹ For a discussion see Savedoff, see note 16, p. 2.

⁴² Transparency International, see http://www.transparency.org/news_room/faq/corruption_faq, accessed May 2010.

⁴³ In this respect the definition is more useful for our purposes than for example Bardhan's definition: 'the abuse of *public* office for personal gain' [emphasis added]. P. Bardhan, 'Corruption and development: a review of issues.' *Journal of Economic Literature*, September 1997, no. 25, pp. 1320-1346. See also Savedoff, see note 16, p. 2 and Daniel Kaufmann and Pedro C. Vicente, 'Corruption, Governance and Security: Challenges for the Rich Countries and the World', 2005, available at www.worldbank.org/wbi/governance, accessed May 2010.

⁴⁴ U4, FAQ, available at <http://www.u4.no/document/faqs5.cfm#pettycorruption>, accessed May 2010.

⁴⁵ U4, FAQ, available at <http://www.u4.no/document/faqs5.cfm#pettycorruption>, accessed May 2010.

⁴⁶ For a useful report see International Council on Human Rights Policy, *Corruption and Human Rights: Making the Connection*, Switzerland: International Council on Human Rights Policy, 2009.

⁴⁷ Goodwin and Rose-Sender, see note 13.

⁴⁸ In addition to Article 12 International Covenant on Economic, Social and Cultural Rights (ICESCR), the right to health is recognized by provisions in a number of other international human rights instruments, including Article 25 of the Universal Declaration on Human Rights (UDHR); Article 5(e) of the International Convention of All Forms of Racial Discrimination (CERD); Articles 11.1 and 12 of the Convention on the Elimination of All forms of Discrimination Against Women (CEDAW) and Article 24 of the Convention on the Rights of the child (CRC). At the regional level we come across the right to health in Article 11 of the (revised) European Social Charter (ESC), in Article 16 of the African Charter of Human and Peoples' Rights and in Article 10 of the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights. Furthermore, over 100 national constitutional provisions include a right to health.

⁴⁹ General Comment 14, see note 9.

⁵⁰ General Comment 14, see note 9, paragraph 3.

⁵¹ Right to life: *inter alia*, article 6 of the International Covenant on Civil and Political Rights (ICCPR), Article 2 European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR); principle of non-discrimination: *inter alia*, common Article 2 of the ICCPR and the International Covenant on Economic, Social and Cultural Rights (ICESCR), freedom of expression and the right to information: *inter alia*, Articles 19 ICCPR and 10 ECHR; the right to (political) participation: *inter alia*, Article 25 ICCPR, the right to a remedy: *inter alia*, Articles 2(3) ICCPR and 13 ECHR.

⁵² General Comment 14, see note 3, paragraph 12.

⁵³ See in particular the UN General Comments on the rights to water, education, food and housing, available at [http://www.unhchr.ch/tbs/doc.nsf/\(Symbol\)/E.C.12.GC.17.En?OpenDocument](http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/E.C.12.GC.17.En?OpenDocument), accessed May 2010. For an example of the use of these principles in a national context, see Toebe, 2006, see note 31, p. 105.

⁵⁴ See Articles 25 ICCPR, 23(2) American Convention on Human Rights, and 13(1) African Convention on Human and Peoples' Rights.

⁵⁵ See General Comment 14, see note 3, paragraphs 11 and 59-62.

⁵⁶ Helen Potts, *Participation and the Right to the Highest Attainable Standard of Health*, and *Accountability and the Right to the Highest Attainable Standard of Health*, University of Essex Human Rights Centre (no date mentioned), available at http://www.essex.ac.uk/human_rights_centre/research/rth/docs/Participation.pdf , accessed May 2010.

⁵⁷ Derick Brinkerhoff, 'Accountability and Health Systems: Overview, Framework and Strategies', January 2003, available at <http://www.who.int/management/partnerships/accountability/AccountabilityHealthSystemsOverview.pdf> , accessed May 2010.

⁵⁸ See Potts, *Accountability and the Right to the Highest Attainable Standard of Health*, University of Essex Human Rights Centre, available at http://www.essex.ac.uk/human_rights_centre/research/rth/docs/HRC_Accountability_Mar08.pdf , accessed May 2010. According to Potts, monitoring is aimed at providing governments the information that they need to create transparent health policies, as well as providing rights-holders with essential health-related information, 'Accountability mechanisms' can be judicial or quasi-judicial (for example a health ombudsman or other independent complaint mechanism), as well as administrative, political or social in character, and Potts mentions the following forms of remedies: restitution, compensation, rehabilitation, and satisfaction, and guarantees of non-repetition.

⁵⁹ For a comprehensive overview see Potts, see note 57.

⁶⁰ For an elaborate analysis of a human rights impact assessment for the right to health see Paul Hunt and Gillan MacNaughton, *Impact Assessments, Poverty and Human Rights: A Case Study Using The Right to the Highest Attainable Standard of Health*, available at http://www.who.int/hhr/Series_6_Impact%20Assessments_Hunt_MacNaughton1.pdf , accessed June 2010.

⁶¹ For a similar analysis in relation to health care privatization and commercialization see also Toebes, 2006 and 2008, see note 31.

⁶² World Medical Association (WMA), International Code of Medical Ethics, last amended in 2006, available at <http://www.wma.net/en/30publications/10policies/c8/index.html> , accessed May 2010. On the independence and 'dual loyalty' of doctors see also Physicians for Human Rights, 2002, see note 40.

⁶³ IshØy and Sampson, see note 21, p. 6.

⁶⁴ Examples are the 'Principle of social justice', the 'Commitment to honesty with patients', the 'Commitment to maintaining appropriate relations with patients', the 'Commitment to a just distribution of finite resources', and the 'Commitment to scientific knowledge'. ABIM Foundation (American Board of Internal Medicine), ACP Foundation (American College of Physicians), and the European Federation of Internal Medicine (EFIM), "Medical Professionalism in the New Millennium: A Physician Charter", available at <http://www.annals.org/cgi/content/full/136/3/243> (accessed May 2010). See also, for example, the Principles of Medical Ethics of the American Medical Association, available at <http://www.cirp.org/library/statements/ama/> , (accessed May 2010).

⁶⁵ See <http://www.phrma.org/files/attachments/PhRMA%20Marketing%20Code%202008.pdf> .For criticism to this code see The Carlat Psychiatry Blog, at <http://carlatpsychiatry.blogspot.com/2010/04/medical-societies-new-ethics-code.html> . accessed May 2010.

⁶⁶ See the Inter-American Convention Against Corruption (1996); the OECD Convention on Combating Bribery of Foreign Public Officials (1997); the Council of Europe Criminal Law Convention on Corruption (and Additional Protocol) (1999) and the Civil Law Convention on Corruption (1999); the Convention drawn up on the basis of Article K.3 (2) (c) of the Treaty on European Union, on the fight against corruption involving officials of the European Union Communities or officials of Member States of the European Union (1999); the Southern African Development Protocol Against Corruption 2001; the African Union Convention on Preventing and Combating Corruption (2002) and the UN Convention on Corruption (2003) that is discussed below. For an overview see Indira Carr, 'The United Nations Convention on Corruption: Making a Real Difference to the Quality of Life of Millions?', 3 *Manchester J. Int'l Econ. L.* 11 2006, p. 11, and International Council on Human Rights Policy, see note 47, pp. 18-21.

⁶⁷ The UNCAC was adopted in 2003 by the UN General Assembly (resolution 58/4 of 31 October 2003). It entered into force in 2005 and has now been ratified by 144 Member States. In accordance with article 68 (1) of the afore-mentioned resolution, the Convention entered into force on 14 December 2005. See <http://www.unodc.org/unodc/en/treaties/CAC/index.html> , accessed May 2010.

⁶⁸ For example, the Council of Europe Conventions contain a description of corruption in Article 2.

⁶⁹ Chapter II of the UNCAC.

⁷⁰ Articles 15, 16 and 21 UNCAC (in Chapter III: ‘Criminalization and Law Enforcement’). A distinction is generally made between active bribery (offering a bribe) and passive bribery (passive bribery). If the undue advantage is given in the context of international business the act is called transnational bribery, while bribery solely involving the private sector is addressed as bribery in the private sector. See International Council of Human Rights Policy, see note 47, p. 19.

⁷¹ Article 17 UNCAC.

⁷² Article 18 UNCAC.

⁷³ Article 19 UNCAC.

⁷⁴ Article 20 UNCAC.

⁷⁵ Part II - Articles 12 and 13 UNCAC.

⁷⁶ See, *inter alia*, Audrey R. Chapman, *Violations of the Right to Health*, in: T.C. van Boven, C. Flinterman and I. Westendorp (eds.), *The Maastricht Guidelines on Violations of Economic, Social and Cultural Rights*, Utrecht: SIM, 1998, pp. 87-112.

⁷⁷ H. Shue, *Basic Rights, Subsistence, Affluence and U.S. Foreign Policy*, (New Jersey: Princeton, 1980), A. Eide, ‘Economic, Social and Cultural Rights as Human Rights’, in *Economic, Social and Cultural Rights: A Textbook*, Dordrecht/Boston/London: Martinus Nijhoff Publishers, 2001, pp. 21-41, and G.J.H. van Hoof, ‘The Legal Nature of Economic, Social and Cultural Rights: a Rebuttal of Some Traditional Views,’ in P. Alston and K. Tomaševski (eds.), *The Right to Food* (Utrecht: SIM, 1984), 97-111

⁷⁸ For a more critical analysis of this concept see Ida Elisabeth Koch, ‘Dichotomies, Trichotomies or Waves of Duties?’, *Human Rights Law Review* 5:1 (2005), 81-103, pp. 91-93.

⁷⁹ General Comment 14, see note 9, paragraphs 34-37.

⁸⁰ For an elaboration of such duties see Brigit Toebes, 2010, see biography. See also Right to Health Unit of the Essex University Human Rights Centre, Draft Human Rights Guidelines for Pharmaceutical Companies, available at http://www.essex.ac.uk/human_rights_centre/research/rth/projects.aspx , accessed May 2010.

⁸¹ Maastricht Guidelines on Violations of Economic, Social and Cultural Rights, Maastricht, January 22-26, 1997, available at http://www1.umn.edu/humanrts/instree/Maastrichtguidelines_.html , accessed May 2010.

⁸² Maastricht Guidelines, see note 82, paragraph 11. This paragraph also indicates that an act of discrimination constitutes a violation.

⁸³ Maastricht Guidelines, see note 82, paragraphs 14 and 15.

⁸⁴ U4, see note 24.

⁸⁵ Maastricht Guidelines, see note 82, paragraph 13: a State claiming that it is unable to carry out its obligations for reasons beyond its control has the burden of proving that this is the case.

⁸⁶ For more concrete examples see Toebes, 2010, see biography.