



universität
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MASTER-THESIS

Titel der Master-Thesis

„Assessment of the adequacy of Romania’s measures
to protect the right to health against corruption“

Verfasserin

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angestrebter akademischer Grad

Master of Arts (MA)

Wien, 2015

Studienkennzahl lt. Studienblatt: A992884

Universitätslehrgang: Master of Arts in Human Rights

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Acknowledgements

It is with immense gratitude that I would like to acknowledge the guidance of my supervisor, Mag. iur. Martin Kreutner, MSc. It is an honour for me to have the support of such a professional. Without his enriching and quick feedback to my research, completing this thesis would not have been possible.

In the health sector, I would like to thank all of the patients for taking their time to fill in the questionnaire that helped me complete my thesis. I wish them strength and a quick recovery! This thesis is dedicated to all of those who fight for their right to health and for a corruption free zone in the health sector worldwide.

I would like to acknowledge my parents for giving me the opportunity to study a field of my choice at an international university. I feel very fortunate to conclude the Master in Human Rights at the University of Vienna with this research.

Friends and dear sister, thank you for spending many of your nights debating the topic of this research with me

LIST OF ABBREVIATIONS, ACRONYMS AND SYMBOLS

%	Per cent
€	Euro currency
\$	American Dollar currency
AAAQ	Availability, Accessibility, Acceptability and Quality
ANAF	Romanian National Agency for Fiscal Administration
ANI	Romanian National Integrity Agency
ANM	Romanian National Agency of Drugs and Medical Devices
ARC	Alliance for a Clean Romania
Art.	Article
CE	Council of Ethics
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
Chap.	Chapter
CNAS	National Health Insurance House of Romania
CoE	Council of Europe
CRC	Convention on the Rights of the Child
DLAF	Romanian Fight Against Fraud Department
DNA	National Direction of Anti-corruption
EC	European Commission
ECOSOC	Economic and Social Council
e.g.	Example given
ESC	European Social Charter
EU	European Union
FABC	Federation of Association of Ill Persons
FCPA	Foreign Corrupt Practices Act
FDSC	Foundation for the Development of the Civil Society
GA	General Assembly
GDP	Gross Domestic Product
GOPAC	Global Organisation of Parliamentarians against Corruption
GRECO	Group of States against Corruption
HG	Romanian Governmental Decision
HIV/AIDS	Human immunodeficiency virus infection/ Acquired Immune Deficiency Syndrome
HRC	Human Rights Committee
IACA	International Anti-Corruption Academy
ICESCR	International Convention on Economic, Social, and Cultural Rights
ICJ	International Court of Justice

IO/IOs	International Organisation/International Organisations
INGO	International Non-Governmental Organisation
MDGs	Millennium Development Goals
mill.	Million/Millions
MPH	Ministry of Public Health
n/a	Not Available
No.	Number
NGO/NGOs	Non Governmental Organisation/ Non Governmental Organisations
NHS	National Health Strategy
OECD	Organisation for Economic Co-operation and Development
OHCHR	Office of the High Commissioner for Human Rights
OLAF	European Anti-Fraud Office
p. /pp.	Page/Pages
Para./paras.	Paragraph/Paragraphs
Pers.	Persons
Res.	Resolution
SG	Secretary General
SNA	National Anti-corruption Strategy
sub-para.	Sub-paragraph
TI	Transparency International
UDHR	Universal Declaration of Human Rights
UK	United Kingdom
UKBA	United Kingdom Bribery Act
UN	United Nations
UNCAC	United Nations Convention against Corruption
UNDP	United Nations Development Programme
UPR	Universal Periodic Review
U.S.	United States of America
WB	World Bank
WHO	World Health Organisation

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Chapter I

Introduction

This first chapter will present the rationale of the research topic, the reason of the chosen topic, the research question, along with its hypotheses, as well as the general layout of the dissertation and its limitations.

1.1. Rationale

In a period where corruption is a worldwide concern, where States allocate financial and human resources to crop corruption, where countries also construct national anti-corruption strategies and authorities and where the international community organises conferences, adopt conventions and creates entities to combat corruption; this present dissertation links corruption to human rights and researches in particular the adequacy of measures taken by a State to protect the right to health against corruption (in Romania).

The interest in the linkage between corruption and the right to health came during an assignment during a six-month internship at the International Anti-Corruption Academy (IACA) in Austria. In this context, a thesis correlating corruption to human rights seemed appropriate and accessible. The thesis is focused on my home country, Romania, as many of the research documents are accessible in Romanian (my mother tongue).

1.2. Research question and hypothesis

In Romania, corruption in the public oncological sector has been exposed to criticism since 2010. International and national media, NGOs, national institutions, the international community and patients themselves have pointed to this problem but no source has closely analyzed the situation in order to see how adequate the State's measures are in protecting the public health sector against corruption. The research problem lies in the fact that corruption is hindering the full enjoyment of patients' availability, accessibility, acceptability and quality (AAAQ) of the right to health in the oncological public health sector in Romania. In this matter,

the research question assesses if Romania's measures are adequate to protect the right to health in the oncological public health sector against corruption.

This Master thesis is focused on assessing to what extent Romania's measures are adequate to protect the right to health against corruption. The dependent variables (or explained variable) are the right to health and corruption. The independent variables are the State's measures (or explanatory variable).

Regarding the relationship between theory and research, the thesis uses deductive reasoning. Data is collected in order to accept or reject hypothesis (the top-down approach).¹ For this research, positive and negative hypotheses are considered:

Positive Hypothesis: Romania's measures are properly adequate to protect the right to health in the oncological public health sector against corruption because they permit the availability, accessibility, acceptability of the right to health.

Negative Hypothesis: Romania's measures are not adequate to protect the right to health in the oncological public health sector against corruption because they do not permit the availability, accessibility, acceptability of the right to health.

1.3. Layout of the dissertation

This dissertation will start with a literature review in order to establish the context regarding corruption, the right to health and their relationship at the global level (first part) and in Romania (country specific, second part). The following chapter will present the background problem throughout various sources. Next, the consequences of the findings on the availability, accessibility, acceptability and quality of the right to health will be discussed. This chapter is essential in understanding the relation between corruption and the right to health in the oncological health sector in Romania, in order for the next chapter to assess the adequacy of Romania's measures in protecting the right to health in the oncological public health sector against corruption. The chapter will evaluate the adequacy of Romania's measures by measuring the impact of the findings on the availability, accessibility, acceptability and quality of the right to health. The dissertation will end with a review of the findings, a series of recommendations for

¹Theory→ Hypothesis→ Observation→ Confirmation. William M.K. Trochim, (Professor at Cornell University), "Research Methods Knowledge Base", <http://www.socialresearchmethods.net/kb/dedind.php>, consulted on 17 January 2015

Romania's measures, as well as for future researches and some closing remarks (See Chapter II, 2.2, for a detailed overview of each chapter's design and methods).

1.4. Strengths and weaknesses

The main discipline of focus is the political science perspective, as it is also written by a political scientist. However, the research will also focus on the legal perspective. The dissertation will deal with issues such as health and anti-corruption strategies, legislation, national reports, policies, monitoring systems and others.

The aim of this dissertation is similar to a fact-finding mission, as it does not seek to blame and shame, but rather to identify the gaps and strengths of a system and assess how adequate measures can be, in order to protect the right to health against corruption. If the outcome of this thesis will be taken into account during a reform of Romania's measures, the right to health will benefit from properly adequate measures, which are optimal for making the health sector less prone to corruption.

The outcome of this dissertation could serve for other countries dealing with the same challenges, especially in those states where corruption is one of the major elements hindering the health system, or any other system. Although this research uses indicators and benchmarks adapted specifically to the topic, the same indicators can be adapted to countries worldwide that intend to rethink the adequacy of their own measures to protect general human rights against corruption.

This dissertation will not search for the causes of corruption in the oncological public health sector. The research will be limited for the period 2010-2015 and it will focus on Romania's measures concerning four indicators: the legal context, the national strategy and plan of action, the participation and coordination and the monitoring and accountability indicators.

This dissertation, as any other, has certain limitations. Aside from the space limitation that it is required to respect, the findings of the research are not definitive facts, as the dissertation is based on a number of non exhaustive lists of items, indicators and sources. Romania's measures and their implementation are constantly evolving and more indicators should be evaluated for more complete conclusions. Moreover, this research evaluates Romania's measures from the contemporary period, focusing on the past 5 years, thus, changing the timeframe of analysis could also change the outcome.

Chapter II

Methodology

The chapter on methodology describes the research methods used to create the thesis. This section will discuss how relevant data is organised and collected.

2.1. Research methods

For the purpose of this thesis, it is first necessary to present the background problem (corruption in the oncological public health sector) and to understand how corruption harms the right to health. It is only after, that the adequacy of Romania's measures to protect the right to health against corruption can be analysed. This adequacy is evaluated through the WHO elements of the right to health (AAAQ) and each benchmark will be "weighed" in terms of the availability, accessibility, acceptability and quality that are offered in the oncological public health sector. This is why the qualitative approach is suitable, together with some quantitative features.

2.2. Research Design

Chapter III on theory gathers qualitative information on corruption, the right to health and their relationship. It goes from general data (part A) to the specific case of Romania (part B). The first part collects theories, perceptions, indicators for measurement, definitions, concepts, history, situations linking corruption to human rights and corruption to the right to health, justice cases and international structures. The second part underlines perceptions of corruption in Romania, Romania's anti-corruption structures and obligations, Romania's health structures and obligations and relations between corruption and the right to health in Romania.

The Chapter IV on the background problem is presented through a qualitative method: the analysis of corruption through a non exhaustive list of sources: international and national

media, NGOs, national institutions, the international community and patients (via questionnaires). The aim is to understand how these sources describe corruption in the oncological public health sector in the period 2010-2015. The problem is measured and interpreted using the AAAQ criteria. The findings are presented in a matrix aiming to design a landscape of corruption in its different forms in the period 2010-2015 and then to identify how each finding affects the availability, accessibility, acceptability and quality of the right to health.

After understanding the relation between corruption and the right to health in the oncological health sector, Chapter V aims to evaluate Romania's measures that are meant to protect the right to health against corruption. Data will be collected through specific benchmarks (details to look at inside an indicator) for each of the following indicators: the legal context, the national strategy and plan of action, the participation and coordination and the monitoring and accountability indicators.

There is no specific recognised method of interpreting the adequacy of Romania's measures. International organisations are currently working on developing such a system of indicators, but it is difficult to answer the question on how indicators can be used appropriately.² For the purpose of this thesis, the indicators chosen to analyse the adequacy of Romania's measures are chosen from the ones recommended by the UN Economical and Social Council (E/CN.4/2006/48; 3 March 2006)³.

Although indicators can be used independently from the dissertation, the chosen benchmarks are formulated exclusively to fit the purpose of the thesis.

The findings of each assessed indicator will answer the research question by first responding if and how each finding is available, accessible, and acceptable and of good quality for protecting the right to health against corruption. This type of results will help provide a comprehensive analysis (mainly based on qualitative data) of the gaps Romania's measures are facing and how those measures affect each indicator. This thesis should not be a blaming and shaming procedure. This dissertation should be able to help the State to further review its problems and take into account the recommendations proposed in the conclusions. The final

²Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (Mr. Paul Hunt), E/CN.4/2006/48; 3 March 2006, <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G06/114/69/PDF/G0611469.pdf?OpenElement>, pp. 8-9.

³Idem

outcome will be presented using charts and explanatory tables. The conclusion will then confirm or infirm the positive and negative hypotheses of the dissertation.

2.3. Sources and data collection

This thesis mainly emerged from a primary report of the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt⁴. The UN report will be used as the main source in order to best adapt the indicators to the specific theme of the thesis.

In addition, another source used in the development of this thesis is the work of Karen Hussmann entitled “Addressing corruption in the health sector”, published in January 2011 at the U4 Anti-Corruption Resource Centre. This paper is a source of information regarding general matters on connections between corruption and the right to health.

The book on Human Rights Indicators provided by the United Nations Human Rights Office of the High Commissioner, in 2012, is an important guide for measuring the adequacy of State’s measures. It is a complex book offering illustrative indicators and benchmarks on the right to health that can be used for the purposes of this thesis.

One last publication that needs to be mentioned is the paper of Maureen Lewis, “Governance and Corruption in Public Health Care Systems”, published by the Centre for Global Development in January 2006. This paper is a source of factual evidence on corruption, informal payments and mismanagement in the public health sector in developing countries.

This thesis will collect information from both primary and secondary sources. Every chapter is equipped with balanced sources, citing monographs, scientific articles, legal documents, governmental open sources, periodical reports and publications by different national authorities from Romania and elsewhere, as well as information from NGOs’ and IOs’ statistics and reports, films, reportage, newspapers, television news, booklets, brochures, declarations, recommendations and questionnaires (See bibliography).

2.4. Questionnaires

⁴Report of the Special Rapporteur, E/CN.4/2006/48; 3 March 2006, op. cit.

The questionnaire⁵ applied in chapter III uses a quantitative approach in order to collect primary data. As it is impossible to question each and every person affected by cancer on their knowledge of corruption in the oncological public sector, the methodology in questioning cancer patients is applied in six hospitals in Bucharest⁶ (there are six districts in Bucharest, one hospital per district chosen alphabetically). Since most hospitals have their own privacy policy on disclosing patient confidential data (such as name, e-mail address, etc), it is difficult to get in contact with cancer patients by other means than contacting them face-to-face in hospitals (the location that reveals that a certain person is familiar with the oncological public health system). For this reason, the questionnaire was administered in person by distributing one standard copy of the questionnaire per patient in Romanian. The administration of the questionnaires lasted five hours/day for six working days in the six public hospitals chosen for this case study. For each of the six days, a different timeframe was used for the five hours, in order to allow for a bigger diversity of age category, number of people, etc.

The aim of the questionnaire was not completely disclosed to the patients. According to its title, the questionnaire pursued the general evaluation of healthcare services provided in a specific hospital, however the majority of the questions are formulated in the interest of obtaining corruption-related information. Not entirely revealing the specific interest of the study allowed obtaining objective and fearless answers (as some persons can be reluctant in discussing the issue of corruption freely).

The number of respondents was impossible to anticipate, as each hospital can appoint a different number of patients per day. The number of respondents rose to 63 persons. Participants in the questionnaire have been asked to leave a contact address (e-mail, tel. or post address), if a follow-up of the questionnaire is wanted. As requested, 6 of the respondents are in possession of a detailed outcome of the questionnaire (Appendix B).

⁵ See Appendix B for a questionnaire sample and Appendix C for a detailed report on questionnaires' findings.

⁶This type of study cannot have a specific choice of hospitals (not the best and not the worse ones, as the corruption factor can be absent in the best ranked hospitals or too much present in the last ranked hospitals). Hospitals were then chosen in alphabetical order (first hospital starting with A for the first district, starting with B for the second district, and so on until the sixth district). The used alphabetical list of hospitals was the one provided by the Medical College of Bucharest. See <http://www.cmb.ro/spitale/>, consulted on 18 January 2015. The outcome of the chosen hospitals is: 1st district- *Spitalul Universitar de Urgente Elias*, 2nd district- *Spitalul Clinic Colentina*, 3rd district- *Spitalul Clinic Coltea*, 4th district- *Spitalul de Bolnavi Cronici si Geriatrie "Sf. Luca"*, 5th district- *Spitalul Clinic Prof. Dr. Burghiele*, 6th district- *Spitalul Universitar de Urgent a Bucuresti*

Chapter III

Theoretical Framework

This chapter will discuss some of the existing literature on corruption, the right to health and correlations (facts and figures) between them. It goes from general matters (part A) to the specific context of Romania (Part B), as it is the country analysed in this thesis.

A. 3.1. The phenomenon of corruption

The phenomenon of corruption is probably too old to be tracked down. Corruption happens in all societies, on all continents and it can affect the political, economical, social, educational environment or even all together. Corruption existed at the royal court, it existed in Empires, in totalitarian regimes, as well as in democratic ones and it transgresses all epochs of human kind.

Corruption is a concept cited even in religious scripts. The Bible uses the word corruption to remind of a sinful world: “He has granted to us his precious and very great promises, so that through them you may become partakers of the divine nature, having escaped from the corruption that is in the world because of sinful desire.”⁷

Experts attest that even the Codex Hammurabi (about 1800 BC) applied punishment to public officials for acts of corruption.⁸

In the Roman Catholic Church of the 16th century, it was believed that individuals could buy their place in Heaven by offering money or goods to their priests and therefore attain salvation for their soul. If one could interpret this gesture based on a legal document from the 21st century, it could be seen as an act of corruption.

In 1977, the Foreign Corrupt Practices Act (FCPA) of the US became effective. It is a federal law aiming to account for transparency by declaring the illegality of bribery of foreign officials

⁷ Bible, 2 Peter 1:4

⁸ Martin Kreutner in M. Nowak, All Human Rights for All: Vienna Manual on Human Rights, Vienna, Intersentia, 2012, p.548

(the law especially targeted private companies). The UK (based on the same principle as the FCPA) established the Bribery Act in 2010. The UKBA is an Act of the UK Parliament that “makes provision about offences relating to bribery”.⁹ On the same note, the Russian legislation (2013) “goes beyond the FCPA and the UKBA as nothing in the law limits its application to commercial organizations or to purely Russian organizations”.¹⁰

Since the 90s, the number of conventions and documents on fighting corruption has been booming. New documents emerged, such as the Inter-American Convention against Corruption (1996), the OECD Convention on Combating Bribery of Foreign Public Officials in International Business Transactions (1997), the CoE Criminal Convention and the Civil law Convention on Corruption (1999), the African Union Convention on Preventing and Combating Corruption (2003) as well as the United Nations Convention against Corruption (UNCAC, 2003). All of these documents represent a union and the acknowledgment of the need of anti-corruption regimes worldwide. This is why the International Anti-Corruption Academy was created in 2010 as a place where States from all over the world could gather their forces in learning mechanisms and exchanging ideas on fighting corruption.

Today, there are various international structures that fight corruption, contribute to practices against corruption and develop new anti-corruption strategies. To name some of those structures: the Global Organizations of Parliamentarians Against Corruption (GOPAC), the European Partners Against Corruption (EPAC), the Basel Institute on Governance, the Group of States Against Corruption (GRECO) and others.

⁹ UK Government website, <http://www.legislation.gov.uk/ukpga/2010/23/introduction> (accessed 15 July 2015)

¹⁰ Th. Firestone, “New Russia law goes beyond FCPA, Bribery Act”, 5 March 2013, FCPA Blog, <http://www.fcpablog.com/blog/2013/3/5/new-russia-law-goes-beyond-fcpa-bribery-act.html> (accessed 10 February 2015)

A. 3.1.1. Definitions and typology

As there is no single worldwide used definition for corruption, it is important to understand the definitions (plural) of corruption, and not only one definition (singular) on corruption. Corruption comes from the Latin word *corrumpere* which means destroy, annihilate, break.¹¹

Since corruption is in continuous evolution and manifests itself differently from one society to another, it is one of the phenomena that does not have a universally agreed upon definition. However, corruption is not the only word without an international definition. The same happens with concepts such as terrorism, journalist, civil society, etc. When corruption is discussed in resolutions or conventions, the word has a non exhaustive list of interpretations. By not defining corruption, more (and even all) corrupt behaviours can be included. The only certain fact is that corruption is evolving in terms of techniques and tools.

In 2002, at the beginning of the United Nations Conventions against Corruption (UNCAC), the agreed option was to include a list with corruption typologies instead of a static definition of corruption.¹²

There are ways of defining corruption by impact, as grand or petty corruption, or by modalities, as active or passive corruption (as well as others public and private corruption or domestic and international corruption). Corruption can be ranged by typology and it can go from bribery to embezzlement, abuse of functions, trading in influence, illicit enrichment, laundering of proceeds of crime, conflict of interest or concealment¹³.

While looking for definitions of corruption in the available literature, one common feature is revealed: the use of a position of power for an illegitimate benefit. In *Corruption and Government*, Rose-Ackerman defines corruption as the “misuse of public power for private gain”.¹⁴ Joseph S. Nye defines corruption as a “behaviour which deviated from the normal

¹¹ Robert Klitgaard, *Controlling Corruption, USA*, University of California Press, 1988, p. 23

¹² Ch. Sampford, A. Shacklock, C. Connors and F. Galtung, *Measuring Corruption*, USA, Ashgate Publishing Limited, 2006, p. 9

¹³ UNCAC, http://www.unodc.org/documents/treaties/UNCAC/Publications/Convention/08-50026_E.pdf (accessed 11 March 2015)

¹⁴ Susane Rose-Ackerman, *Corruption and Government: Causes, Consequences, and Reform*, USA, Cambridge University Press, 1999, p. 91

duties”¹⁵. However, the problem that arises from Nye’s definition is that individuals living in societies where a corrupt behaviour represents a habit of the daily life cannot be seen as deviating, as it is a part of a practice of the majority.

The Oxford dictionary cites corruption as “dishonest or fraudulent conduct by those in power, typically involving bribery”¹⁶. The Cambridge dictionary defines the concept as “illegal, bad or dishonest behaviour, especially by people in positions of power”¹⁷.

For the immediate purpose of the thesis (analysis of corruption in the public healthcare system), corruption will be referred to as the misuse of public power for private benefits that can happen through various modalities as earlier discussed in this chapter. However, this definition exempts some sectors from being accused of corruption. The most appropriate definition for including various types of corruption from every sector (the private sector as well) will be the one used by Transparency International or the European Commission (and others): “the misuse/abuse of entrusted authority/power for private gain”.¹⁸ This last definition, also including private sector corruption, calls “for a discourse that goes beyond criminal justice frameworks” and accepts the concept of corruption coming from different cultures (different moral systems).¹⁹

3.1.2. Perceptions

The United Nations Development Programme offers a perception on corruption which divides it into two types: spontaneous and institutionalised.²⁰ Spontaneous corruption refers to corrupt behaviours that arrive in societies with “strong ethics and morals in public service”, while institutionalised corruption can be found in societies where corruption is pervasive, being included in a society’s habits.²¹

¹⁵ Jon S.T. Quah, “Curbing corruption in Asian countries: an Impossible Dream?” in *Research in Public Policy Analysis and Management*, Vol. 20, UK, Emerald Group Publishing, 2011, p. 9

¹⁶ Oxford Dictionaries, [online version], <http://www.oxforddictionaries.com/definition/english/corruption> (accessed 8 February 2015)

¹⁷ Cambridge Dictionaries, [online version], <http://dictionary.cambridge.org/dictionary/british/corruption> (accessed 8 February 2015)

¹⁸ Transparency International, <http://www.transparency.org/whatwedo> (accessed 10 February 2015)

¹⁹ Martin Kreutner in M. Nowak, 2012, op cit., p.550

²⁰ J. Balboa and E. M. Medalla, “Anti-Corruption and Governance: The Philippine Experience” by *APEC Study Center Network* for Asia-Pacific Economic Cooperation, 2006/ASCC/014, Session IV, Viet Nam, 23-24 May 2006, http://www.apec.org.au/docs/06ascc_hcmc/06_9_1_balboa.pdf, p.3 (accessed 10 February 2015) pp. 93-94

²¹ *Idem*

Corruption has been explained throughout the literature from different perspectives. It goes from psychological explanations, to cultural approaches. Melgar affirms that corruption depends on cultures.²² Marta perceives corruption as depending on personal characteristics, educational and religious background.²³

J. Balboa and M. Medalla explained Van Roy's position that corruption can even be a "social network phenomenon"²⁴. For example, he studied the issue of corruption in Thailand and concluded that the Thai social order depends on exchanges between individuals. It can be an exchange between same-level members or between an employee and his/her employer and it can be an exchange of goods or benefits. Van Roy interprets these illegal exchanges as social exchanges. The importance of these exchanges is to secure a place or a future in a society.

A. 3.1.3. The State's obligations

A State does not have to fight corruption because it is morally wrong (even if it is), but because the consequences of corruption can affect every social group, every institution (private or public), every market, every individual, every state and every component of a society (political, economical, educational, judicial, etc.)

State obligations depend internationally on the conventions (covenants, treaties, etc.) that the country signed and ratified. Taking for instance the case of North Korea, as a country that is absent from all international structures, its obligation to fight corruption remains only at its internal consideration. At international level it should condemn corruption of all kinds and it should implement national strategies. However, North Korea cannot be held directly accountable to most international legal instruments structures (not human rights instruments, such as UDHR and neither to anti-corruption instruments, such as UNCAC).

States also have different obligations depending on their national legislation. For instance, in some countries, corruption is regulated by the administrative legislation and not under the criminal one. There are also countries with and without national anti-corruption or national anti-

²² N. Melgar, M. Rossi, T.W. Smith, "The perception of Corruption in a Cross-Country Perspective" in *Economia Aplicada*, V.14, n. 2, 2010, pp. 183-198

²³ . Marta, C. Heiss and S. DeLugio, "An Explanatory comparison of Ethical Perceptions of Mexican and US Marketers, in *Journal of Business Ethics*, 2008, 82, pp. 539-555

²⁴ J. Balboa and E. M. Medalla, op. cit, p. 19

corruption strategies. The obligation of a State to fight corruption and the consequences of non-compliance with its obligations are not universal applicable to all States, however the UNCAC was ratified by a large majority of the UN Member States (175 out of 193 member States).

3.1.4. Indicators for measurement

Corruption can be measured in many different ways by different people (*inter alia* by international observers, groups of experts, NGOs, students, rapporteurs, etc.) Even if it is very often said that corruption cannot be measured because each country has its habits and rules and that corruption can be subjective in terms of perception, corruption is actually measured. Daniel Kaufmann argues in a World Bank paper that corruption can mainly be measured in three ways: “by gathering the views of relevant stakeholders, by tracking countries’ institutional features or by careful audits of specific projects”.²⁵

The indicators used to measure corruption differ not only from one country to another, but also from one source to another. For instance, the Sustainable Governance Indicators (SGI) examine governance and policymaking in the OECD Member States by looking at asset declarations, conflict of interest rules, codes of conduct, citizen and media access to information and others.²⁶

The World Bank Country Policy and Institutional Assessment 2013 (CPIA) evaluates countries using a set of 16 criteria. Some of the indicators used are: access to relevant and timely information, access of civil society to information on public affairs, accountability of the executive to oversight institutions, institutional checks (looking at the Inspector General, the Ombudsman or conducting an independent audit) and others.²⁷

The INGO Transparency International (TI) established a system which analyses how corrupt countries are worldwide (focusing on the public sector). TI collects data from national and international institutions and observers from each country and releases an annual world report called the Corruption Perceptions Index (since 1995). Each country scores a number that

²⁵ D. Kaufmann, A. Kraay, M. Mastruzzi, “Measuring Corruption: Myths and Realities” in *World Bank*, Dec. 2006, <http://www1.worldbank.org/publicsector/anticorrupt/corecourse2007/Myths.pdf>, p. 2 (accessed 5 February 2015)

²⁶ D. Schraad-Tischler, “Sustainable Governance Indicators 2014 and Policy Coherence for Development, OECD, 11.03.2014, http://www.oecd.org/pcd/OECD_Paris_0503148_DST_Rev.pdf, p.4 (accessed 30 January 2015)

²⁷ Constitution of the WB, <http://www.worldbank.org/ida/IRAI/2011/CPIAcriteria2011final.pdf>, p. 51 (accessed 30 January 2015)

represents the degree of corruption on a scale of 0 to 100 (0- highly corrupt and 100- very clean). TI evaluates corruption using indexes from 12-14 sources that have different indicators (collection of different polls). For example, the methodology for the Corruption Perceptions Index 2014 was based on calculating 12 different sets of data from 11 institutions that observed corruption within the past two years. Each country is covered by different sources (that evaluates different indicators) and then the average is calculated.²⁸ The TI method of measuring corruption can also be seen as using proxy indicators, as it is impossible to observe corruption in 175 countries so closely (on the ground).

A.3.2. The right to health

A.3.2.1. Definitions and History

The UN GA did not agree upon a definition of health, but in the Constitution of the WHO, health is defined as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”.²⁹ However, a wider definition of health also includes “socially-related concerns as violence and armed conflict”.³⁰

The right to health is included in multiple human rights documents. It was proclaimed universally in 1948 among other human rights on the list of the Universal Declaration of Human Rights (UDHR), Art. 25: “Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services.”³¹ In the same year, the WHO started its activity. It was not by incident. The WHO was about to become the warrior for the right to health which had to carry the battle of promoting the right to health as a fundamental right. The WHO also has the responsibility to

²⁸ TI, http://www.transparency.org/cpi2014/in_detail#myAnchor2 (accessed 30 January 2015)

²⁹ WHO, http://www.who.int/governance/eb/who_constitution_en.pdf, p.1 (accessed 31 January 2015)

³⁰ Report on the 22, 23 and 24 Sessions of the Committee on Economic, Social and Cultural Rights, ECOSOC Official Records, 2001, Supplement No. 2, UN, (E/2001/22; E/C.12/2000/21), <http://www.un.org/documents/ecosoc/docs/2001/e2001-22.pdf>, p .130 (accessed 31 January 2015)

³¹ UDHR, 1948, Art. 25

seek the improvement of the lives of about 100 million people who are “pushed below the poverty line as a result of healthcare expenditure”.³²

In 1966, the right to health became part of the International Covenant of Economic, Social and Cultural Rights (ICESCR) as “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”³³. Article 12 stipulates that the right to health should include the following charges³⁴:

- reduce infant mortality and ensure the healthy development of the child;
- improve environmental and industrial hygiene;
- prevent, treat and control epidemic, endemic, occupational and other diseases;
- create conditions to ensure access to healthcare for all.

Regional human rights treaties also defend the right to health, for instance through the European Social Charter (1961), through the African Charter on Human and Peoples’ Rights (1981) or through the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (1988).

In a time when the economic and social rights were in competition with the civil and political rights, in 1978, the Declaration of Alma-Ata on Primary Health Care put an emphasis on primary healthcare as the route to achieve the highest attainable standard of physical and mental health for all.³⁵

The right to health is also mentioned in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW, 1979) and in the Convention on the Rights of the Child (CRC, 1989). In the CEDAW, it is essential for women to receive information on health and well-being, including advice on family planning. It is also necessary to protect women’s health, to provide safe working conditions and to eliminate all forms of discrimination against women in the field of healthcare (equality to access to healthcare services)³⁶. The CRC recognises the importance of health and moral integrity of a child (including disabled children). Art. 24 of

³²WHO, Fact Sheet No. 323, <http://www.who.int/mediacentre/factsheets/fs323/en/> (accessed 28 January 2015)

³³ICESCR, 1966, UN, Art. 12, <http://www.ohchr.org/Documents/ProfessionalInterest/cescr.pdf>, p. 4 (accessed 28 January 2015)

³⁴*Idem*

³⁵Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, 6-12, September 1978, WHO, http://www.who.int/publications/almaata_declaration_en.pdf?ua=1 (accessed 1 February 2015)

³⁶CEDAW, UN, adopted on 18 December 1979 and entered into force on 3 September 1981, OHCHR, <http://www.ohchr.org/Documents/ProfessionalInterest/cedaw.pdf> pp. 1, 4-5 (accessed 1 February 2015)

the CRC stipulates that States have the responsibility to ensure that children enjoy the highest attainable standard of health and, in order to implement the right to health, States should take measures: to diminish infant and child mortality, to ensure the provision of necessary medical assistance, to combat diseases, to ensure appropriate pre-natal and post-natal assistance for mothers, to inform children on basic child health and nutrition and to develop a preventive healthcare plan.³⁷

In 2000, eight international development goals were established under the name of Millennium Development Goals (MDGs). All UN Member States have agreed to commit to the MDGs by 2015. As part of the goals in the health sectors, States undertake to reduce child mortality, to improve maternal health and to combat HIV/AIDS, malaria and other diseases. In this regard, the right to health gained further importance in the international arena (to the detriment of other human rights that were not part of MDGs).

In 2002, a UN Special Rapporteur on the Right to the enjoyment of the highest attainable standard of physical and mental health was appointed. The importance of the right to health receives international attention once again (through the Rapporteur's reports and monitoring mechanisms).

A. 3.2.2. Framework

The UN General Comment No. 14 on the right to health, issued in 2000, reminds the three levels of healthcare that are known in the medical sphere³⁸:

- Primary health as dealing with “common and relatively minor illnesses and is provided by health professionals and/or generally trained doctors working within the community at relatively low cost”.
- Secondary health regarding centres or hospitals that “deal with relatively common minor or serious illnesses that cannot be managed at community level, using specialty-trained health professionals and doctors, special equipment and sometimes inpatient care at comparatively higher cost”.

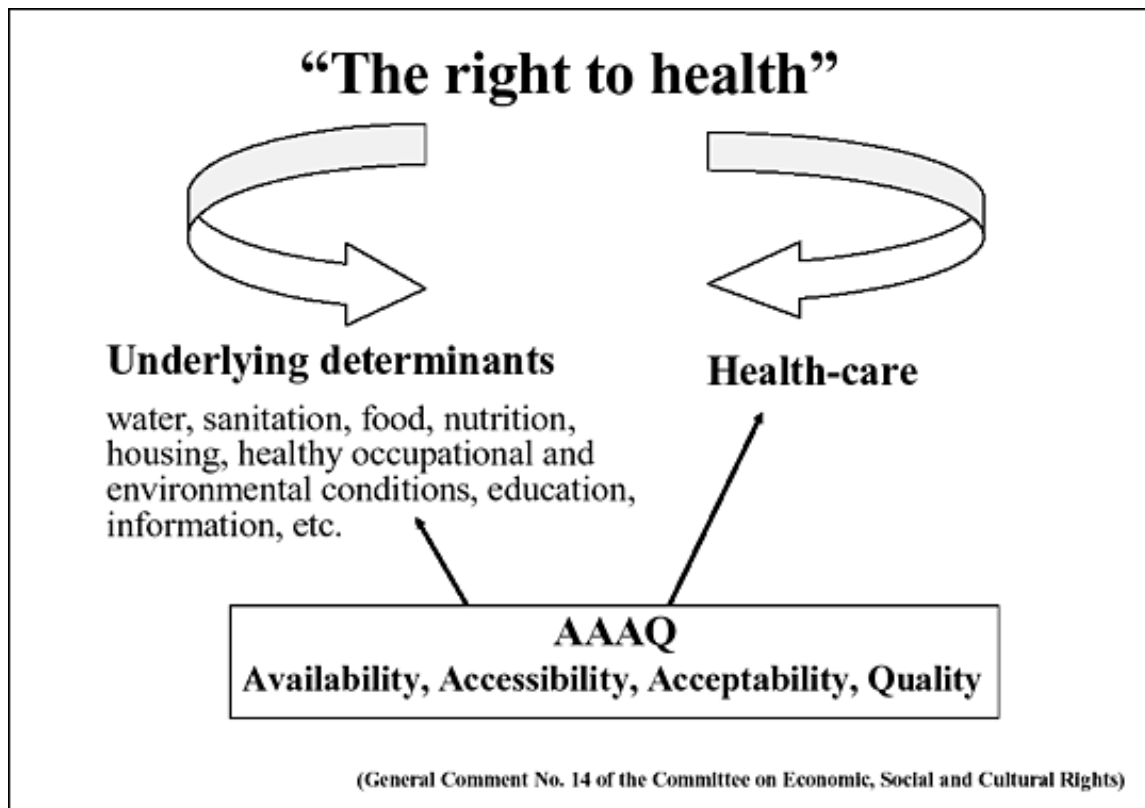
³⁷ CRC, UN, adopted on 20 November 1989 and entered into force on 2 September 1990, OHCHR, <http://www.ohchr.org/Documents/ProfessionalInterest/crc.pdf> p.7 (accessed 1 February 2015)

³⁸ Report on the 22, 23 and 24 Sessions of the Committee on Economic, Social and Cultural Rights, op. cit. p. 132 (accessed 16 February 2015)

- Tertiary health “provided in relatively few centres, typically deals with small numbers of minor or serious illnesses requiring specialty-trained health professionals and doctors and special equipment, and is often relatively expensive”.

When referring to a framework of the right to health, it is important the approach of its elements (or its composition). Those elements that are referred to were established by the General Comment No. 14 (2000) of the Committee on Economic, Social and Cultural rights. The full application of the right to health will depend upon some conditions, called “interrelated and essential elements”: the availability, the accessibility, the acceptability and the quality of the right to health (the AAAQ criterions).³⁹

Figure 1: The AAAQ of the WHO



Source: WHO, <http://www.who.int/mediacentre/factsheets/fs323/en/> (accessed 12 February 2015)

³⁹*Idem*, pp. 131-132 (accessed 16 February 2015)

- i. **Availability:** It is about the availability (sufficiency) of functioning healthcare systems, facilities, public hospitals, clinics, healthcare buildings, experts and professionals (doctors and nurses), sufficient services and good (including essential drugs, water, and proper equipment for treatment and diagnosis) and also programmes.⁴⁰ A sufficient quantity of those services needs to be made available to patients by the State.
- ii. **Accessibility:** The possibility to have access to buildings, drugs, public hospitals and doctors. The mere existence of these materials is not sufficient, if they the materials are not accessible. The accessibility element has four dimensions as mentioned by the WHO⁴¹:
 - a) *Non-discrimination*: healthcare systems and their goods and services must be accessible to all individuals, without discrimination, especially to the most vulnerable groups of the population.
 - b) *Physical accessibility*: the healthcare systems and their goods and services must be physical accessible to all individuals, especially to the most vulnerable groups. This dimension includes access to potable water and sanitation facilities, services and goods that are safe to be physically accessed (including buildings for persons with disabilities).
 - c) *Economic accessibility*: This dimension refers to the affordability aspect. Financial contributions to healthcare services must be based on the principle of equity and must guarantee the access to health services even for poor people and for financially or socially disadvantaged groups. This category responds to the problem of access to healthcare for both poor and rich households.
 - d) *Information accessibility*: This aspect does not refer to the right to breach the confidentiality data between doctor and patient. The information accessibility is about having access to the right information and ideas concerning health issues. In order for patients to make informed choices, it is necessary for them to seek and receive the right information concerning diseases, treatments, side effects of drugs and other consequences.

⁴⁰ Report on the 22, 23 and 24 Sessions of the Committee on Economic, Social and Cultural Rights, op. cit. p. 131 (accessed 16 February 2015)

⁴¹ *Idem*, pp. 131-132 (accessed 16 February 2015)

- iii. **Acceptability:** The healthcare systems and services must respect adequate medical ethics. For instance, it will not be acceptable for doctors to violate the confidentiality terms of patients. It is used as a synonym of adaptability. The moral duty of the health sector is to be culturally appropriate (should include cultural attitudes towards a certain illness). Furthermore, it will not be acceptable for doctors to abuse the patient's status or to abuse their body or rights.
- iv. **Quality:** Although there are clear working laws in medicine, the quality dimension is still debatable as it is often a subjective element of the State's capacity to progressively realise the right to health (and it depends on the region or on the general services and resources of the State in question). However, health services and goods must be scientifically approved as being of good quality (good to be on the market, good for patients to use a certain drug for treatment). For example, an expired drug administered to a patient will be one of bad quality; therefore, such event will violate the quality of the patient's right to health.

A. 3.2.3. State's obligations

The WHO draws attention to the fact that the right to health is not to be mistaken for the right to be healthy.⁴² The right to health is about the need for States to distribute proper conditions, facilities, sanitations, hygiene, etc. in which every individual can be as healthy as possible. A State cannot guarantee to right to be healthy (free of diseases), but it has to generate conditions for those ill people to get proper treatment in good healthcare centres, by professionals and with an adequate treatment and medicine. Therefore, the right to health is about the State doing everything in its capabilities to ensure the highest attainable standard of health.

Art. 12 para. 2 of the ICESCR illustrates non-exhaustive types of States' obligations (such as: improving child and maternal health, improvement of environmental and industrial hygiene, etc.). Every sub-para. (a), (b), (c), (d) of Art. 12 para. 2 comes with a list of obligations for

⁴² WHO, <http://www.who.int/mediacentre/factsheets/fs323/en/> (accessed 12 February 2015)

Member States.⁴³ For instance, the right to prevention, treatment and control of diseases means the creation of a system of urgent medical care in case of accidents or hazards. It also includes duties for the States to make use of technologies and data collection to control diseases. It is the responsibility of States to seek how to best implement Article 12 into national mechanisms and legislations.

Concerning the right to equality and non-discrimination in the healthcare systems, States “have a special obligation to provide those who do not have sufficient means with the necessary health insurance and healthcare facilities “.⁴⁴

The right to health is guided by the principle of progressive realisation. States can only improve the right to health by resources. The lack of financial possibilities is understandable, thus a State must take responsibilities to ensure a step-by-step realisation of the right to health through international assistance, through the use of maximum available resources and by having a progressive strategic plan (long-term vision on how the right to health can develop in three, five or ten years, for instance).⁴⁵

The UN General Comment No. 14 on the right to health, issued in 2000, agreed on the core content of the right to health. This content is about a minimum level of essential elements of the right to health. The General Comment identifies core elements such as primary healthcare, minimum essential and nutritious food, sanitation, safe and potable water and essential drugs⁴⁶. WHO also mentioned the need for each State to adopt a national health strategy or a plan of action.⁴⁷

As in the case of other human rights, it is necessary that the States comply with three levels of obligations: the obligations to respect, protect, and fulfil the right to health. The obligation to respect means that the States have to refrain from any interference that will harm the enjoyment of the right to health (the obligation to not harm the right to health). To protect the right to health

⁴³ CESCR, adopted on 16 December 1966 and entered into force on 3 January 1976, UN, <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx> (accessed 10 February 2015)

⁴⁴ Report on the 22, 23 and 24 Sessions of the Committee on Economic, Social and Cultural Rights, op. cit. p. 135 (accessed 16 February 2015)

⁴⁵ H. Nygren-Krug, “Health and Human Rights- A historical Perspective”, *UN Special*, No. 673, May 2008, <http://www.unspecial.org/UNS673/t24.html> (accessed 16 February 2015)

⁴⁶ Report on the 22, 23 and 24 Sessions of the Committee on Economic, Social and Cultural Rights, op. cit. p. 135 (accessed 16 February 2015)

⁴⁷ WHO, Fact Sheet No. 323, November 2013, <http://www.who.int/mediacentre/factsheets/fs323/en/> (accessed 17 February 2015)

means that the States have to take measures so that no third party can harm the right to health. The obligation to fulfil requires the States to adopt national measures (legislative, judicial, budgetary, etc) that will lead towards the full realisation of the right to health.

In the CESCR General Comment No. 3 on the nature of states parties' obligations (1990), the Committee on Economic, Social and Cultural Rights required that the Members States take steps towards the realisation of human rights, "individually and through international assistance and cooperation, especially economic and technical".⁴⁸ Also, in case of international need and depending on the country's wealth, States should provide disaster relief and humanitarian aid to other countries where the right to health is endangered due to certain circumstances (hazards, natural disaster, internal conflict, etc.)

A. 3.2.4. Indicators for measurement

There is no single (best) way to measure the adequacy of measures within a State. Every State has a margin of discretion in establishing which measures to implement at their national level for protecting the right to health. A State evaluates its own needs and has to take steps in resolving its own challenges and needs to develop proper measures (health strategy) for specific national circumstances.

A set of indicators and benchmarks have been developed by international organizations. For instance, the OHCHR has a guide on Human Rights Indicators that offers an objective list of illustrative indicators on the right to health.⁴⁹ The guide is designed to measure the general situation of a State's right to health (by measuring the situation of child mortality, the accessibility to health facilities, the existence of essential drugs, etc.)

The UN Special Rapporteur on the right to health released a report in 2006 that contains a table with indicators and specific questions to respond to (benchmarks). It is a guide made especially for experts that monitor health situations. Among others, the report presents ways in evaluating the situation in reproductive healthcare. For example, such an evaluation can be done by: looking at the financial context (indicator) and checking if the State has a law to ensure the

⁴⁸ CESCR General Comment No. 3: The Nature of States Parties' Obligations (Art. 2, Para. 1, of the Covenant) Adopted at the Fifth Session of the Committee on Economic, Social and Cultural Rights, on 14 December 1990 (Contained in Document E/1991/23)

⁴⁹ OHCHR, "Human Rights Indicators", United Nations, 2012, p. 90

universal access to sexual and reproductive health, assessing the percentage of government budget allocated to sexual and reproductive health, etc. (benchmarks).⁵⁰

In order to measure a particular situation in a State, there is a need to create specific indicators and benchmarks that will allow for an appropriate measurement.

3.3. Correlations

The title on correlations refers to connections between (i) corruption and human rights, in general, and (ii) corruption and the right to health, in particular: impacts, influences and consequences.

3.3.1 Corruption and human rights

NGOs, IOs, States have declared on numerous occasions that corruption is one (if not probably the most) of the dangerous threats to human rights. The acts of corruption are connected to human rights, as the corrupt behaviour violates at a certain point the right of others to life, health, information, education, food, etc. even if connections may not be visible at first. On International Anti-corruption Day in 2013, the UN SG confirmed at the high-level plenary that “corruption defies and undermines fundamental human rights”⁵¹. Moreover, the UN Secretary General, explicitly attested in his address at the inaugural conference of the International Anti-Corruption Academy, in 2010, that the money stolen from corruption is hindering the achievement of the Millennium Development Goals, meaning that corruption is not only a violation of daily human rights, but a harm to development and a harm to the respect of human rights on a long-term basis.⁵²

Even in the private sector corruption is connected to human rights. At the initiative of the Special Representative on the issue of Human Rights and Transnational Corporations and Other Business Enterprises, corruption has been included on the list of abuses of human rights

⁵⁰ Paul Hunt, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, UN ECOSOC, E/CN.4/2006/48, 3 March 2006, <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G06/114/69/PDF/G0611469.pdf?OpenElement> p. 23 (accessed 17 February 2015)

⁵¹ Secretary-General's remarks on International Anti-corruption Day High-level Plenary: "The Role of Good Governance and the Post-2013 Development Agenda" [delivered by Jan Eliasson, Deputy Secretary-General], NY, 9 December 2013, <http://www.un.org/sg/statements/index.asp?nid=7345> (accessed 17 February 2015)

⁵² UN SG remarks to inaugural conference of IACA, Vienna, 2 September 2010, UN, www.un.org/sg/statements/?nid=4749 (accessed 17 February 2015)

committed by multinational corporations.⁵³ The UNDP attests that “corruption hinders economic development by distorting markets and damaging private sector integrity”.⁵⁴ Some figures can show the costs of corruption: \$1,000 billion paid in bribes per year and \$1.8 trillion of illicit financial flows from Africa between 1970 and 2008.⁵⁵

National strategies worldwide make connections between corruption and human rights and each State has its own way to approach the problem. The US 2010 National Security Strategy aims to “promote the recognition that pervasive corruption is a violation of basic human rights”.⁵⁶ In Moldova, the national strategy for preventing corruption aims to increase public information on human rights and citizens’ possibilities to actively fight corruption”.⁵⁷

Lately, as corruption has been so harmful to human rights, experts and researchers have even considered the possibility to link corruption to human rights by prosecuting grand corruption as an international crime. The GOPAC has started a campaign advocating and researching on possibilities to include corruption among other international crimes and to enable international institutions to “apprehend, prosecute, judge and sentence the guilty”.⁵⁸ This initiative can change perception on corruption by making it the main target of human rights defenders (or influence public attitudes towards corruption).

Corruption and human rights have also been linked in courts of justice. For instance, in *South African Association of Personal Injury Lawyers v Heath* (in front of the Constitutional Court of South Africa), corruption was described in court as being “*inconsistent with the rule of law and the fundamental values of the Constitution [South African] and that it undermines the constitutional commitment to human dignity and [...] the advancement of human rights and freedoms*”.⁵⁹

⁵³ International Council on Human Rights Policy, “Corruption and Human Rights: Making the Connection”, Switzerland, 2009, p. 2

⁵⁴ UNDP, http://www.undp.org/content/undp/en/home/ourwork/democraticgovernance/focus_areas/focus_anti-corruption.html (accessed 17 February 2015)

⁵⁵ *Idem*

⁵⁶ US National Security Strategy, May 2010, p.38

⁵⁷ Moldova’s National Strategy for Corruption Prevention and Fighting, December 2004, http://www.coe.int/t/dghl/cooperation/economiccrime/moneylaundering/projects/molico/AC/Output1.6/CCCEC%20risk%20assess%20methodology_draft_eng.pdf, p.6 (accessed 17 February 2015)

⁵⁸ GOPAC, http://gopacnetwork.org/programs/grand_corruption/ (accessed 17 February 2015)

⁵⁹ *South African Association of Personal Injury Lawyers v. Heath*, para. 4, <http://www.saflii.org/za/cases/ZACC/2000/22.pdf>, p.2 (accessed on 12 June 2015)

In *SERAP v. the Nigerian Government*, it has been proven that the right to education of Nigerians has been breached under the African Charter on Human Rights and People's Rights by massive grand corruption in the public education budget. Implicitly, the argument could be reformulated that grand corruption has been the cause of the violation of human rights.⁶⁰ In the same context, the plaintiff submitted that *“government’s obligation to protect the right to health requires it to investigate and monitor the possible health impacts of gas flaring and for the government to take concerns of the communities seriously and take steps to ensure independent investigation into the health impacts”*.⁶¹ On this note, a socio-economical right has been declared affected by corruption in a court of justice.

A. 3.3.2 Corruption and the right to health

Corruption in the health system can take different forms, from bribery to blackmail or conflict of interest. The health system can mean public hospital, but it can also be the pharmaceutical industry or the private practice of doctors. In a healthcare system, “3 to 10% of the overall expenses are lost to fraud and corruption”.⁶²

The documentary film “Fed Up”(2014) revealed that a report from the WHO was buried due to extortion of \$406 million from the United States. The US continued to financially contribute to the WHO under the condition that a report entitled “Diet, nutrition and the prevention of chronic diseases” would disappear. The report could have revealed that the amount of sugar used in more than 80% of the food market is harmful to human body. The report wanted to recommend that no more than 10% of calories in a daily diet should come from sugar.⁶³ The publication of the report could have changed the entire concept of sugar in food products, but instead, the extortion blocked a global fight against obesity.

A group of 20 doctors from the American Academy of Family Physicians publicly resigned, because the Academy joined forces with a private company that sponsored some of the Academy

⁶⁰ *SERAP v. Nigerian Government*, ECOWAS, http://www.chr.up.ac.za/images/files/documents/africancases/institution/ecowas/ecowas_serap_federal_republic_nigeria_2012.pdf (accessed on 12 June 2015)

⁶¹ *Idem*, para. 17

⁶² Martin Kreutner address (Chair IACA International Steering Committee) at the Inaugural Conference 02 September 2010 of IACA.

⁶³ *Fed Up* [documentary movie], USA, 2014, Director Stephanie Soechtig, see min. 40:40

members to develop a study in favour of the private company's beliefs. The study was in favour of the company's products but was against the values of the Academy.⁶⁴

Regularly, informal payments (bribes) are asked from patients in exchange for treatment or consultation. In the book *Corruption and Human Rights: Making the Connection* by the International Council on Human Rights Policy, it is explained that a bribe in the healthcare system is not only a violation of the patient's right to health, but also a violation of the principle of non-discrimination, "because the bribe places the patient in a position of inequality vis-à-vis other".⁶⁵

Another problem in the health sector can be exemplified by the fact that "in many countries poor people report that they are asked to pay for medicine that should be available to them at no charge"⁶⁶. There are multiple examples: in Ethiopia, drugs are stolen from the public sector in order to be resold and therefore to make profit. The drugs that should be free of charge are no longer available for patients and the drug becomes a leaked product.⁶⁷ In other cases, doctors simply demand an extra charge for medicine that should be free of charge under existing law; therefore it is a problem of records of administered drugs (case of Dominican Republic).⁶⁸

All of these cases reveal that corruption in the health sector does not have a specific area, nor a specific form. In all of the above-mentioned cases, corruption damages the situation of the right to health.

Corruption can derive from many factors. It can be seen as a form of habit or culture or as a form of accepting (only if the patient is offering). Corruption can also be the consequence of unsatisfactory salary or working conditions.⁶⁹

In a study where 23 countries, selected randomly from all over the world, were analysed (from Latin-America, Europe, Central Asia, South Asia and Africa), the health sector appeared

⁶⁴ *Idem*, see min. 16:09

⁶⁵ International Council on Human Rights Policy, *op. cit.*, p.52

⁶⁶ P.C. Richard, B. H. Weston, "Human Rights in the World Community: Issues and Action", *Pennsylvania Studies in Human Rights*, University of Pennsylvania Press, 2006, p. 209

⁶⁷ Maureen Lewis, "Governance and Corruption in Public Health Care Systems", *Center for Global Development*, working paper No. 78, January 2006, http://www.cgdev.org/sites/default/files/5967_file_WP_78.pdf, p.21 (accessed 19 February)

⁶⁸ *Idem*, p.22 (accessed 19 February)

⁶⁹ P.C. Richard, B. H. Weston, *op. Cit.*, pp. 208

to be the most corrupt in Moldova, Slovakia and Tajikistan and for other seven countries health was in the top four most corrupt sectors.⁷⁰

B. 3.1. The phenomenon of corruption in Romania

B. 3.1.1. Perceptions

As mentioned in *Chapter III. A 3.1.2. Perceptions*, the evaluation of corruption in a certain country is somehow subjective (depending on the methods, the indicators and the criteria that are analysed). Some internal and international examples on how corruption is perceived in Romania are:

- The number of economical offenses in Romania has increased 6 times in the period 1990-1999 (from 18.618 offenses to 113.036 offenses).⁷¹

- The barometer of public opinion reveals that 40% of the public perceives corruption before 1989 (communist regime) as big or very big. After the year 2000 (democratic regime) 94% of the respondents perceived corruption as big or very big⁷². The Eurobarometer surveys No.374 and No.379 (2013) prove that 65% of the respondents consider corruption to be a problem in Romania when doing business and 64% consider patronage and nepotism as a problem when doing business (EU average of 43% and 41% and the EU maximum was of 71% and 69%).⁷³

- The latest Corruption Perceptions Index of TI (2014) placed Romania on the 69th position out of 175 evaluated countries as being corrupt with a score of 43 points (0-highly corrupt and 100-very clean). The score is the same as the one obtained in 2013.⁷⁴

⁷⁰ Maureen Lewis, op. cit., p.14

⁷¹ Annual Statistics of Romania, National Statistical Institute, 2000, in *Coruptia in administratiapublicalocala, FundatiapentruDezvoltareaSocietatiiCivile*, <http://www.fdsc.ro/documente/26.pdf> , p.4 (accessed 18 February 2015)

⁷² Annual Statistics of Romania, op. cit., p.5

⁷³ EU Anti-corruption Report 2014, Country Sheet on Romania, EC, http://ec.europa.eu/dgs/home-affairs/what-we-do/policies/organized-crime-and-human-trafficking/corruption/anti-corruption-report/docs/2014_acr_romania_factsheet_en.pdf, p.1 (accessed on 19 February 2015)

⁷⁴ TI, <http://www.transparency.org/cpi2014/results> (accessed on 19 February 2015)

- Regarding the control of corruption, the WB Governance Indicators (of 2012) ranks Romania on the last position among EU countries.⁷⁵

- The European Commission (EU anti-corruption report, 2014) ranked the effectiveness of the Romanian Government efforts to combat corruption at 27%. (EU avg. 23%; EU max. 54%). The report also considered that the successful prosecutions in Romania that deter people from corrupt practices are evaluated at 34% (EU avg. 26%; EU max. 50%)⁷⁶.

B. 3.1.2. Romania's anti-corruption structure

Internally, Romania has various structures (institutions) through which corruption is discovered, combated, prevented and prosecuted. Those institutions are guided by the National Anti-Corruption Strategy (the latest of 2012-2015) and the Plan of Action for the implementation of this strategy.

The Romanian anti-corruption system is not directed by one institution only; there is a network of functional public agencies, councils and directions. The entire system is composed of the following important institutions:

- *The National Anti-Corruption Direction (DNA)*: Founded in 2002, the DNA is the instrument to combat medium and grand corruption by discovering, investigating and bringing cases of corruption to court. This institution is mostly specialised in high-level and white-collar corruption cases. The DNA deals with the same corruption typology established in the Romanian Criminal Code and do not limit its cases to the public sector (these cases extend into the private sector as well). The results of the DNA ought to discourage corruption at all levels in Romania.⁷⁷

- *The National Authority for the Regulation and Monitoring of Public Procurement (ANRMAP)*. The public institution was founded in 2005 in order for Romania to become consistent with the EU ratification process. Its fundamental role is to promote and implement policies in the public procurement spheres (elaborating strategies, monitoring, surveillance and counselling).⁷⁸

⁷⁵ EU Anti-corruption Report 2014, op. cit., p.2

⁷⁶ *Idem*, p.

⁷⁷ DNA, http://www.pna.ro/faces/about_us.xhtml (accessed 20 February 2015)

⁷⁸ ANRMAP, <http://www.anrmap.ro/organizare> (accessed 20 February 2015)

- *The Unit for Coordination and Verification of Public Procurement (UCVAP)*. Every contracted authority has the obligation to inform the UCVAP of the procedures of public procurement that will follow. Since 2013, the Government has been considering uniting the ANRMAP with the UCVAP for the benefit of public procurement regulation and monitoring system (Chamber of Deputies' interpellation No.618B/24-09-2013 by Alexandru Nazare representing the Democrat Liberal Party).⁷⁹

- *The National Agency for Integrity (ANI)*. At the EU institutions' initiative, the ANI was founded in 2007 as an independent administrative agency to assess incompatibility cases, administrative and criminal conflicts of interest by mainly examining asset disclosures or statements of interests.⁸⁰

- *The National Agency for Fiscal Administration (ANAF)*. This public administration agency aims to collect and manage taxes, social contributions and all kinds of amounts of money belonging to the general public budget. One of its targets, as part of its 2013-2017 objectives is to combat tax evasion.⁸¹

- *The General Inspectorate of Romanian Police- Direction for the Investigation of Fraud (IGPR-DIP)*. This Direction acts as a structure that leads and coordinates territorial structures with the possibility of also carrying out its own activities of investigation of fraud.⁸²

- *Fight Against Fraud Department (DLAF)*. This Department acts under the coordination of the Prime-Minister and is financed by the budget of the General Secretariat of the Government. The department is also the contact point for the European Anti-Fraud Office (OLAF) and the national coordinator of the anti-fraud fight. DLAF ensures the protection of the EU economical interests in Romania. Romania is in this regard the one of the few countries first having an exclusive institution (DLAF) for the protection of Community's financial interests and implementing a National Anti-fraud Strategy⁸³.

⁷⁹ Chamber of Deputies, <http://www.cdep.ro/pls/parlam/interpelari.detalii?idi=35540> (accessed 20 February 2015)

⁸⁰ ANI, "6 years of National Integrity Agency", Romania, 2014, p. 16

⁸¹ ANAF, https://static.anaf.ro/static/10/Anaf/Prezentare_R/Strategia_ANAF_2013_2017_V7_1.pdf, p.7 (accessed 20 February 2015)

⁸² Romanian Police, <http://www.politiaromana.ro/ro/structura-politiei-romane/unitati-centrale/directia-de-investigare-a-fraudei> (accessed 20 February 2015)

⁸³ DLAF, http://www.antifrauda.gov.ro/en/about_us/who_we_are_and_what_we_do/ (accessed 20 February 2015)

- *National Office for Prevention and Combat money laundering (ONPCSB)*. It is the institution that elaborates, coordinates and implements the national system for combating money laundering and for combating financing terrorism. It was founded in 1999 under the supervision of the Government and it refers to the High Court of Cassation and Justice or the Romanian Intelligence Service whenever a suspicious act of money laundering is discovered.⁸⁴

B. 3.1.3. Romania's obligations vis-à-vis countering corruption

Corruption in its various forms is criminalised in the Romanian Criminal Code. The Romanian National Anti-Corruption Strategy over a certain period of time (the latest covers the period 2012-2015) represents the State's objectives and struggles in countering corruption. It is also a document representing the State's obligations regarding the fight against corruption.

In the Law No. 78/2000 on preventing, discovering and sanctioning of corruption acts, four different categories are identified:

- Offenses of corruption
- Offenses assimilated to offenses of corruption
- Offenses directly tied to the two above-mentioned offenses
- Offenses against the financial interests of the European Communities.

The Romanian Criminal Code does not define corruption per se (neither does the UNCAC), but it does incriminate certain activities such as: fraud (Criminal Code, Art. 244), embezzlement (Criminal Code, Art. 246), patrimonial exploitation of a vulnerable person (Criminal Code, Art. 247), financial fraud (Criminal Code, Art. 250, Art. 251), acceptance of bribe (Criminal Code, Art. 254), offering bribes (Criminal Code, Art. 255), the acceptance of inappropriate benefits (Criminal Code, Art. 256), traffic of influence (Criminal Code, Art. 257).⁸⁵

Internationally, Romania is obliged to respect the signed and ratified anti-corruption frameworks (their values, principles and duties). Structures:

- Romania is one of the founding members of IACA; it signed the agreement on 2 September 2010 and ratified it in August 2011.
- The UNCAC was signed by Romania in December 2003 and ratified in November 2004.

⁸⁴ ONPCSB, <http://www.onpcsb.ro/html/prezentare.php> (accessed 20 February 2015)

⁸⁵ Romanian Criminal Code, <http://www.just.ro/LinkClick.aspx?fileticket=Wpo7d56ll/Q=> (accessed 5 February 2015)

- Romania is not a member of the OECD, but its National Anti-Corruption Strategy admits that the country wishes to accede to the Organisation and its anti-corruption strategy is in line with OECD principles as well.⁸⁶
- As a member of the EU, Romania coordinates and cooperates with the European Commission and OLAF in countering corruption.
- Romania ratified the Council of Europe Civil Law Convention on Corruption of 1999 and the Council of Europe Criminal Law Convention on Corruption of 1999.
- As a member of the World Bank, the country is engaged in anti-corruption working sessions.
- Romania is also countering corruption by actively participating as a member to GRECO, EPAC, GOPAC and other international structures (such as Transparency International –the Romanian Chapter).

B. 3.2. The right to health in Romania

B.3.2.1. Romania's public health structure

On a periodic basis, Romania formulates and implements a National Health Strategy dealing with current issues (the latest of 2012-2014) and sets a list of objectives to deal with in the healthcare system. This current strategy focuses on controlling diseases (TB, HIV/AIDS, cancer, Hepatitis B, C), reducing the number of abortions, improving the development of health sector for Roma people, developing policies for access to medicine, monitoring the quality of health services, developing the E-health sector and the infrastructure for health to reduce the inequality of access to health services and also some national plans for specific issues (prevention, cancer, diabetes, rare diseases and cardiovascular diseases).⁸⁷

In the national health structure, the Ministry of Public Health is the central authority of the public health sector. However, several institutions compose the entire health system:

⁸⁶ National Anti-Corruption strategy of Romania 2012-2015, Governmental decision, No. 215, 20 March 2012, [Ministry of Internal Affairs], http://www.mai.gov.ro/documente/obiective/HG_nr_215-2012.pdf , p. 9 (accessed 5 February 2015)

⁸⁷ National Health Strategy 2014-2020, Ministry of Public Health (MPH), <http://www.ms.ro/upload/Anexa%201%20-%20Strategia%20Nationala%20de%20Sanatate%202014-2020.pdf> , pp. 3-5 (accessed 6 February 2015)

- *The Ministry of Public Health*. The attributes and duties of the MPH as revealed in the regulation are: elaborating and coordinating the implementation of policies of the health sectors and the health supervision of public health. The MPH approves the regulations of medical institutions, establishes the general norms and monitors the organisation of public and private medical centres, ensures the quality of the health services received by the patients and applies measures to improve quality if needed. The MPH also represents the Romanian Government in international relations with the WHO or other health structures (Art. 2, HG No. 144/2010)⁸⁸

The MPH has to intervene every time a person seizes the Ministry because their right to health has been violated. If the person is not satisfied with the intervention of the Ministry regarding the violation, the actions of the Ministry can be disproved in court.

- *National Agency of Drugs and Medical Devices (ANM)*. The institution is under the supervision of the MPH since its foundation, in 2010. Its mission is to evaluate and supervise drugs in order to use a highly qualitative and efficient drug on the market for the patients' needs. It is the duty of the ANM to maintain a high level of medical devices and to carefully evaluate the quality of such devices in medical institutions. The ANM elaborates specific technical procedures for the use of medical devices and it ensures the efficiency and transparency of the practices and procedures used with such devices.⁸⁹

- *National Centre for the Organisation and Ensurance of the Informational and Informatics System in the Health Sector (CCSS)*. The National Centre is an institution dealing with the study of demography (statistics and causes of death), as well as the research on the sector of medical informatics and informatics equipment for medical purposes.⁹⁰

- *Technical Office for Medical Devices (OTDM)*. The Office exists for more than 50 years under different names and is under the public coordination of the MPH but fully financed from its own resources. The OTDM is the institution that certifies the medical devices in order to give insurance to patients that devices are in conformity with their purpose.⁹¹

- *Medical Institutions (public and private medical care centres)*. Hospitals and national health research institutions are under the supervision of the MPH. Some of the institutions are fully financed from the State budget, other are independent or partially financed by the State.

⁸⁸ MPH, Government Decision, No. 144/2010, <http://www.ms.ro/?pag=19&id=9415> (accessed 6 February 2015)

⁸⁹ ANM, http://www.anm.ro/anmdm/despre_noi.html (accessed 6 February 2015)

⁹⁰ Ministry of Public Health, <http://www.ms.ro/?pag=59> (accessed 6 February 2015)

⁹¹ OTDM, <http://www.otdm-certificare.ro/despre/> (accessed 6 February 2015)

Concerning public health insurance, the State offers two alternatives of national health insurance depending on the employment of persons: the *National Health Insurance House (CNAS)* and the *House of Insurance of Health of Defense and Public Order, National Security and Judicial Authorities (AOPSNAJ)*. Both insurance houses offer health services based on a system where employees contribute to the payment of the Unique National Fund of Social Health Insurances.⁹² After the accession of Romania to the EU in 2007, the insured citizens that leave the country can be reimbursed by the CNAS if they have the EU insurance card (available in EU countries) which is valid for 6 months.⁹³

B. 3.2.2. Romania's obligations vis-à-vis the right to health

Romania uses the definition of health provided by the Constitution of the WHO (See Chapter 3, A, 3.2.1) because the country has signed the ESC which recognises this particular definition of health under Art. 11.

In Chapter II (Rights and Fundamental Freedoms) of the Romanian Constitution as amended in 2003, Art. 34, it is attested that the right to protect health is guaranteed (1), that the State is obliged to take measures to ensure hygiene and public health, (2) and that the organisation of medical assistance, of the insurance system and of other protection measures for physical and mental health is established by the law.⁹⁴

Romania has the responsibility to formulate, implement and periodically review a national policy (Art. 31 ESC). Thus, the Romanian National Health Strategy 2014-2020 is oriented towards the needs and problems of the society.

Law No. 95/2006 is the Romanian health law adopted by the Parliament, which institutions and healthcare centres are obliged to respect. In this respected law, some of the State's obligations that need to be mentioned are⁹⁵:

- Inform, educate and communicate the promotion of health
- Ensure the quality of the public health services

⁹² AOPSNAJ, <http://www.aopsnaj.ro/?action=iDespreNoi#> (accessed 6 February 2015)

⁹³ CNAS, <http://www.cnas.ro/page/scurt-is.html> (accessed 6 February 2015)

⁹⁴ Romanian Constitution 1991, revised in 2003, Chap. II Rights and Fundamental Freedoms, Art 34 (1), (2), (3).

⁹⁵ Law number 95/2006 concerning the Reform in the Health system, published in the M.Of. nb. 372/28 April 2006. Available at http://www.cdep.ro/pls/legis/legis_pck.http_act_text?id=72105 (accessed on 6 February 2015)

- Evaluate the quality, efficacy, efficiency and the access of medical services

Chapter 6 of the health law deals with the obligations of the medical assistance in the primary sanitary system (for instance the ethical and deontological obligations). Chapter 7 presents the obligations of public health employees such as the application of hygiene measures, and disinfection and also the responsibility of the asset declarations by the persons in charge of hospitals.⁹⁶

Internationally, Romania is bound by the obligations of health conventions and of signed and ratified health frameworks for cooperation. As the right to health is a human right, Romania is obliged to protect, respect and fulfil the right to health (see Chapter 3, A.3.2.3).

Romania complies with the obligations as a member of certain IOs and with the obligations of the ratified documents and conventions. Romania, as part of the EU, the OSCE, the WHO, the UN and the CoE, should comply with:

- The revised European Social Charter (in 1999), signed and ratified in 1999 (but Romania did not ratify the Collective Complaints Protocol, 1995). The ESC does not only mention the safety and protection of public health, but also of the health of children (Art. 7, 11), of pregnant women (Art. 8, 17) and of elderly persons (Art. 23).
- The Treaty of Accession of Romania to the EU and the plans for implementation of EU community acts that refer to the health sector (EU working groups and plenary sessions of the right to health).
- The UN Covenant on Economic, Social and Cultural Rights, 1976. Art. 12 provides information on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (See Chapter 3, A. 3.2.3).
- The UNDHR (Art. 25 is referring to the right to health)
- The Strategy Europe 2020 of the WHO
- The European Commission's recommendations to Romania for Europe 2020, (elaborated on 8 July 2014; 2014/C 247/21) on the right to health: to accelerate the reforms in the health sector in order to boost the efficiency, accessibility and quality of the health system.⁹⁷

⁹⁶ Ministry of Public Health, http://www.ms.ro/documente/Legea%2095%202006_12548_11878.pdf , pp. 22-40, 103 (accessed 7 February 2015)

⁹⁷ European Commission's recommendations to Romania for Europe 2020, (8 July 2014; 2014/C 247/21) http://ec.europa.eu/europe2020/pdf/csr2014/csr2014_council_romania_ro.pdf, p. 5 (accessed 7 February 2015)

B. 3.3. Correlations in Romania

B. 3.3.1 Corruption and human rights

In the US Department of State report on human rights in Romania (2013), the word “corruption” appears 24 times in a document of 34 pages. The Romanian National Anti-Corruption strategy 2012-2015 does not mention the word “human rights” within the document. The US report reveals that government corruption affects all sections of society.⁹⁸ The report also presented data where, financially speaking, conflict of interests in procurement contracts “rose from 67,200 lei to 134,400 lei (\$20,300 to \$40,600) for products and services, and from 67,200 lei to 448,000 lei (\$20,300 to \$135,000) for public works”⁹⁹. The sanctions and inspections system did not provide any substantial law enforcement in this regard.

The National Association against Corruption, Abuses and for Human Rights (ANICADO) is a Romanian NGO that fights for human rights by countering corruption. Since its existence in 2005, one of the NGO’s objectives is to initiate public demonstration to denounce and act against the great dangers for society represented by corruption, abuses and discrimination as being a violation of human rights.¹⁰⁰

The Centre for Analysis and Prevention of Corruption in Romania (CAPC) demonstrates during a talk show the consequences of corruption over human rights in Romania, as perceived by Romanians in a survey¹⁰¹:

- Corruption affecting Medical Health – 57% yes
- Corruption affecting Constructions- 41% yes
- Corruption affecting the Public Administration – 34% yes
- Corruption affecting the Military Service- 27% yes
- Corruption in the judicial sector- 20% yes

⁹⁸ US Department of State report on HR in Romania (2013) http://media.hotnews.ro/media_server1/document-2014-02-27-16698841-0-raportul-privind-respectarea-drepturilor-omului-romania-2013-engleza.pdf, p.1 (accessed 7 February 2015)

⁹⁹⁹⁹ US Department of State report on HR in Romania (2013), op. cit., p. 15

¹⁰⁰ ANICADO, <http://www.anicado.ro/default.asp?id=23&mnu=23> (accessed 7 February 2015)

¹⁰¹ CAPC, <http://capc.md/ro/radio/1.html> (accessed 7 February 2015)

The WB figures within the Report on Corruption in Romania reveal the percentages of persons who think that all or almost all public officials are corrupt in certain State agencies.

Survey: All or almost all of the public officials in this State agency are corrupt¹⁰²:

- In customs authorities: 62% yes
- In the judiciary system: 53% yes
- In State property found (budget): 52% yes
- In the parliament: 37% yes
- In the health system: 41% yes

B. 3.3.2 Corruption and the right to health

Regarding the general correlation between corruption and health system, the international press released some representative titles such as: “Why corruption in Romania’s healthcare system is forcing its doctors to work abroad” (The Independent, UK)¹⁰³, “Medical Care in Romania Comes at an Extra Cost” (The New York times)¹⁰⁴, “Bribes for basic care in Romania” (The Guardian)¹⁰⁵, “Bucharest, Health- Small corruption affects the system” (Le petit Journal)¹⁰⁶.

The National Health Strategy 2014-2020 recognised that the persistence of informal payments affects the perception of the health system, the rights of the patients and also the judgment of patients of the quality of the services they receive (thinking that the informal payments means better quality).¹⁰⁷

¹⁰²WB, “Diagnostic surveys of Corruption in Romania”, Analysis prepared by the WB at the request of the Government of Romania, 2001, <http://www1.worldbank.org/publicsector/anticorrupt/romenglish.pdf>, p. 7 (accessed 7 February 2015)

¹⁰³ Elena Stancu, “Why corruption in Romania’s healthcare system is forcing its doctors to work abroad”, The Independent, UK, 2 January 2014, <http://www.independent.co.uk/news/world/europe/mass-exodus-why-corruption-in-romania-healthcare-system-is-forcing-its-doctors-to-work-abroad-9035108.html> (accessed 8 February 2015)

¹⁰⁴ D. Bilefsky, “Medical Care in Romania Comes at an Extra Cost”, The New York Times, 8 March 2009, <http://www.nytimes.com/2009/03/09/world/europe/09bribery.html?pagewanted=all&r=0> (accessed 8 February 2015)

¹⁰⁵ The Guardian, “Bribes for basic care in Romania”, 26 March 2008, <http://www.theguardian.com/society/2008/mar/26/health-romania> (accessed 8 February 2015)

¹⁰⁶ J. Mercier, “Bucharest, Health- Small corruption affects the system”, Le Petit Journal, 18 October 2007, <http://www.lepetitjournal.com/bucarest/accueil/actualite/19986-sante-la-petite-corruption-mine-le-syst> (accessed 8 February 2015)

¹⁰⁷ Health Strategy 2014-2020, op. cit., p.25

Health Consumer Powerhouse monitors medical services in Europe through a combination of statistics, public opinion questionnaires and researches. The yearly outcome appears under the Euro Health Consumer Index (EHCI). In 2008, the indicator of informal payments was introduced for the first time to calculate the health index. This concept was defined as making any hidden payment or “under-the-table payment” to doctors in addition of the official payment required by the health system. In 2013, Romania had the highest level of informal payments of Europe, with a clear detached score from the rest of the evaluated countries (Romania scored 1.25 and the following country scored 1.37, where 1.0= yes to informal payments and 3.0= no to informal payments).¹⁰⁸ The outcome of informal payments reveals, in the opinion of the EHCI, the “low level of attention paid by [...] institutions to the problem of parallel economy in healthcare”.¹⁰⁹

In 2014, the EHCI showed that the situation of informal payments scored 1.0 in Romania, as 100% yes to informal payments to doctors.¹¹⁰ The same EHCI 2014 attested that a good performance also depends on the absence of corruption (among other criteria) and compared the score of the TI Corruption Index with the poorest countries in the health index. The correlation was of 81%.¹¹¹

The World Bank published a document with the title “Diagnosis of Corruption in Romania” in 2001. The perceived level of corruption in the health sector reached 41% due to corrupt public officials (while customs authorities reached the highest level of 62% and the army reached the lowest level of 6%).¹¹²

When respondents were asked about informal payments¹¹³ in different situations, the first 4 situations were related to health system: 66% respondents chose hospital stay (highest rank), emergency 62%, dentist 56% and medical specialist 52%.¹¹⁴ After the WB analysed informal payments, it concluded that 2 out of 3 respondents gave informal payments and that the

¹⁰⁸ Health Consumer Powerhouse, EHCI 2013, <http://www.healthpowerhouse.com/files/ehci-2013/ehci-2013-report.pdf>, p.77 (accessed 8 February 2015)

¹⁰⁹ Health Consumer Powerhouse, EHCI 2014, http://www.healthpowerhouse.com/files/EHCI_2014/EHCI_2014_report.pdf, p.44 (accessed 8 February 2015)

¹¹⁰¹¹⁰ Health Consumer Powerhouse, EHCI 2014, op. cit., p.86

¹¹¹ Consumer Powerhouse, EHCI 2014, op. cit., p.5, 15

¹¹² WB, “Diagnostic Surveys of corruption in Romania”, op. cit., p.7

¹¹³ Informal payments in the WB survey on corruption in Romania means bribery, tips and other offerings that some people interpret as expressions of gratitude (gifts).

¹¹⁴ *Idem*, p.11

amount paid was between 10,000 lei (0,22€) to 3,000,000 lei (67€) or gifts. Respondents attested that informal payments are done by tradition (21%) or to express gratitude (11%).¹¹⁵ The WB proved that Romanians could not access needed medical care because of the inability to provide informal payments (including gifts).¹¹⁶

On 8 July 2014, the European Commission elaborated general recommendations for the reform of Romania's National Development Programme. For the period 2014-2015, the EC recommends that Romania intensify its "efforts to reduce the informal payments, including by means of appropriate systems of administration and control".¹¹⁷

C. 3.1. Concluding remarks

This theoretical chapter offers a perspective on corruption, human rights and their relationship. The elaboration of this chapter was divided in two parts: the first part comprised general information which stemmed from putting together cases, situations, theories and practices from all periods of time and all continents; the second part reunited cases, situations, theories and practices concerning the Romanian territory (as it is the country studied in this thesis).

Even if international conventions and structures have put together definitions and criteria that have the aim to be applicable worldwide, corruption is perceived differently depending on the territory (as a habit, as a cultural practice, as a social custom, etc.). There is no country in the world exempt from the danger of corruption. Corruption has many diverse ways of being measured, of being approached and of being punished (criminalised or not). There is, however, a fact about corruption that is applicable everywhere: corruption always causes harm and this harm affects people.

¹¹⁵*Idem*, p. 30

¹¹⁶*Idem*, p. 12

¹¹⁷European Commission's recommendations to Romania for Europe 2020, op. cit., p. 5

Chapter IV

Background case

A. 4.1 Presentation of the background case:

Presenting a background case through several sources can lead to valuable information and insights. Therefore, the existence of corruption cases in the oncological health system will be presented in this chapter through various sources. The background problem will be shaped from the findings of this chapter and the consequences of the findings on the availability, accessibility, accessibility and quality (AAAQ) of the right to health. The sources presented throughout the chapter are part of a non exhaustive list and rely on information from mass media (national and international), NGO reports, international community's engagement, national institutions and authorities' acts and questionnaires applied to patients.

A. 4.1.1. Media Sources

a) National Media

National media refers to Romanian mass media sources (online, audio-visual or printed version of information). Anon exhaustive list of national televisions and newspapers is taken into account, with no precise order or quantity, but with information on corruption in the oncological public health sector in the period 2010-2015 (2010 has been reported by the media to be a critical year of corruption in the health sector)¹¹⁸

¹¹⁸ ProTV, "Doi medici din Deva, retinuti in dosarul retetelor false cu medicamente oncologice", April 6 2013, http://stiri.tvr.ro/doi-medici-din-deva-retinuti-in-dosarul-retetelor-false-cu-medicamente-oncologice_29065.html (accessed on 11 June 2015)

The *Romania Libera* journal attests that the patients at the Oncological Institute in Bucharest usually pay a bribe for each consultation (3-5 €), for each chemotherapy¹¹⁹ (10€) session or a bigger bribe when it comes to a surgery (1.000 €).¹²⁰

Sources from Romanian media issued tens of articles to prove using a hidden camera that doctors take bribes in the oncological public health sector. To mention some of these sources: The *DIGI24 TV* channel proved with a hidden camera that various oncologists were accepting bribes from patients after a treatment or consultation session in the oncological sector.¹²¹

In January 2014, the *EVZ* journal started an online campaign “*Doctor on call*”, publishing articles on corruption in the Romanian healthcare system. More than 50% of the news was related to the oncological sector.¹²² The articles were describing the situation regarding corruption in the health system and were reporting information on a number of legal cases on corruption in the oncology sector.

The Romanian TV channel *PROTV* revealed during a reportage (40 minutes) in 2013 that cancer patients cannot find proper drugs to treat their disease (missing anti-cancer drugs), but, by bribing some of the doctors, treatments for cancer patients could be provided.¹²³

Starting with 2013-2014, Romanian media issued several pieces of reportages and articles on how medicines for treating cancer could not be found on the Romanian drug market anymore and how some drugs “suddenly appeared” each time a bribe was involved. Romanian journalists from *DIGI24 TV* openly accused oncologists of selling drugs to cancer patients (drugs which are normally free of charge under the Romanian law).¹²⁴

¹¹⁹ Chemotherapy refers to “the treatment of disease by the use of chemicals substances, especially the treatment of cancer by cytotoxic and other drugs”, Oxford Dictionaries, <http://www.oxforddictionaries.com/definition/english/chemotherapy> (accessed 4 April 2015)

¹²⁰ Ramona Samoila, “Spagile in spitale”, February, 2 2011. Available from <http://www.romaniailibera.ro/societate/utile/%C5%9Epagile-in-spitale--afla-cat-se-da-pentru-o-operatie-pe-inima-sau-pentru-o-cezariana-215522> (accessed 3 March 2015)

¹²¹ Digi 24, “Specialist oncolog acuzat de mita”, July, 10. 2014. Available from <http://www.digi24.ro/Stiri/Digi24/Actualitate/Sanatate/Specialist+oncolog+acuzat+de+mita+600+de+bolnavi+de+cancer+raman> (accessed 2 March 2015)

¹²² EVZ, “Medicul de garda”. Available from <http://www.evz.ro/medicul-de-garda?&page=1> (accessed 3 March 2015)

¹²³ Pro TV, Reportage, 43:38 minutes, 2013. Available from <http://romaniateiubesc.stirileprotv.ro/emisiuni/adevarata-drama-e-lupta-cu-sistemul-nu-cu-maladia-un-reportaj-romania-te-iubesc-despre-lumea-bolnavilor-de-cancer.html> (accessed 2 March 2015)

¹²⁴ Digi 24, “Medic prins in flagrant in timp ce lua mita de la un bolnav de cancer”, July, 9 2014. Available from <http://www.digi24.ro/Stiri/Digi24/Actualitate/Sanatate/Medic+prins+in+flagrant+in+timp+ce+lua+mita+de+la+un+bolnav+de+c> (accessed 12 March 2015)

In January 2015, another incident was revealed by the media: several pharmacists from a Romanian public hospital are under investigation for stealing hundreds of medicines designed to treat cancer patients. According to the Head of the oncology department of the hospital, the medicines that were stolen were the most expensive ones and according to the legislation, such medicines could only be administered in specialised health centres.¹²⁵

b) International Media

International media refers to outside (foreign) mass media sources (online, audio-visual or printed version of information). Media sources include a non exhaustive list of televisions and newspapers from English, French and Spanish speaking countries that contain related information on corruption in the oncological public health sector in the period 2010-2015.¹²⁶

In 2013, *The Economist* published an article on “A Shortage of cancer drugs”.¹²⁷ The press article reveals that Romania has known a difficulty in providing cancer drugs to patients in the past two years for more than 20 types of drugs. This phenomenon was referred to as “*the cytostatics crisis*” where the majority of the cheapest cancer medicines were impossible to find in Romania. An oncologist attested for the *Economist* that “*the problem is not the money [...] the problem is those who are in charge of providing the drugs*”¹²⁸. However, the question asked is if the persons behind the drug companies are even coordinating a legal activity and why those companies that cannot provide cheap medication are not held accountable? (the Oncology Institute in Bucharest itself has experienced a shortage of cancer drugs)

The same article quotes a cancer patient (Marius) according to whom the hospital offers cytostatics to cancer patients only if the right person is bribed. If a regular patient comes in for treatment, the healthcare staff members respond that no medication (cytostatics) is available. However, with a bribe, “*the cytostatic appears out of the blue*”.¹²⁹

¹²⁵PRO TV, “La Braila, medicamentele bolnavilor de cancer au disparut din farmacia spitalului”, January, 30 2015. Available from <http://stirileprotv.ro/stiri/sanatate/medicamentele-bolnavilor-de-cancer-furate-din-spital-pastilele-cu-preturi-exorbitante-ar-putea-ajunge-pe-piata-neagra.html> (accessed 13 March 2015)

¹²⁶ International media will be analyzed from English, French and Spanish sources (languages that I speak)

¹²⁷Liliana Ciobanu, “A shortage of cancer drugs”, *The Economist*, Jan. 28 2013. Available from <http://www.economist.com/blogs/easternapproaches/2013/01/romanian-politics> (accessed 1 March 2015)

¹²⁸*Idem.*

¹²⁹Liliana Ciobanu, “A shortage of cancer drugs”, op. cit.

The *Balkan Insight* reports in an article from 2013 that the lack of vital medicines for cancer patients is due to “*corruption and abuse of the system*”.¹³⁰ The same information is written in the article of *Romania-Insider* (2013).¹³¹ This latest article also mentions that cancer drugs are free of charge for patients under the Romanian law, but with the impossibility of finding the 20 cheapest cancer drugs on the market, informal payments are rising and making the shortage of drugs a profitable business for some.

The *Medical Xpress* presented a court case in an article from 2014 and mentioned that a nine-year-old boy won a court case against the Romanian Government: the boy got free access to newer anti-cancer medicines, as the Government had not updated the list of drugs in six years, making the anti-cancer therapies outdated, while in Europe more drugs have been updated for cancer patients. The article mentions that in this regard the healthcare system “*is beset with corruption*”.¹³²

The *Newsroom* reported in 2014 that the CNAS has detected fraud in the oncological medical prescription. Therefore, several oncologists (13) have been interrogated, because they were suspected of filling in false medical prescriptions for cancer drugs in order to get reimbursed by the CNAS.¹³³

A. 4.1.2. NGO reports

The background case deals with both the health sector and the anti-corruption mechanisms. This section will analyse the findings of two types of NGOs (oncological/health and anti-corruption/transparency) dealing with or referring to corruption in the oncological public health sector.

¹³⁰ M. Chiriac, “Cancer Cases on the Rise in Romania”, *Balkan Insight*, April, 16 2013. Available from <http://www.balkaninsight.com/en/article/cancer-cases-in-romania-on-the-rise> (accessed 1 March 2015)

¹³¹ Irina Popescu, “Over 78,000 new cases of cancer diagnosed in 2012 in Romania, study shows”, April, 15 2013. Available from <http://www.romania-insider.com/over-78000-new-cases-of-cancer-diagnosed-in-2012-in-romania-study-shows/86474/> (accessed 2 March 2015)

¹³² Medical Xpress, “Court orders Bucharest to provide free cancer drugs”, June, 18 2014. Available from <http://medicalxpress.com/news/2014-06-court-bucharest-free-cancer-drugs.html> (accessed 2 March 2015)

¹³³ Newsroom, “La maladie chronique du système de santé roumain”, May, 23 2014. Available from <http://newsroom.fr/la-maladie-chronique-du-systeme-de-sante-roumain/> (accessed 2 March 2015)

In 2012, the white book of the Romanian NGO sector was published.¹³⁴ The document represents a collection of proposals that various NGOs issue for political parties and public institutions. The chapter on Health, coordinated by the *Association M.A.M.E. (Mothers)*¹³⁵, included a table on oncology.¹³⁶ The table presents problems, solutions (policies) to problems and the estimated time needed to implement the proposed policies. Among other problems in the oncology sector, it is mentioned that Romanian hospitals experience “dysfunctions” in providing oncological medicines to patients (because of their non existence or because of some other financial interests of some distributors or producers). The suggestion was “*to create a mechanism that could avoid any dysfunction in providing drugs to cancer patients*”.¹³⁷ The message confirms the problem of some irregularities in drugs due to financial interests, but the chapter does not come up with a proper solution or more precise explanations on the matter.

The *Alliance for a Clean Romania (ARC)*¹³⁸ recognised the problem of the disappearance of cancer drugs because of corruption and, in 2013, addressed a letter to the Minister of Public Health and to the Romanian Prime Minister explaining the situation observed regarding cancer drug trafficking for illegal benefit.¹³⁹

The letter of the ARC included the following points¹⁴⁰:

- To create a compulsory list of medication that every hospital is obliged to have permanently and to also include medication for cancer patients on this list, in order to eliminate the possibility for doctors or nurses to commit embezzlement with hospital’s medication.

¹³⁴ The white book of the NGO sector in Romania is a publication with the support of the Centre of Resources for Public Participation, the Foundation for the Development of the Civil Society and with the financial support from the USA Embassy in Romania. Available at <http://www.ce-re.ro/upload/Carta%20Alba%20a%20sectorului%20ONG%20din%20Romania.pdf> (accessed 7 March 2015)

¹³⁵ Official website: www.asociatiamame.com. The Association M.A.M.E. is an NGO, founded in 2009 and focusing on health and advocacy. Its projects are focused among others in campaigning for medication, social protection, maternity, patients, health insurance, awareness and others.

¹³⁶ *Idem*, p. 104

¹³⁷ *Idem*, p. 105

¹³⁸ Official website: www.romaniacurata.ro. The ARC is a civil movement that started in 2008 by an anti-corruption expert Alina Mungiu-Pippidi and it is opened to NGO’s, syndicates, persons or organisations that are willing to promote good governance and transparency in Romania. See <http://www.romaniacurata.ro/despre-noi/> (accessed 12 March 2015)

¹³⁹ ARC, the letter was send by the ARC to the Prime Minister and to the Public Health Minister on 28 January 2013 with the recommendation to take the letter into consideration when the Government will discuss the issue on corruption via anti-cancer drugs. Available at: <http://www.romaniacurata.ro/solutii-pentru-stoparea-jafului-din-buzunarele-bolnavilor-opriti-drama-pacientilor-din-spitale-obligati-sa-si-cumpere-singuri-medicamentele/> (accessed 12 March 2015)

¹⁴⁰ *Idem*

- To evaluate anti-cancer drugs using a health technology assessment (HTA) where medicines could be economically evaluated in all hospitals.

- To eliminate the need for patients to first obtain first signature of the hospital manager in order to be reimbursed by the National Health Insurance House for the drugs that the patient purchased on his/her own because of the shortage of drugs in hospitals. This procedure was criticised as being a paradox, because the person who signs the patient's form is the one being corrupt by not offering the drugs which are free of charge.

The *Federation of Association of Cancer Ill Persons* (FABC) expressed concern regarding missing drugs for cancer patients for the first time in April 2011.¹⁴¹ However, declarations were not made referring to corruption, but rather referring to a proper legislation in providing medication for patients. Further press statements on the same matter were released in 2013 and 2014.¹⁴²

At the 6th Conference of the FABC on 29 June 2014, the President of the Federation, Cezar Irimia, acknowledged the problem of corruption in the oncological sector openly affirming that *"corruption in the oncological sector takes more lives in Romania than cancer itself"*.¹⁴³ The President announced that if the people responsible for corruption in the oncological sector will ever be convicted by the courts of justice, *"the accusation cannot be other than genocide"*.¹⁴⁴ Additionally, the President attested that *"we [the federation] are going to stop the demonstration and radical actions only when our situation [of cancer patients] will become normal and we will be there, with our vote, when others [political power] will decide for us"*.¹⁴⁵

A. 4.1.3. National institutions and authorities

While searching for cases of corruption in the oncological public health sector (or cancer) on the website of the Ministry of Justice, 74 open court cases on corruption related to cancer

¹⁴¹ Official website: www.fabc.ro. The FABC was founded in 2005 and is composed by 12 regional and national associations and has more than 35 000 patients, survivals and representatives of cancer ill persons; <http://fabc.ro/comunicate-de-presa/> (accessed 12 March 2015).

¹⁴² *Idem*

¹⁴³ FABC, <http://fabc.ro/2014/06/comunicat-conferinta-nationala-fabc-2014-ed-a-vi-a/> (accessed 7 March 2015)

¹⁴⁴ FABC, <http://fabc.ro/portfolio/conferinta-nationala-fabc-editia-a-iii-a/> (accessed 4 March 2015)

¹⁴⁵ *Idem*

patients (drugs, medicines or chemotherapy) were found.¹⁴⁶ Out of the 74 cases, 60 of them are older than one year (only 8 of the cases appeared in the last year).¹⁴⁷

In 2010, Romanian prosecutors started an investigation involving false medical prescriptions for anti-cancer medication. The prosecutors found that several doctors from the oncological public health sector were committing tax evasion with cancer medicine. Doctors were issuing legal medical prescription (on behalf of a patient) and instead of giving it to a patient in order to for him/her purchase the medicine, doctors offered the prescriptions directly to the pharmacy which approved with an official stamp that the medicine was purchased. As in Romania the anti-cancer treatment is free of charge, pharmacies usually provide the drugs freely to patients and request the reimbursement from the CNAS. The prosecutors discovered that some pharmacies had an arrangement with oncologists: splitting the reimbursement of the false medical prescriptions after obtaining the money from the Health Insurance.¹⁴⁸ Prosecutors found that the money was registered as loans obtained from the same pharmacies.¹⁴⁹

In the same context, prosecutors proved that oncologists also used false prescriptions that attested the use of certain public hospital's devices in detecting and treating cancer patients. Doctors filled in false medical papers that attested the use of hospital's devices for hundreds of patients that never benefited from that treatment in reality.¹⁵⁰

Moreover, members of the nursing staff were sometimes involved in embezzlement, along with the doctors of the hospital. The doctor falsely recommended to fictitious cancer patients to do blood tests and the nurses from the laboratory falsely confirmed that the patients underwent those tests. A reimbursement of used needles and other hospital devices was asked from the CNAS (more than 14.000 counterfeit medical prescriptions).¹⁵¹ Prosecutors presented to

¹⁴⁶ Ministry of Justice's portal, <http://portal.just.ro/SitePages/cautare.aspx?k=cancer&r=sitenam%3D%22AQ12ZG9zYXJfdmRvc2FyCHNpdGVuYW1lAQFeASQ%3D%22> (accessed 15 March 2015)

¹⁴⁷ *Idem*

¹⁴⁸ DNA, <http://www.pna.ro/comunicat.xhtml?id=5197> (accessed 10 March 2015)

¹⁴⁹ ANAF, <http://www.antifrauda.ro/Direc%C5%A3ia-General%C4%83-Antifraud%C4%83-Fiscal%C4%83-a-identificat-un-prejudiciu-de-2,1-milioane-euro-a-10.html> (accessed 10 March 2015)

¹⁵⁰ *Idem*

¹⁵¹ Gandul, "Medici acuzati de decontari inexistente", March, 29 2013. Available from <http://www.gandul.info/stiri/medici-acuzati-de-decontari-inexistente-cum-functioneaza-retelele-de-frauda-din-sanate-retete-pentru-morti-analize-fictitious-si-achizitii-supraevaluate-10699226> (accessed 10 March 2015)

the court that blood tests of real patients existed in parallel, only that the used chemical products were expired and the scientific information on diseases was unreliable.¹⁵²

In 2013 the prosecutors revealed that the CNAS had reimbursed over 500.000 Euro because of false medical prescriptions. 44 persons were arrested for the investigation of this case. Out of those investigated, 37 persons were convicted for fraud and forgery.¹⁵³

The National Anti-Corruption Direction (DNA) is currently (2015) investigating the oncologist Csiki Csongor and the prosecutors have already sent the case to the suitable court to judge Mr. Csongo for constantly accepting bribes from 13 cancer patients in the period 2011-2014.¹⁵⁴

In 2013, in a discussion about the shortage of cancer medicines in Romania, Prime Minister [Victor Ponta] declared: *“I saw a case of a person who needed [cancer] drugs and went to Fundeni [a public hospital in Bucharest] where he did not receive the cancer medicines, although it was revealed that the doctor just didn’t want to give him the drugs”*.¹⁵⁵

In January 2015, the spokesperson of the Government, Corneliu Calota, declared that in order to stop the fraud involving cancer medicines, the persons who buy cancer drugs and do not receive a receipt for their purchase are required to call the police or the services of the *National Agency against Fraud* (ANAF).¹⁵⁶

The CNAS declared that some sources misinformed the public by attesting that there is a crisis regarding free medicines provided by the insurance house.¹⁵⁷ The CNAS indicated that there is no data to prove that the funds allocated to free medicines for patients are lower than the previous year. The CNAS also confirmed that the misinformation concerning some problems inside the CNAS could have been due to corruption and fraud practices at the health sector level.¹⁵⁸

¹⁵² *Idem*

¹⁵³ Court/ Bucharest Tribunal, 16.12.2014, <http://ptbucuresti.mpublic.ro/anunturi/2014/16.12.2014.html>, (10 March 2015)

¹⁵⁴ DNA, <http://www.pna.ro/comunicat.xhtml?id=5821> (accessed 15 March 2015)

¹⁵⁵ Liliana Ciobanu, *The Atlantic*, Op. Cit.

¹⁵⁶ ObiectivVoceaBrailei, <http://www.obiectivbr.ro/social-guvern-persoana-care-nu-primeste-bon-fiscal-sa-sune-la-serviciul-112-sau-sa-id101008> (accessed 17 March 2015)

¹⁵⁷ CNAS, <http://www.cnas.ro/post/type/local/afirmatiile-despre-existenta-unei-crize-a-medicamentelor-compensate-si-gratuite-sunt-false-si-reprez.html> (accessed 11 March 2015)

¹⁵⁸ *Idem*

In the control report No. 243/15.06.2012 operated by a mixed commission (CNAS and MPH), the insurance house of *Valcea* [name of the city] concluded that in the Public Emergency Hospital in *Valcea* there is no concordance between the medical prescriptions of cancer medicines on paper issued by doctors and the registration book of medicines held by the hospital's pharmacy.¹⁵⁹

A.4.1.4. International Community

In the *European Commission* report on corruption in the health sector, it is reported that there is a problem in Romania regarding the sale of public medicines for private gain. The EC reports that Romania deals with “*embezzlement of medicines paid from public funds in hospitals and resold (under the table) to patients or directed to parallel export*”.¹⁶⁰ In addition, the report mentions the problem of false prescriptions [of medicines] and notes that therefore “*no or much less medicines are released*”.

In Romania's second cycle of the Universal Periodic Review (UPR)¹⁶¹, a Joint Submission (JS1)¹⁶² in the summary of stakeholder's information revealed that it is “*customary that patients and their family pay additional money to receive adequate care, in addition to the cost of consultation and medications*”.¹⁶³ The JS1 also attested “*that lack of medicines, adequate*

¹⁵⁹ CAS, Nr. 243/15.06.2015. The document can be accessed directly at: <http://webcache.googleusercontent.com/search?q=cache:W2EIWaHFn0wJ:www.prefecturavalcea.ro/documents/article/571/Raport%2520de%2520control%2520-%2520Spit.%2520Jud.%2520de%2520Urg.%2520Valcea.doc+&cd=1&hl=ro&ct=clnk&gl=ro> (accessed 13 March 2015)

¹⁶⁰ The European Commission, Study on Corruption in the Healthcare Sector, HOME/2011/ISEC/PR/047-A2, October 2013, http://ec.europa.eu/dgs/home-affairs/what-is-new/news/news/docs/20131219_study_on_corruption_in_the_healthcare_sector_en.pdf, p. 175 (accessed 17 March 2015)

¹⁶¹ The UPR is a periodic review of the human rights records of all 193 UN Member States, as an innovation of the Human Rights Council in 2006. See more at: <http://www.ohchr.org/EN/HRBodies/UPR/Pages/BasicFacts.aspx> (accessed on 12 June 2015)

¹⁶² A Joint Submission to the UPR is a submission of a report concerning the situation of human rights in a certain country coming from different stakeholders (including NGO's). See more at: <http://www.ohchr.org/Documents/HRBodies/UPR/TechnicalGuideEN.pdf> (accessed on 12 June 2015)

¹⁶³ Human Rights Council, WG on the UPR, 15th session, “Summary prepared by the Office of the High Commissioner for Human Rights in accordance with paragraph 5 of the annex to Human Rights Council resolution 16/21”, (UNGA; A/HRC/WG.6/15/ROU/3). Available at <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G12/179/03/PDF/G1217903.pdf?OpenElement>, p. 8 (accessed 18 March 2015)

*medical equipment, and available beds also affected public health facilities”.*¹⁶⁴ However, the comments do not refer to a specific department in the public health sector in Romania, but rather to the entire public health system (not the oncology sector specifically).

A.4.1.5. Patients: questionnaires

In order to find out the situation of corruption in the oncology sector from the patients themselves, a questionnaire was developed for the purpose of this thesis. The questionnaire comprised 15 points (see Appendix A) and evaluated corruption in the oncological system. It was conducted in March 2015 in 6 different public hospitals covering all 6 districts in Bucharest. Aside from the outcome of the questionnaire presented in the following paragraphs, a document with the detailed overall findings is attached in Appendix B.¹⁶⁵

¹⁶⁴ *Idem*

¹⁶⁵ The questionnaire did not entirely reveal the interest in corruption findings. The respondents believed that the questionnaire was aiming to evaluate the general services provided by the hospital in the oncological sector. The questionnaire’s methodology is entirely developed in Chapter II Methodology of this paper.

Demographics¹⁶⁶

Respondents

- The questionnaire was applied to **63 persons** (declared as patients) from 6 public hospitals

Age groups

- 52,4 % (33 pers.) of the respondents were over 60 years old, followed by 23,8% (15 pers.) between 50-59 years, 15,9% (10 pers.) between 40-49 years, 4,7% (3 pers.) between 30-39 years and 3,2% (2 pers.) between 18-29 years (92% of the respondents were over 40 years old)

Gender

- 57,1% (36 pers.) were male respondents and 42, 9% (27 pers.) were female respondents.

Occupation

- 76,2% (48 pers.) of respondents were retired public officials, 11,1% (7 pers.) were working in the public sector, 9,5% (6 pers.) in the private sector and 3,2% (2 pers.) had no occupation

Nationality

- All respondents were Romanian, however, 3 patients declared themselves as being part of the Hungarian minority.

Diagnosis

- The health diagnosis of the respondents was distributed among 6 different types of cancer : 25,6% (16 pers.) colon cancer, 20,6% (13 pers.) lung cancer, 19,1% (12 pers.) liver cancer, 12,7% (8 pers.) uterine cancer, 11,1% (7 pers.) breast cancer and 11,1% (7 pers.) throat cancer.

Regularity of treatment

- 79,5% (50 pers.) declared that they came in for treatment or consultation 1-3 times/month, 9,5% (6 pers.) came 1-3 times/week, 7,9% (5 pers.) on a daily basis and 3,2% (2 pers.) rarely.

Familiar with the hospital

- A percentage of 42,8% (27 pers.) of the respondents were familiar with the respective hospital's oncology department since 3-5 years before, 30,2% (19 pers.) started being patients of the oncology department 1-2 years before, 14,3% (9 pers.) started more than 5 years before, 9,5% (6 pers.) started 0-1 years before and 3,2% (2 pers.) had been patients at the hospital for more than 10 years.

¹⁶⁶ The exact percentages are also mentioned in the overall finding sheet in Appendix B.

Experiences of corruption:

- When asked if the quality or the availability of a treatment/medication depends on informal payments/gifts given to hospital staff members, 90,5% (57 pers.) confirmed that they were familiar with such a hypothetical situation. Another 9,5% (6 pers.) of patients confirmed that it happened that doctors or nurses asked for informal payments in order to access a service that is normally free of charge at the hospital. However, not one respondent was familiar with the hypothetical situation where the quality or the availability of a treatment/medication depends on the patient's personal relations with the hospital staff members.

- Participants also had to evaluate the importance of four situations in the medical service (on a scale ranging from no concern, a certain concern or an important concern). The majority of respondents answered with "an important concern" to all four situations, as follows: a percentage of 92,1% (58 pers.) considered informal payments, bribes and gifts provided to hospital staff members to be an important concern, 100% (63 pers.) considered an adequate and qualitative treatment and drugs to be an important concern, 82,5% (52 pers.) considered the absence of treatment or drugs in hospitals to be an important concern and 69,8% (44 pers.) considered the situation of poor sanitation, hygiene or potable water to be an important concern.

- In other public hospitals in Romania¹⁶⁷, 73% (46 pers.) experienced medical staff requesting informal payments or gifts from patients, 95,2% (60 pers.) experienced situations of medical staff accepting informal payments and gifts offered by patients and 69,8% (44 pers.) also experienced the availability of treatment or medication only after offering informal payments or gifts to medical staff members (69%).

- Another important aspect is the fact that 96,8% (61 pers.) answered to such a questionnaire on the quality of services in a public hospital for the first time, 3,2% (2 pers.) had completed such questionnaire(s) before, but no one was familiar with a questionnaire from monitoring experts or national observation mechanisms evaluating a hospital regarding the right to health.

The table below shows how familiar patients are with two hypothetical corruption situations in the oncology sector of public hospitals:

¹⁶⁷ Aside from the ones where the questionnaire was applied.

Table 1: Familiarity of patients with hypothetical situations

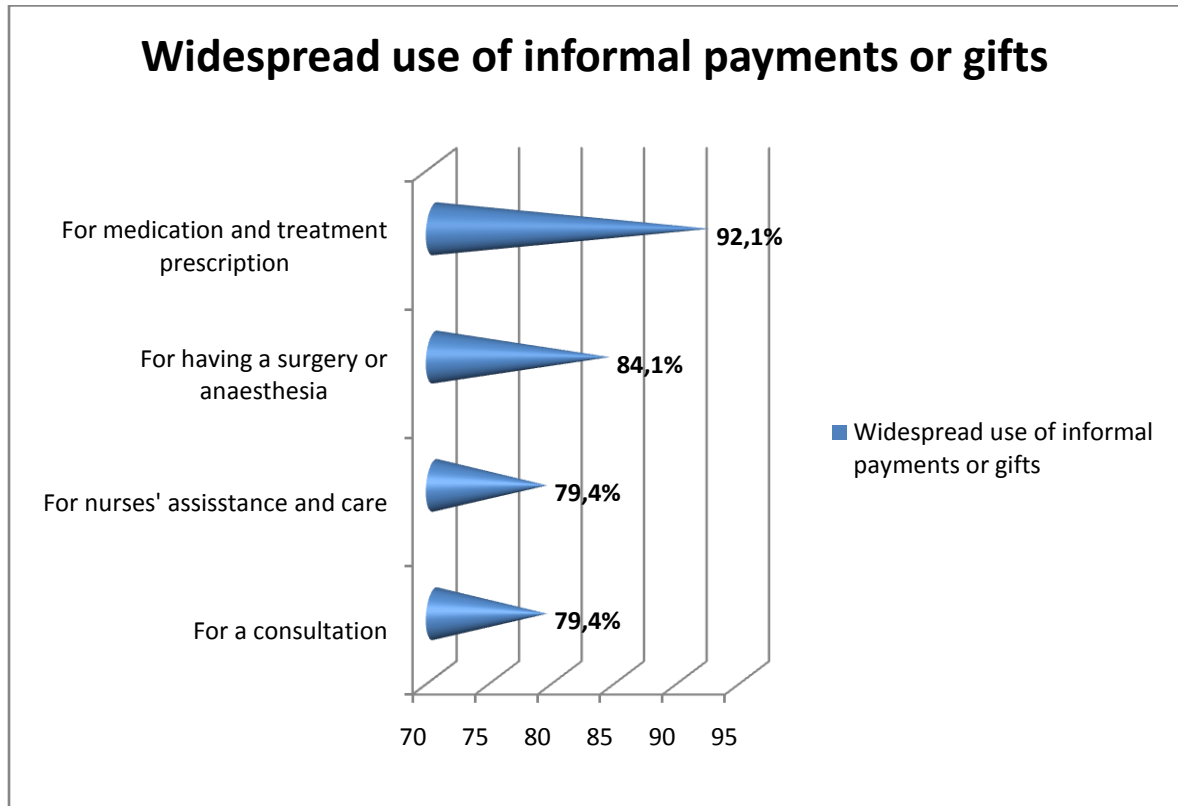
Familiarity with hypothetical situations	At the end of a consultation/treatment	Sometimes	Very rarely	Never
Giving small attentions to doctors/nurses to obtain (better) services or (better) medication/treatment	60,3% (38 pers.)	28,6% (18 pers.)	7,9% (5 pers.)	3,2% (2 pers.)
Doctors or nurses can help access medication, treatment or medical equipment that not available elsewhere by providing small attentions (gifts, informal payments, bribes or other)	Always	58,7% (37 pers.)	Not aware	7,9% (5 pers.)
	20,7% (13 pers.)		12,7% (8 pers.)	

Source: Personal table made with statistical information from the applied questionnaire

Table 1 reveals that 60,3% (38 pers.) are familiar with giving (at the end of a consultation or treatment) attentions (bribes, informal payments, gifts) to doctors or nurses in order to obtain services, medication or treatment or even better services, medication or treatment at the hospital. 28,6% (18 pers.) answered that they are sometimes confronted with the hypothetical situation, 7,9% (5 pers.) have very rarely been confronted with the hypothetical situation and 3,2% (2 pers.) have never experienced such a situation.

58,7% (37 pers.) are sometimes confronted with situations where doctors or nurses can provide access to medication, treatment or medical equipment at a hospital if they are offered attentions(gifts, informal payments, bribes or other). 20,7% (13 pers.) are *always* confronted with such situations, 12,7% (8 pers.) of the respondents were *not aware* of such situation and 7,9% (5 pers.) have never been confronted with such a situation.

Figure 2: Perception of the widespread of informal payments or gifts



Source: Personal table made with statistical information from the applied questionnaire

Figure 2 accentuates the fact that informal payments or gifts are perceived as widespread especially for medication and treatment prescription by 92,1% (58 pers.) of the respondents. However, in all four situations, the respondents perceived informal payments or gifts as widespread.

Table 2: Evaluation of different situations in hospitals at three different moments in time

Evaluation of :	Relevance (average)				
	Very bad		Very good		
	1	2	3	4	5
a. The accessibility of medical staff members of the hospital					
- Without giving/being requested informal payments/gifts to hospital staff members	1	2	3	4	5
					3,53
-When offering informal payments or gifts to hospital staff members	1	2	3	4	5
					3,95
- When a hospital staff member is requesting informal payments/gifts	1	2	3	4	5
					4,23
b. The professionalism of doctors and nurses					
- Without giving/being requested informal payments/gifts to hospital staff members	1	2	3	4	5
					2,68
- When offering informal payments or gifts to hospital staff members	1	2	3	4	5
					4
-When a hospital staff member is requesting informal payments/ gifts	1	2	3	4	5
					4,46
c. The availability of medication					
- Without giving/being requested informal payments/gifts to hospital staff members	1	2	3	4	5
					1,28
- When offering informal payments or gifts to hospital staff members	1	2	3	4	5
					4,46
- When a hospital staff member is requesting informal payments/ gifts	1	2	3	4	5
					4,66
d. The quality of sanitation and hygiene					
- Without giving/being requested informal payments/gifts to hospital staff members	1	2	3	4	5
					3,17
- When offering informal payments or gifts to hospital staff members	1	2	3	4	5
					3,52
- When a hospital staff member is requesting informal payments/ gifts	1	2	3	4	5
					4,60

Source: Personal table made with statistical information from the applied questionnaires

Table 2 evaluates different situations experienced in a public hospital (oncological department). Every situation is evaluated at three different moments in time: without giving or being asked to pay a bribe, while offering a bribe and while a patient is asked to pay a bribe. The bribe can take the form of an informal payment or a gift.

The table's importance lies especially in its evolution at those three different moments in time (and not in the grades themselves). For instance, for each of the four different situations presented in Table 2, the items are considered to be not very bad, but they are better each time a bribe is involved. The initial moment (without a bribe) always has the lowest grade. Once a patient offers a bribe, the situation gets better and once a patient is asked for a bribe the situation gets even better (better than without a bribe and better than by offering a bribe). While comparing the averages of the three different moments in time, the availability of medication presented an enormous gap: from 1,28 (without bribe) to 4,46 (when offering a bribe) and then to 4,66 (when asked for a bribe). Other averages present a less important gap between the three different moments, for instance, the accessibility of medical staff members in the hospitals presented the lowest average gaps: from 3,52 (without bribe) to 3,95 (when offering a bribe) and then to 4,53 (when asked for a bribe). However, the fact that those average gaps even exist is a sign that a bribe influences the perception of a situation.

Table 2 also reveals that the quality or accessibility of a situation in a hospital is directly proportional with the involvement of a bribe (getting better by offering a bribe and even better when a patient is asked for a bribe).

B.4.2. Concluding remarks

The background case of the present Master thesis lies in facts arising from a non exhaustive list of different sources from mass media (internal and international), NGO reports, international community's engagement, national institutions and authorities' acts and questionnaires applied to patients.

The findings are deducted from reasoning after analysing the abovementioned types of sources referring to corruption in the oncological public health sector in Romania. What is considered to form the background problem is in fact the list of findings of different types of corruption.

Table 3 delineates the findings in a matrix (outcome of each source) and adds the reasoning on the consequences of the findings on the AAAQ of the right to health.

Table 3: Matrix of findings

Source	Findings	Consequences on the AAAQ of the right to health
National media	<ul style="list-style-type: none"> - Bribery for consultation and treatment -Bribery for obtaining medicines that should be freely available - Embezzlement involving cancer medicines by medical staff members 	The availability and the accessibility of medicines are affected
International media	<ul style="list-style-type: none"> - Bribery for obtaining medicines - Fraud involving medical prescriptions 	The availability, the accessibility of medicines and the quality of medical staff performances are affected
NGO's	<ul style="list-style-type: none"> - Embezzlement of cancer medicines 	The availability and the accessibility of medicines are affected
National institutions	<ul style="list-style-type: none"> - Fraud involving medical prescriptions - Tax evasion involving cancer medicines - Embezzlement of cancer medicines - Bribery for medication and treatment 	The availability, the accessibility of medicines and the quality of medical staff performances are affected
International community	<ul style="list-style-type: none"> - Embezzlement of cancer medicines - Resale to patients medicines that should be freely available 	The availability and the accessibility of medicines are affected
Patients	<ul style="list-style-type: none"> - Bribery for medication and treatment raised at 92% of respondents - Bribery is widespread because it increases the availability and quality of medical services 	The availability, accessibility of medications and the quality of medical services are affected. The AAAQ is directly proportional with the involvement of bribery

Source: Personal table made with the findings of chap. IV

The background case has proven the existence of a trafficking network in public hospitals dealing with embezzlement involving cancer medicines, the fraud of medical prescriptions, bribery, tax evasion and sale of medication to patients that should be provided free of charge.

The affected elements of the right to health are:

- The **availability** of medications that are no longer at the disposal of every patient and suffer from embezzlement. Sometimes medication can be available, but is then conditioned upon informal payments and sometimes medication entirely disappears from the open market because of embezzlement committed by medical staff members or even by pharmacists who cooperate with medical staff members in hospitals.

- The **accessibility** (affordability or financial element) of cancer medicines is blocked and conditioned upon informal payments. In this situation, it is the economical accessibility element that is affected. Poor people and socially disadvantaged groups cannot have access to the same medication as richer people, who can afford the financial contribution of informal payments.

- The **acceptability** of trafficking cancer medicines, devices or prescriptions affects the medical ethics of the right to health. The right to health cannot ethically depend on corrupt practices, fraud and informal payments in order to treat a disease. In the applied questionnaire on cancer patients, 60,3% (38 pers.) declared themselves unsatisfied with the hospital healthcare services, but never have reported a concern to a competent authority. Other 15,9% (10 pers.) unsatisfied respondents have reported irregularities to a competent authority. Other 9,5% (6 pers.) declared themselves very satisfied and 14,3% (9 pers.) were satisfied with the hospital healthcare services. It could be noticed that the reporting of patients to a competent authority might have an impact on the improvement of the medical system and might call into question the medical ethics.

Answering another question of the survey (on the competences of staff members), 33,3% (21 pers.) described the competences and services offered by the hospital as being unprofessional, solving issues through corrupt practices, 34,9% (22 pers.) declared the staff members as incompetent, unwilling to improve the general services of the hospital, 25,4% (16 pers.) declared that the medical staff are competent and 6,4% (4 pers.) declared that medical staff are highly competent, true professionals. Again, the medical ethics are called into question.

- The **quality** of the performances of the medical staff members dealing with false medical prescriptions and tax evasion and the quality of medical services become directly proportional with the involvement of bribery.

Being certain that the background case is true, problematic and present in the oncological department of different public hospitals, there is an incontestable need for the State to take actions in protecting the right to health against corruption. The following Chapter (V) will assess the adequacy of Romania's measures in order to protect the health sector against corruption (in particular the oncological public health sector).

Chapter V

Assessment on Romania's measures

A.5.1. Evaluating Romania's measures

This present chapter is aiming to assess if Romanian State's measures are adequate to protect the right to health in the oncological public health sector against corruption. It should be noted that Romania needs to protect the right to health against corruption, because, as shown in the previous chapter (Chapter IV) using a variety of sources, the oncological public health sector in Romania is hindered by different forms of corruption(See Ch. IV B 2.1).

A.5.2. Indicators and benchmarks

In order to assess how Romania's measures protect the right to health against corruption practices, four non-exhaustive indicators were chosen, covering multiple contexts that provide a structured evaluation of a State's measures. The indicators examined in this chapter are: the legal context, the national strategy and the plan of action, the participation and coordination and the monitoring and accountability system¹⁶⁸. These indicators are usually mentioned by the UN Special Rapporteur on the right to health as being indicators commonly available for countries without lying beyond the capacity of States¹⁶⁹.

Each indicator, when put in a specific context, has its benchmarks (a specific list of items) that help assess all aspects of an indicator. Benchmarks also allow the evaluation process to be critical of State's measures regarding the availability, accessibility, acceptability and quality of a State measure. Each indicator is disaggregated, where possible, by public health departments, sections and sectors in order to touch upon the oncological health sector. Those

¹⁶⁸ There is no international agreed system of indicators in measuring the effectiveness of a State's measure in protecting the right to health from corruption practices.

¹⁶⁹ Those indicators are recommended by the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, in E/CN.4/2006/48; 3 March 2006, op. cit.

points of reference are adapted to the purpose of this thesis and follow the example of the benchmarks provided by the UN Special Rapporteur on the right to health who attested that “a State might wish to add to, or subtract from, the table [regarding examples of indicators on the right to health]”¹⁷⁰.

Each indicator has its own table of benchmarks¹⁷¹ presented at the beginning of the subtopics. The points of reference are in fact questions that helped structure the analysis of the indicator. A complete table of all indicators and of the benchmarks used for each indicator is presented in Appendix C.

A. 5.2.1. Legal context

The legal context indicator evaluates the State’s legislation concerning countering corruption in public hospitals. It takes into consideration laws and regulations which apply to every public hospital. The legal context indicator is based on benchmarks in order to assess:

- (a) the capacity of the State’s legal framework to successfully contain corruption in public hospitals,
- (b) the capacity of the legal system to protect the patients against damages cause by acts of corruption
- (c) the ability to reform the legal framework in order to respond to acts of corruption in the health system.

¹⁷⁰ *Idem*, annex, para. 6

¹⁷¹ Benchmarks are specific points of reference, adapted to the purpose of this thesis, in order to find State’s actions in protecting the right to health when it is hindered by corruption cases in the oncological public health sector. Each indicator is equipped with its own table of benchmarks.

Table 4: Legal context indicator and appropriate benchmarks

Indicator	Benchmarks Structural / organizational	
Legal context	a) Does the State have proper legislation and national institutions to counter embezzlement of public resources or forgery in the public health sector?	Is there a law/policy criminalising forms of corruption? Is the law properly implemented? Has the law been reformed or updated in the past 2-3 years? Is there an independent judicial authority with the power to try ministries/public officials for abuses? What is the efficiency of the activity of the national anti-corruption authorities in the health sector: number of prosecutions, number of arrests of medical staff members for corruption, etc. Does the whistleblower protection apply in the health sector? Financially speaking, are anti-corruption institutions capable of countering corruption? Has the number of these types of activities increased in the past 2-3 years?
	b) Does the State have a policy to allocate any reparation allowances to patients or any financial resources to replace the assets hindered by corruption (medicines, devices)?	Is the percentage of the reparation policy sufficient to cover the prejudice brought by the embezzlement of medicines?
	c) Does the State have the ability to adjust/reform the legal framework to respond to corruption acts in the health system?	Did the legislation suffer any modification in order to counter corruption acts in the healthcare system? Are the changes helpful and well received in the healthcare system?

Source: Personal table made with benchmarks adapted to assess the context of corruption in public hospitals

Assessment of the legal context indicator:

a) State legislation criminalises corruption in the public healthcare sector as well as in every work sector in private or public institutions. The different criminalised types of corruption are written in the criminal code (latest from 2009) and depending on the type of corruption different types of sanctions are applicable (see chapter III B.3.1.3.)

The current Romanian criminal code established by Law No. 268/2009, criminalises different forms of corruption, such as embezzlement (see more details in Chapter III, B.3.1.3.).¹⁷² According to the criminal code (2009), Art. 295 (1), embezzlement is the “appropriation, use or trafficking by a public official, in his own or another person’s interest of money, values or other goods that he is managing or administering”.¹⁷³ The consequences of such an act are the punishment by imprisonment from 2-7 years and the prohibition to hold public office. Art. 295(2) stipulates that attempted embezzlement is also punishable.¹⁷⁴ In the previous criminal code (2006), embezzlement was part of crimes against patrimony.¹⁷⁵ Since 2009, embezzlement is included in the group of crimes in the workplace, because it was considered that embezzlement affects social relations at work.¹⁷⁶ Also, the sentence provided in the new criminal code is shorter than the imprisonment term provided in the old criminal code (1 to 15 years in the criminal code from 2006). The new criminal code adds the prohibition to exercise a public function, a provision which did not exist before. Until February 2014, Romania used the old criminal code from 2006, where corruption was also criminalised (with a small difference regarding the way sentences are carried out).

The whistleblower mechanism is protected by Law No. 371/2004. The whistleblower has different advantages and the protection of his/her identity is ensured by law.¹⁷⁷ The mechanism applies to all public institutions and in case the whistleblower defends a public interest situation,

¹⁷² Romanian Criminal Code, law number 286/2009, published in MO number 510 on 24 July 2009, modified by three laws in 2012: law number 27/2012, law number 63/2012 and law number 187/2012, available at the Ministry of Justice, <http://www.just.ro/LinkClick.aspx?fileticket=Wpo7d56ll%2FQ%3D>, accessed on 20 May 2015.

¹⁷³ Idem, Ch. II, Art. 295 (1).

¹⁷⁴ Op. Cit., Romanian criminal code, law number 286/2009, Art. 295(2).

¹⁷⁵ Romanian criminal code 2006, Ch. IV, Art. 215, available at http://www.dscllex.ro/coduri/cod_penal_2006.htm, accessed on 21 May 2015.

¹⁷⁶ Op. Cit., Romanian criminal code, law number 286/2009, Art. 295, Mentions (1).

¹⁷⁷ Romanian law number 371/2004, Chap. IV, Art. 7, published in M.O. number 1214 from 17 December 2004. Available at: <http://legislatie.resurse-pentru-democratie.org/legea/571-2004.php> (accessed on 11 June 2015)

he/she is directly put under witness protection.¹⁷⁸ It is important to note that there is no specific policy concerning the protection of whistleblowers in the Romanian private sector.

The MPH does not publish any report or periodical assessment regarding the number of whistleblowers. Looking through the contributions of the MPH to the evaluating commission of the implementation of the National Anti-corruption Strategy 2012-2015, we discover that in 2012, the MPH published a document regarding preventive anti-corruption measures in the public health sector. Whistleblower protection was described as fully applicable in the public health sector, indicating a whistleblower participation of 58% (more than half of the total contributions).¹⁷⁹

Romania has different authorities countering national corruption (see chapter III B 3.1.2). The DNA, as a national institution countering medium and grand corruption in Romania, had an allocated budget as shown in Table 5. Over the past 5 years, the DNA's budget for countering corruption in Romania has constantly increased from 15 million € in 2011 to 22 million € recently attributed for 2015 (see Table 5). Those numbers show that the anti-corruption fight is present and, financially speaking, the State has attributed more and more importance to this fight with every new budget. From an economic point of view, the DNA system has the possibility to counter corruption in the health sector. However, the estimated value of the prejudice cause by corruption discovered by the DNA since 2011 until 2014 has decreased, even if the budget has increased. The amount of valuable resources recovered by the DNA's operations is not proportional to the increase of the DNA's total budget. The DNA has recovered more assets with less money available at their disposal and fewer assets with a higher budget. Yet, the budget and their work in the field are available and accessible.

¹⁷⁸Idem, Art. 8

¹⁷⁹MPH, Evaluation of preventive anti-corruption measures, 2012, <http://sna.just.ro/Portals/0/Documente%20platforma/MS%20Inventar%20Mas%20Preventive.pdf>, p. 10 (accessed on 11 June 2015)

Table 5: DNA budget and activity

DNA	2011	2012	2013	2014	2015
Budget	15 mill. €	17 mill. €	19 mill. €	20 mill. €	22 mill. €
Estimated value of prejudice caused by corruption discovered by the DNA	350 mill. €	330 mill. €	300 mill. €	310 mill. €	n/a

Source: Personal table made with data from DNA, available from <http://www.pna.ro/buget.xhtml?id=28> and <http://www.pna.ro/results.xhtml>. The data in Table 5 is presented by round numbers converted to Euro currency.

Table 6 regarding the activity in anti-corruption (of all national institutions) reveals that in 2014, the DNA sent 708 persons to court for corruption acts, a lower number than in 2011 (740 persons). However, the total number of persons sent to court in Romania for corruption acts has increased from 2011 to 2014 (from 1119 persons to 1364 persons). Table 6 shows that the criminal code is being applied and the authorities are implementing the legislation in countering corruption.

Table 6: Activity in anti-corruption in Romania

Activity	2011	2012	2013	2014	2015
Number of persons sent to court by the DNA for allegations of corruption	740 pers.	451 pers.	635 pers.	708 pers.	n/a
Total number of persons sent to courts for allegations of corruption (by DNA and others)	1119 pers.	926 pers.	1184 pers.	1364 pers.	n/a

Source: Personal table made with data from the Public Ministry of Romania, report of activity 2014, available from: http://www.mpublic.ro/presa/2015/raport_activitate_2014.pdf.

b) The Government allocated additional financial resources to the MPH in order to purchase medicines for cancer patients and to redistribute them to the oncological sectors where medicines were absent because of corruption.¹⁸⁰ The Government modified the Law regarding the health sector (No. 95/2006) in order to allow the MPH to increase the budget of UNIFARM (national pharmacy) by 800.000 € (additional money given by the Government to the budget of the MPH) in order to purchase new cancer medicines which were then given directly to public hospitals.¹⁸¹ However, the MPH identified 18 to 24 cancer medicines whose availability in hospitals was discontinued.¹⁸² Increasing the budget of UNIFARM has only solved the problem concerning the purchase of 13 cancer medicines, while the purchase of rest of the medicines is still under negotiation with producers.¹⁸³ The direct increased budget of the MPH has solved only a part of the issue, but not all the entire range of needed medicines is available.

c) In January 2013, the MPH announced that one option in solving the problem of corruption could be to change the law concerning the financing system of the private medical healthcare.¹⁸⁴ According to Law No. 95/2006, the private medical units are excluded from any financing by the State (financing by the National Found for Social Health Insurance).¹⁸⁵ The MPH requested to finance medical services in private hospitals when the public hospitals are not capable of offering health services to individuals for any reason.¹⁸⁶ Thus, when medical devices are not available, on the grounds that they are dysfunctional or, in the case of the oncological department, intentionally dysfunctional, patients could request to be treated in a private hospital and to be covered by insurance. In the opinion of the MPH, this is also a way to eliminate the negative effects caused by medical staff members who work in both private and public institutions.¹⁸⁷ For instance, the MPH reveals that a high number of doctors working for the

¹⁸⁰ MPH, <http://www.ms.ro/?pag=62&id=12343>, 25 January 2013, accessed on 15 April 2015

¹⁸¹ *Idem*. In Romania, public hospitals purchase cancer medicines only through the national pharmacy, UNIFARM. Producers cannot distribute directly on the market cancer medicines, it is the duty of UNIFARM to do so with the authorization of the MPH and the National Agency of Medicines.

¹⁸² National Press Agency, <http://www.agerpres.ro/sanatate/2013/01/25/ministerul-sanatatii-a-prezentat-guvernului-o-nota-privind-criza-medicamentelor-oncologice-13-39-02>, 25 January 2013, accessed on 15 April 2015.

¹⁸³ *Idem*.

¹⁸⁴ MPH, <http://www.ms.ro/?pag=62&id=12329>, 16 January 2013.

¹⁸⁵ Law concerning reform in the health sector, No. 95 from 14 April 2006, published in the M.Of. No. 372/28 Apr. 2006.

¹⁸⁶ MPH, <http://www.ms.ro/?pag=62&id=12329>, 16 January 2013.

¹⁸⁷ *Idem*.

public sector also opened their own private practices.¹⁸⁸ Therefore, the doctors could easily block the access of patients to medical devices in public hospitals, so that the patients have to pay an extra fee in order to have access to the medical devices in the private health institutions owned by the doctors. The MPH proposes to allocate a budget out of public funds to the private sector in situations where there is a temporary or permanent deficiency of medical equipment and devices or a complete absence of medical devices in a public hospital.¹⁸⁹ In this way, the trafficking of medical devices will be reduced, because patients who cannot be provided with medical services at any public hospital are entitled to free access to these services in a private hospital.

The MPH has no public information available regarding the number of patients who have had turn to the private health sector and to its resources. The MPH cannot confirm or inform if and how the legislation from 2013 has been successful so far.

A. 5.2.2. National strategy and plan of action

The national strategy and plan of action indicator is chosen in order to assess (a) the inclusion of the health sector in anti-corruption strategies and (b) the inclusion of anti-corruption measures in health strategies. This subtopic will evaluate national strategies and plans of action concerning health or anti-corruption (from general to particular) and if and how the problem of corruption is included and implemented in those documents.

¹⁸⁸ *Idem.*

¹⁸⁹ *Idem.*

Table 7: National Strategy and plan of action indicator and appropriate benchmarks

Indicator	Benchmarks	
	Structural / organizational	
National strategy and plan of action	a) Does the State have a national anti-corruption strategy and plan of action and does it include the public healthcare system?	How do public hospitals implement national the anti-corruption strategy?
	b) Does the State have a national health strategy and plan of action regarding the health care system and does it include countering corruption or enhancing transparency and integrity?	How do public hospitals implement the national health strategy?

Source: Personal table made with benchmarks adapted to assess the context of corruption in public hospitals

Assessment on the national strategy and plan of action indicator:

a) The latest national strategy on anti-corruption (SNA) 2012-2015 does not particularly focus on anti-corruption in the public health sector or in the oncological public health sector.¹⁹⁰ However, the SNA's objectives are also directed towards public hospitals (as public institutions). Table 8 names the objectives of the SNA regarding public hospitals and also follows the way in which the MPH responded to those objectives and how it is implementing them.

¹⁹⁰ SNA, 2012-2015, <http://sna.just.ro/SNA/SNA20122015.aspx>, accessed on 27 April 2015

Table 8: Implementation of the objectives of the national strategy by the Ministry of Public Health

The objectives of the National Anti-Corruption Strategy (SNA) to be implemented by public institutions ¹⁹¹	Implementation of the SNA by the Ministry of Public Health (MPH) in public hospitals ¹⁹²	Remarks regarding the level of implementation
<p align="center">Objective 1 of the SNA</p> <p>Prevent corruption in public institutions. One of the objectives of the SNA is that public institutions systematically implement the following preventive measures</p>		
a. Intensify the implementation of internal controls within a public institution	There is a half-yearly evaluation of the degree of implementation of the internal controls within the MPH and its 215 subordinated units. However, the MPH revealed that the report bears a risk: the evaluation has not sufficiently assessed every implementation of the internal control in-depth.	The report exists and the objective was achieved, however, the quality of the evaluation compromises the report.
b. Gradually introduce a uniform methodology for evaluation of corruption risks	The MPH had a meeting on the 11 th July 2012 with officials from the Ministry of Internal Affairs in order to set up the details regarding the collaboration for the development of a unitary methodology for evaluation corruption risks in the MPH. The collaboration was finally approved and the protocol was signed on 18	A unitary methodology for evaluation of corruption risks was developed in collaboration with the Ministry of Internal Affairs, in order to for it

¹⁹¹ SNA 2012-2015, <http://sna.just.ro/SNA/SNA20122015.aspx>, accessed on 27 April 2015

¹⁹² The implementation of the SNA objectives within the MPH and its subordinated institutions (public hospitals) was evaluated by the MPH in a report of activities available at: <http://sna.just.ro/Portals/0/Tabel%20de%20progres%20PlanFebr.%202013.pdf>, accessed on 26 April 2015

	August 2013 with the agreement that activities for the development of the methodology would start in March 2013. However, the MPH notified the monitoring system of the SNA that the risk of this activity could result in the insufficiency of human resources for the development the methodology within the MPH.	to be gradually introduced in public hospitals. There is no timeline concerning the full implementation of the objective.
c. Implementation of a code of conduct	A code of conduct exists in a formal way by including law texts in internal documents of public hospitals. However, there is no analysis on the efficiency of internal documents in the context of activities. It was reported by the MPH that the civil servants in public health sector are not familiar with the code of conduct and its implications.	The quality of the existing code of conduct compromises the implementation of the SNA measures.
d. Implementation of a call-centre system within a public institution	The MPH submitted a financial request in October 2012 for the development of a call-centre system with the purpose of notifying acts of corruption. ¹⁹³ The request is still pending (i.e. in 2014) and the MPH is taking into consideration the possibility of a negative response regarding the financial request.	The call-centre was not implemented. The formal request to receive financing for such measure was filed, but no further steps have been made.

¹⁹³ The project for developing a call-centre to notify corruption activities within the public health institutions was requested by the MPH to be financed by the system called Norwegian Financial Mechanism 2013-2014. This is a grant system concluded by a Memorandum between Romania and Norway where public institutions can request a financial grant to develop several sectors such as justice, social development, innovation, research, etc. See more at <http://norwaygrants.just.ro/ro-ro/primapagina.aspx> (accessed on 11 June 2015).

Objective 2 of the SNA Developing an anti-corruption component in the professional education of public employees		
a. Participation of staff members of public institutions to periodical classes concerning ethics, integrity and conduct	In 2012 there has been no class for medical staff members concerning ethics, integrity or conduct. In 2013, the MPH started a project called “Good Governance through Integrity and Responsibility in the Medical Health System” and there have been classes on integrity for medical staff members. However, classes were optional and the participation level was low.	Existing measure without real efficiency (only one class was organised and the participation of health staff members was low.)
b. Elaboration and dissemination of informative guides and materials concerning the risks and consequences of acts of corruption or integrity incidents	Previous to 2013 no informative materials concerning the consequences of acts of corruption or integrity incidents have been developed and distributed. The MPH informed that in 2013 informative materials on integrity would be developed and distributed. The creation of such informative materials is still pending in 2015.	No implementation of the SNA objective.

Source: Personal table made with data from the SNA 2012-2015 and the report of activities by the MPH available at <http://sna.just.ro/Portals/0/Tabel%20de%20progres%20PlanFebr.%202013.pdf> and <http://sna.just.ro/Portals/0/Documente%20platforma/MS%20Inventar%20Mas%20Preventive.pdf>, accessed on 26 April 2015

Not all of the SNA objectives for 2012-2015 have been implemented by the MPH and its subordinated institutions (public hospitals). Even in cases where the SNA objectives have been implemented, the efficiency or quality of the implemented measure is missing (see observations in Table 8).

In 2013, the MPH filed a report on the implementation of the SNA, on behalf of all subordinated public health institutions. The monitoring commission of the SNA collects annual

reports from local and central institutions regarding their progress on the implementation of the SNA 2012-2015. There is no other report on behalf of the MPH from recent years, such as 2014.

b) In Romania, the latest National Health Strategy (NHS) 2014-2020 includes one provision regarding anti-corruption in the health sector. The NHS has the following objectives¹⁹⁴:

- i. "to implement rigorous control in the public hospitals, especially the control of public expenses as a measure to reduce informal payments"
- ii. "to review the financing and reimbursement system of health services and cost controls"
- iii. to "increase transparency of the public health funds by means of annual reports issued by the CNAS and the MPH".

As the strategy was only issued last year, there is no report from the MPH on the level of implementation of the NHS in public hospitals. The plan of action regarding the implementation of the NHS requires an annual reporting mechanism based on several indicators that help measure the above-mentioned objectives on this subject- no report has been issued so far.¹⁹⁵

It also seems that when comparing the two National Strategies -the one on anti-corruption and the one on the health sector - there is no common ground on combating corruption with the same tools. The SNA refers to specific activities for public institutions and civil servants (such as trainings on integrity, installing a call-centre for preventing corruption, distribution of informative anti-corruption materials and others), while the NHS only mentions the transparency of hospitals' public expenses.

¹⁹⁴ National Health Strategy 2014-2020, http://ms.gov.ro/documente/Anexa%201%20-%20Strategia%20Nationala%20de%20Sanatate_886_1761.pdf, accessed on 25 April 2015

¹⁹⁵ Plan of action of the National Health Strategy 2014-2020, <http://ms.gov.ro/upload/Anexa%202%20-%20Plan%20de%20actiuni>, accessed on 26 April 2015

A.5.2.3.Participation and coordination

The indicator on participation and coordination is the instrument measuring the involvement of the civil society¹⁹⁶ in processes that deal with corruption in the healthcare sector such as the ethics commission, the elaboration of laws, of national strategies and plans, the establishment of regulations and internal evaluations. This indicator will assess (a) the capacity of the civil society to take part in decision-making and monitoring mechanisms in the public health sector and (b) the cooperation between the public health sector and the civil society when formulating and implementing decisions and regulations.

Table 9: Participation and coordination indicator and appropriate benchmarks

Indicator	Benchmarks	
	Structural / organizational	
Participation and coordination	a) Are the representatives of the civil society taking part in decisions and monitoring mechanisms in the public health sector?	Are members of the civil society involved in the decision-making and monitoring process in the MPH or public hospitals? In which structures can civil society be involved in the public health sector?
	b) Is there a successful cooperation between the public health representatives and the civil society when formulating and implementing decisions and regulations?	Are the messages from the civil society listened to by the public health sector? Is the MPH regularly in contact with the civil society in forums and consultations? Does the MPH accept visits from civil society structures, accept and receive reports from the civil society? Do consultations lead to a fruitful agreement and are the recommendations and reports of the civil society being taken into consideration?

Source: Personal table made with benchmarks adapted to assess the context of corruption in public hospitals

¹⁹⁶ By civil society it is understood the involvement of people and patients from NGO's (anti-corruption and health care types), patients associations and federations, associations of professional medical staff and media.

Assessment on participation and coordination indicator:

a) Until 2015, the Council of Ethics (CE)¹⁹⁷ had no member of the civil society in its ranks. In 2015, the composition of the CE was modified by Order No. 145/2015 of the MPH on the approval of the members and the attributions of the CE. Art. 2(f) of the MPH's Order stipulates that every CE must also include a member from patient associations.¹⁹⁸ Art. 4 of the same Order stipulate that in the absence of a nomination of a member from the patient associations, the CE can legally continue its activity and the position can be filled afterwards.¹⁹⁹ Also, if in a certain county there is no established association of patients, the CE of a hospital of that county cannot accept a member from another regional association of patients; in this particular case, the CE continues legally its activity and the position for a member of a patient association can be filled when a patient association is established.²⁰⁰

The subtopic on monitoring and accountability (Ch. V, A 5.2.4) further develops the issue of CE, focusing on if and how CEs are available in public hospitals and if their work is efficient. From a legal point of view, members of the civil society engage in the membership of the CE, however, their availability in hospitals and their work is absent in many public hospitals.

b) The Coalition of Patients' Organizations in Romania (COPAC) has created a National Catalogue of the Associations of Patients, where a number of 40 associations are recorded.²⁰¹ Romania has 41 counties and the 40 associations present in the national catalogue of associations of patients cover only 32 counties. This implicitly means that people do not participate in the CE of any hospital in 9 counties, since there are no local patient associations registered in these counties.

In March 2010, the Foundation for Development of the Civil Society (FDSC) developed a barometer to measure the activity of Romanian NGOs in cooperation with other central and local authorities. Out of the 2297 NGOs which took part in the study, 6,4% were NGOs active in

¹⁹⁷ The Ethics Commission is a monitoring mechanism established by law in each public health institution, in Romania. More information on the functioning and establishment of the Ethics Commission (CE) is provided in the subtopic on monitoring and accountability (Ch. V, A 1.2.4.)

¹⁹⁸ MS, Order number 145/2015, Art.2(f)

¹⁹⁹ Commentaries to the MS order number 145/2015, <http://www.integritate.ms.ro/upload/Mentiuni.pdf>, accessed on 15 May 2015.

²⁰⁰ MS, Order number 145/2015, Art. 4

²⁰¹ COPAC, <http://www.copac.ro/asociatii/business-directory/wpbdm-category/asociatie/>, accessed on 15 May 2015.

the health sector.²⁰² When asked to describe the relationship between them (health sector NGOs) and the MPH, 59,5% answered that there is no collaboration at all, 6,1% answered that the communication is neither bad nor good, 1,8% classified it as rather bad, 2,8% as very bad, 4,9% as rather good, 1,2% as very good and 23,7% did not answer.²⁰³ When asked about the method that NGOs used in order to communicate their messages to the public authorities, the NGOs chose the following answers: contacting an authority (1st place), press releases (2nd place), publication of reports (3rd place) and letters addressed to public authorities (4th place).²⁰⁴ Health NGOs did not add any method that could include organised forums, meetings or organised discussions with public authorities.

Within the MPH, there is no specific employee or department dealing with the collaboration with NGOs or associations. The public authority has no specific order on how a public institution should communicate with the civil society. In 2009, the FDSC, the Assistance Centre for NGOs and the Chamber of Deputies organised a meeting which ended with an cooperation agreement that was signed in order to develop the collaboration between NGOs and public authorities. This is how, in 2011 and 2012, the FDSC, in collaboration with any willing NGO, developed a White Book, in which NGOs, from any sector, can denounce a problem that has been noticed and add suggestions or make draft recommendations in order for to be discussed in the Parliament and taken into consideration when elaborating future laws.²⁰⁵ So far, the White Book of NGOs is available for 2011 and 2012, which includes recommendations for the public healthcare sector (oncology, as well). NGOs and associations can also raise awareness and engage in discussions with civil servants at the National NGOs Forum, which takes place annually.

²⁰² FDSC, Barometer on NGO's, March 2010, http://www.fdsc.ro/library/conferinta%20vio%207%20oct/Barometrul%20liderilor%20ONG_rezultate.pdf, p. 23, accessed on 12 May 2015.

²⁰³ *Idem*, p. 23.

²⁰⁴ *Idem*, p. 30.

²⁰⁵ The NGO's White Book, <http://www.ce-re.ro/upload/Carta%20Alba%20a%20sectorului%20ONG%20din%20Romania.pdf> (accessed on 7 March 2015)

Table 10: Consultation of NGOs and patient associations' recommendations by the public health authorities

Year/ Name of NGO	Recommendation	Source	Taken into consideration ²⁰⁶	Implementation/ Fruitful changes	General type of collaboration Bad/Good/ Excellent
2013/ ARCrare	Invent a form where each cancer patient should register the quantity of the used medication given by the public hospital. The form should be regularly sent by the patient to the CNAS and patients' forms should be compared with the medical prescriptions released by doctors.	Annual report 2013	The report was sent to the MPH, but no further discussions followed.	Recommendation not implemented	Bad
2013/ ARC	Create a compulsory list of medication that every hospital is obliged to have permanently and also include medication for cancer patients on this list in order to eliminate the possibility of doctors or nurses committing tax evasion with medication.	Letter addressed to the MPH	2 meetings were held, the recommendation was discussed with the MPH	The MPH is currently developing a new possibility for reform	
2013/ ARC	Evaluate the anti-cancer drugs by using a health technology assessment (HTA) where medicines could be economically evaluated in all hospitals.	Letter addressed to the	One discussion with the MPH and the proposal was	The recommendation did not add any	

²⁰⁶ The assessment on the consideration and fruitful changes vis-à-vis one recommendation by an NGO to a public institution is made by e-mail conversations with the specific NGO's. Assessment was made on the NGO's opinion on how was their recommendations seen, received, discussed and implemented by the specific authority. The answers in Table 7 represent the direct opinion of each NGO over the impact of their recommendations.

		MPH	consulted during the parliament sessions	changes	
2013/ ARC	Eliminate the need for patients to first obtain the signature from the hospital manager in order to be reimbursed by the CNAS for the drugs that the patient purchased on his/her own because of the shortage in hospitals. This procedure was criticised as being a paradox, because the person who signs the patient's form is the one committing an act of corruption, by not offering the drugs which are free of charge.	Letter addressed to the MPH	No meeting or consultation with the MPH	No new changes	Good
2012/ FABC	Eliminate embezzlement with cancer medicines by using a national strategy in the oncological sector	Report to the MPH	Issue raised at various occasions in letters to the MPH (could not say specifically when and how)	The national strategy on the prevention of cancer does not refer to procedures concerning medicines	Bad

Source: Personal table made with data from NGOs and e-mail discussion with NGO's representatives. The recommendations were found through the reports of the health or anti-corruption NGOs and patient associations or in the white book of NGOs. It was then consulted every NGO that proposed a recommendation in order to find if from their point of view the recommendation was consulted in any matter with any public health authority (1) and if they find that their recommendation was implemented or had any fruitful changes (2). Sources of the recommendations: <http://www.arcrareromania.ro/raportanualpe2013>, <http://www.romaniacurata.ro/solutii-pentru-stoparea-jafului-din-buzunarele-bolnavilor-opriti-drama-pacientilor-din-spitale-obligati-sa-si-cumpere-singuri-medicamentele/>, <http://fabc.ro/comunicate-de-presa/>, consulted on 15 May 2015.

Table 10 unite the recommendations of health/anti-corruption NGOs found in the period 2010-2014 and assesses their impact.²⁰⁷ The purpose of Table 10 is to see if NGOs and patient associations are capable of cooperating with public health authorities and if their recommendations and ideas are consulted and implemented (in the specific case of the oncological sector). Table 10 on the power of NGOs and patient associations to successfully share and discuss their recommendations represents the opinion of the civil society (only one side). The following table (Table 11) will also evaluate if the MPH consults and takes NGOs and patient associations into consideration.

According to Table 10, out of 5 recommendations which are specific to the oncological health sector (coming from two NGOs and one patient association), only one NGO (ARC) attested that the MPH is currently developing a new regulation based on their recommendation. Regarding the rest of the recommendations, the representatives of the NGOs considered that there have been no (new) changes brought by their recommendation. Consultations with the MPH existed only partially: two recommendations were not discussed at all with a public health authority, while the other three were debated at least one time with the MPH.

The general collaboration NGOs-public health authority is classified, on the one hand, as being bad (by 2 organisations) and on the other, as being good (by one NGO).

According to the law on decisional transparency in public administration (Law No.52/2003), the initiator of the draft project decides first if the draft project should be consulted with the civil society, but the consultation of the MPH with the civil society is entirely at the MPH's discretion.²⁰⁸

²⁰⁷ The NGO's taken into consideration are: the ARCCare, the ARC and the FABC. NGO's recommendations are collected through the White Book 2011, 2012, discussions at the National Forum of NGO's 2013,2014 and their official reports and communications published on their websites.

²⁰⁸ Romanian law on decisional transparency in public administration, number 52/2003, Art. 2, published in MO nr. 70 on 3 February 2003, available at: <http://legislatie.resurse-pentru-democratie.org/legea/52-2003.php>, accessed on 17 May 2015.

Table 11: Consultation with the civil society by the MPH when drafting projects

Draft project initiated by the MPH	Date/ registration number	Aim	Importance for the oncological sector	Consultation with the civil society
Approval of the budget per category of medicines for the national medicine company “UNIFARM” (under the authority of the MPH) for 2013	HG, 2013-04-03/2013-04-16	Selection of the budget allocated for categories and types of medicines to be distributed in the public health sector for 2013	The possibility to advocate for an own budget in the oncological sector where medicines suffered from corruption	No consultation with the civil society
Reform of some articles of the Health Law No. 95/2006	OUG, 2013-09-19	Reformation of the public health system	The possibility to include the recommendations of NGOs in the oncological sector (see some of them in Table 10)	No consultation with the civil society
Approval of the budget per category of medicines for the national medicine company “UNIFARM”	HG, 2014-02-04	Selection of the budget allocated for categories and types of medicines to be distributed in the public health	The possibility to advocate for an own budget in the oncological sector	No consultation with the civil society

(under the authority of the MPH) for 2014		sector for 2014	where medicines suffered from embezzlement	
Approval of the extension of the oncological department of the Emergency University Hospital of Bucharest	HG, 2014-03-20	Elaboration of the plan regarding economical and technological needs for the extension of the oncological department of the Emergency University Hospital of Bucharest	The possibility for NGOs to expose their recommendations	No consultation with the civil society
Decision to approve national health programmes 2014	HG, 2014-03-05	Elaboration of the need to develop national health programmes in specific areas for 2014		No consultation with the civil society
Decision to update and supplement the list of medicines that are entirely covered by the CNAS	HG, 2014-05-05	Update of the list of free medicines reimbursed by the CNAS		No consultation with the civil society

Decision to approve the National Health Strategy 2014-2020 and its plan of action for the implementation of the strategy	HG, 2014-07-15/2014-08-13	Approval of the National Health Strategy and its plan of action for the period 2014-2020		Consultations with NGO, representatives initiated by institutions and unions from the health sector (no information on the number of representatives and the number of meetings)
Decision to modify the National Health Strategy 2014-2020	HG, 2014-10-10	Modification of certain provisions and annexes to the National Health Strategy 2014-2020		No consultation with the civil society
Decision to abolish the Technical Office for Certification of Medical Devices(TOCMD)	HG, 2014-11-21	Abolish the existence of the TOCMD because of its lack of sufficient expertise to certify all medical devices in Romania		No consultation with the civil society
Project for the approval of national health programmes for 2015 and 2016	HG, 2015-03-23/2015-03-24	Elaboration of the type of national health programmes needed for the years 2015 and 2016		No consultation with the civil society

Source: Personal table made with data available from the draft projects initiated by the MPH from 2013-2015, available at the General Secretariat of the Romanian Government website: <http://www.sgg.ro/legislativ/domeniu.php?id=13>, accessed on 15 May 2015.

Table 11 unites the draft projects initiated by the MPH in the period of 2013-2015 that implicitly or explicitly involve reform and changes in the oncological health sector or any decision that could affect or improve the oncological sector in the public health.²⁰⁹ . Table 11 establishes if the MPH consulted any association or NGO or if it organised any debate or meeting regarding the draft project with the civil society before bringing the draft project to the attention of the Government.

Each project initiated by the MPH contains information on whether the project was previously discussed or not or whether the civil society was consulted in any matter or not. In the period 2013-2015, out of ten draft projects initiated by the MPH, also touching (implicitly or explicitly) upon the oncological sector, only one project was the object of consultations with NGOs, representative institutions and unions from the health sector.²¹⁰ It was the project regarding the development of the National Health Strategy for 2012-2020, but it contained no information on the number of the NGOs that were consulted and the number of meetings/discussions held with other organisations.²¹¹ For the rest of the nine projects initiated by the MPH, the consultation with NGOs did not exist and was always categorised as “not the case [to hold a consultation]” in each specific report.²¹²

A.5.2.4. Monitoring and accountability

A high degree of accountability within the public hospitals can discourage corruption. Monitoring and accountability is an indicator chosen in order to evaluate the State's control that could protect and prevent the oncological departments of public hospitals against corruption cases.

²⁰⁹ Table 11 does not include draft projects initiated by the MPH in the sector not touching the oncological one, such as the surgery sector, cooperation plans between foreign health ministries, child health care, cosmetic products, and other matters. The Table contains information for 2013-2015 because previous projects initiated by the MPH are not at the public disposal.

²¹⁰ MPH, Project for the approval of the National Health Strategy 2014-2020, http://www.ms.ro/documente/NF%20SNS%20_905_1800.pdf, p. 7, accessed on 17 May 2015.

²¹¹ Idem, p.7

²¹² All of the nine draft reports cited in Table 2.

This indicator will have as benchmarks (Table 12) questions that could assess:

- a) the capacity to keep performances and actions/omissions of medical staff members under continuous monitoring
- b) the capacity to hold medical staff members accountable for their actions and for the use of public resources

Table 12: Monitoring and accountability indicator and appropriate benchmarks

Indicator	Benchmarks Structural/organizational	
monitoring and accountability	a) Do public hospitals have internal control policies?	Is the internal control policy fully implemented? Does the internal control policy include controlling transparency, integrity and other measures?
	b) Are public hospitals controlled concerning the implementation of laws and regulations?	Is the monitoring procedure provided by a group of experts? Does it take place regularly? Are reports and follow-up mechanisms issued? Are doctor's medical prescriptions under a control system within a monitoring system? Does the monitoring system control the accuracy of the ratio of the number of medicines in the hospital's storage to the reports and prescriptions of medicines?
	c) Do public hospitals have a reporting procedure regarding the activity of medical staff members?	Is the reporting procedure verified by a superior commission/authority? Does the reporting procedure include reporting the number of medical prescriptions and patients and any ethics incidents?

	d) Do public hospitals have a complaining system?	To who is the complaining system open? Can patients and medical staff members complain about any type of corruption in public hospitals? Is the complaining system available and accessible? Can medical staff members be verified based on complaints? Do public hospitals collect feedback from patients? Does the MPH undertake questionnaires, check-up or statistics in order to find out the patients' opinion on the quality and services in public hospitals?
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Source: Personal table made with benchmarks adapted to assess the context of corruption in public hospitals

Assessment on the monitoring and accountability indicator:

a) Annually, the Romanian Ministry of Finance has the duty to present a report for the previous year on the level of implementation by each public institution of the internal control systems as stipulated in Law No. 234/2010, according to which every public entity has to develop a regulation regarding the internal control of management and finance.²¹³

Table 13 will evaluate the reports of the Ministry of Finance over 2011, 2012 and 2013 (the only existing reports so far) on the situation of internal control developed by the MPH in public hospitals and by the CNAS.²¹⁴

Early, each public authority had to submit a report on the level of implementation of internal controls. The MPH had to answer how internal control was implemented in its subordinated institutions (public hospitals) by using a 25 standards evaluation mechanism.²¹⁵

²¹³ The law number 234/2010 stipulates that each public institution has to elaborate and implement a policy on the internal control system. The leader of a public entity has to report to the Ministry of finance the way the law 234/2010 is implemented and how does the public institution develop internal controls on finance and management.

²¹⁴ As discussed in the previous chapter, the National Health Insurance House is reimbursing the hospital's pharmacies based on prescription for every cancer medication used by patients as the national policy on cancer attest that medication for cancer patients is free of charge. It is important to evaluate its internal controls policy and know if the control system is efficient and does carefully analyze the situation before reimbursing each entity.

²¹⁵ Each public institution had to analyze if the internal control is implemented in the following 25 standards: ethics and integrity, functions and attributions, competence and performance, sensitive situations, delegation, organizational structure, objectives, planning, coordination, monitoring of performances, management risks, re-

Table 13 reveals the implementation level of internal control in public hospitals (the MPH has filed the report after having received information from 205 public hospitals) and in the CNAS by evaluating 25 standards (as imposed by the Ministry of Finance).

Table 13: Implementation of internal control standards

Year	Public hospitals			Implementation level (%)	National Health Insurance House (CNAS)			Implementation level (%)
	Out of 25 internal control standards I PI NI				Out of 25 internal control standards I PI NI			
2011	15	8*	2*	60%	25	0	0	100%
2012	16	9*	0	64%	23	2*	0	92%
2013	19	6*	0	76%	25	0	0	100%

Source: Personal table made with data from 2011, 2012 and 2013 reports on the implementation of internal control system by public institution, available from the Ministry of Finance²¹⁶

I= Implemented

PI= Partially Implemented

NI= Not Implemented

2*: ethics and integrity, information

8*sensitive situations²¹⁷, organizational structure, monitoring performances, irregularities, procedures, surveillance, control strategies, resources access

9* ethics and integrity, information, sensitive situations, monitoring performances, irregularities, procedures, control strategies, resources access

6* ethics and integrity, information, sensitive situations, monitoring performances, irregularities, resources access

2* ethics and integrity, separation of attributions

evaluations, information, communication, correspondence and archive, irregularities, procedures, separation of attributions, surveillance, deviations management, continuity of activities, control strategies, resources access, verification and evaluation of control and internal audit.

²¹⁶ Report of internal control 2011, Ministry of Finance,

http://discutii.mfinante.ro/static/10/Mfp/control_prev/raport_2011_controlintern.pdf, accessed on 5 May 2015;

Report of internal control 2012, Ministry of Finance,

http://discutii.mfinante.ro/static/10/Mfp/control_prev/raport_2012_controlintern.pdf, accessed on 5 May 2015;

Report of internal control 2013, Ministry of Finance,

http://discutii.mfinante.ro/static/10/Mfp/control_prev/RAPORT_UCASMFC_2013_LG_FINAL.pdf, accessed on 5 May 2015.

²¹⁷ Sensitive situations may refer to uncommon circumstances that medical staff member have to deal with during a medical procedure.

In 2011, the ethics and integrity standard was not implemented at all in the sphere of public hospitals. The standards of control of irregularities, procedures and resources access were partially implemented. In 2012, ethics and standards became partially implemented; however the standards of control of irregularities, procedures and resources access remain partially implemented. In 2013, one more change happened: the standards of control of ethics and integrity, irregularities and resources access remained partially implemented, while the control of procedures became fully implemented.

According to table13, public hospitals have improved their implementation level concerning the standards of internal control. If in 2011 the level of implementation of 25 control standards reached 60%, in 2013 it reached 76%.. This means that the internal control system in public hospitals has improved over the past 3 years and the implementation of internal control policy is in progress.

Concerning the CNAS, in 2011, there was a 100% implementation level of 25 internal control standards. One year later, the CNAS saw a small regression (2 standards became partially implemented) and by 2013 the CNAS showed a 100% implementation level once again. It is important to note that the partially implemented standards in 2012 were ethics and integrity and separation of attributions.

The control of ethics and integrity (among others) was never fully implemented between 2011-2013 neither in public hospitals nor the CNAS.

b) Public hospitals are controlled by commissions established by the MPH (Order No. 1078/2010) when the Ministry considered it was necessary to evaluate a certain issue. During 2010-2014, the MPH carried out controls in public hospitals according to issues established at the national level. During 2010-2014 there was no thematic control on medical prescriptions, use of medicines, integrity and ethics or any specific control on the functioning of the oncology department.²¹⁸

In 2012, the MPH and the CNAS issued a joint Order (No.530/172/30.05.2012) to constitute mixed commissions of verification and control of Romanian emergency hospitals

²¹⁸ Analysis of MPH's annual reports between 2010-2014 available at: <http://ms.gov.ro/?pag=195> (accessed 15 April 2015)

(only).²¹⁹ The commissions annually verify some ethics and financial aspects within each emergency hospital between 01.01.2011 and the first day of the control. The verification lasts a week. The aspects verified by the commissions include the following items:

- Consistency between the annual programme of public procurement and the budget of expenses
- Consistency between the list of medicines provided by the CNAS and the annual programme of public procurement
- The existence and the activity of ethics councils, the influence of the doctor's activity to perform qualitative medical services
- Compliance with the obligation of the hospital to insure medicines to patients
- The methodology of reimbursement of medicines purchased by patients (protected by public funds)

The measures used during the control carried out by the mixed commissions are of great help in cases of corruption. The procedure led to reports that attested that public emergency hospitals do not have a consistency between the medicines declared and the medicines in storage or that there is no consistency between the medical prescriptions and their release from the hospital's pharmacy.²²⁰ As a result, the policies within certain hospitals changed. For example, medical prescriptions can only be issued when a patient is discharged and that medical prescriptions will also be attached to the general observation paper of each patient.

Observations:

1. The control of medical prescriptions was only carried out in the case of inpatients (patients who came in treatment as outpatients and needed medical prescriptions were not included).

²¹⁹ MPH order number 530/172/30.05.2012, http://www.spitjudms.ro/files/Management/Raport_de_activitate_manager_SCJU_-_sem._I_2012.pdf, p. 16 (accessed on 8 May 2015)

²²⁰ It happened in the cases of the hospitals Spitalul Judetean de Urgenta Valcea and the Spitalul Clinic Judetean de Urgenta Targu Mures, http://www.spitjudms.ro/files/Management/Raport_de_activitate_manager_SCJU_-_sem._I_2012.pdf, pp. 16-17 (accessed on 7 May 2015) and <http://www.prefecturavalcea.ro/documents/article/571/Raport%20de%20control%20-%20Spit.%20Jud.%20de%20Urg.%20Valcea.doc>, pp. 6-8 (accessed on 7 May 2015)

2. The mixed commissions find irregularities and take measures to adapt internal policies. The implementation of the policies will once again be measured the following year during the next mixed commission's evaluation.

3. Mixed commissions only evaluate ethics and financial issues starting with 01.01.2011, the period before 2011 is not included in the evaluation.

4. Some of the Romanian emergency hospitals do include oncology departments. For example, in Bucharest, out of 13 emergency hospitals, 8 have an oncology department.²²¹ However, there are other hospitals that have an oncology department but are not submissive to the control of mixed commissions. There are still hospitals (the non "emergency hospitals" type) where mixed commissions do not carry out controls. In this case, the law is not fully adapted to the needs.

c) Apart from external controls, carried out either by commissions from the MPH or by mixed commissions (MPH and CNAS), there is a reporting activity procedure carried out by public hospitals addressed towards the MPH. Every public hospital releases a half-yearly or annual report concerning the activity of the entire hospital.²²² Such a report is elaborated by the Committee of the hospital after evaluating doctors' and nurses' activities. The medical staff members have to complete a General Clinic Observation Paper for each inpatient and daily patient.²²³ Each Observation Paper consists in predefined items to be filled in by the doctor.²²⁴ The hospital has then the obligation to collect the details and to make statistical analyses in order to issue the annual report.²²⁵

²²¹ Medical College Bucharest, list of hospitals in Bucharest, <http://www.cmb.ro/spitale/> (accessed on 8 May 2015)

²²² Law number 95/Apr. 2006 concerning the Reform in the Health system, Ch. V, Art.198 (1), (2), published under number 372/28 April 2006. Available at http://www.cdep.ro/pls/legis/legis_pck.htm?act=text&idt=72105 (accessed on 2 April 2015)

²²³ Annex 2 of the MPH Order number 1782/2006 concerning the Registration and Reporting of patients in hospitals. Available at <http://lege5.ro/Gratuit/geydcmvzha/ordinul-nr-1782-2006-privind-inregistrarea-si-raportarea-statistica-a-pacientilor-care-primesc-servicii-medicale-in-regim-de-spitalizare-continua-si-spitalizare-de-zi> (accessed on 10 May 2015)

²²⁴ The General Clinic Observation Paper has to include the following items: name, hospital, place of patient, information on the identity card of the patient, number of registration in hospital, other statistical data on the patient (place of birth, citizenship, place of work, insurance type), blood type, type of patient (inpatient, for how many days), diagnosis on the first day, diagnosis at the discharge, surgery, type of analysis undertaken by the

The reporting procedure written by doctors in each Observation Paper is not verified by a superior authority. The Observation Paper does contain information on what medical prescription was issued for the patient and what medicine was recommended (among others items), but it does not have to include any ethics comments, additional comments by the patient and not even the signature of the patient (only the signature of the doctor is needed).²²⁶ The absence of the signature of the patient means that the Observation Paper is made exclusively for internal purpose (in order to collect data and issue an activity report), but no verification is made by any other entity from the hospital or from special commissions. It is to say, that the Observation Paper could contain false or fictitious information.

The MPH issued an order by which it creates the Council of Ethics (CE) in order to solve abuses caused by irregularities that appear between deontological and moral obligations and create conflicts between patients and doctors/nurses (Order No. 1209/2006).²²⁷ Law No. 95/2006 provides that every public hospital should establish a CE formed by 7 members with the right to vote (in order to decide if it is or not an abuse).²²⁸

The CE is a body that applies an ex-post perspective and can only decide on situations that already happened, based on complaints from patients or other staff members.²²⁹ Patients and medical staff members can submit complaints to the CE regarding a particular irregularity that appeared between them and a medical staff member. Patients and medical staff members can also complain about informal payments and cases of corruption, not only medical praxis. The CE is obliged to respond to every complaint (via post, telephone or email) and inform the patient on what decision the CE took in a particular case: if a certain case was declared an abuse and whether or not it should be sanctioned. The CE decides by majority. It is uncertain how the CE

hospital, type of medicines administrated, medical prescription and recommended treatment, signature of the doctor.

²²⁵ MPH Order number 1782/2006, Art.6, Art.7, op. cit.

²²⁶ Annex 2 of the MPH Order number 1782/2006, op. cit.

²²⁷ MPH, Order number 1209/2006, Art 1 (2), available at:

http://www.ms.ro/documente/Ordin%20Consiliu%20etic_1018_2022.pdf (accessed on 10 May 2015)

²²⁸ The CE should be formed by: one highly competent doctor, one representative of the hospital, one representative of local council, one care-system responsible (nurse), one representative of the health insurance house, one representative of the patients association and one representative of the public health authority. The CE also has a secretary without the right to vote. See Order number 1209/2006, Art. 2(1), (2)

²²⁹ It is a difference between the CE in Romania (only reunites a posteriori) and the American CE where the Council can also be consulted by doctors and also acts *a priori*.

generally applies sanctions. The Order from the MPH does not describe what type of sanctions exist and who exactly is the one applying the sanction to the medical staff members (the CE only decides on the nature of the abuse and can issue recommendations).

d) The CE also analyses the opinion of patients. The opinion of patients is analysed through already established questionnaires by the MPH (one exemplary to be used by all CE). The questionnaire includes questions related to the availability of medicines, the issue of informal payments and if it is at the request of a medical staff member or at the initiative of the patient.²³⁰ The patient also has to specify the department where he was a patient. The questionnaire could give valuable information to the CE. The patient can also complete the questionnaire online, on the website <http://integritate.ms.ro/chestionar>, which was established by direct order by the MPH²³¹. This method has not been implemented yet. When trying to access the questionnaire online, the page cannot be found. Furthermore, the Order of the MPH provides that the questionnaire can only be applied in the hospital for one week every month and be distributed to inpatients at the time of their discharge. It means that patients coming in for treatment as outpatients or in the case of the oncology department, coming in for chemotherapy, cannot fill in questionnaires, as they are not considered inpatients (sleeping over night in the hospital). The questionnaires cannot give a full overview on behalf of all patients, as the questionnaire is applied only one category of patients.

The CE can issue recommendations and annual and quarterly reports to shape the hospital's ethical culture.²³² Also, the MPH does not have any centralization of all CE in Romanian public hospitals and there is no monitoring mechanism for the implementation of the Order of the regarding the creation and organisation of CE.

By means of a brief analysis consisting of verifying the existence of a CE in every hospital in Bucharest that has an oncological department (Table 14), the following could be attested:

The CE is not a visible entity to patients. It has the duty to submit annual reports on ethics, to apply questionnaires and to solve complaints (as discussed above). The MPH has ordered that each CE should post (on the hospital's website page) information online regarding

²³⁰ MPH, order number 1209/2006, Art 8(f), op. cit.

²³¹ *Idem*, Annex 2 to the order 1209/2006, op.cit.

²³² *Idem*, Art, 8(u), op. cit.

its activity and also to create an online forum where patients can submit a complaint.²³³ Table 14 assesses the compliance with the Order of the MPH concerning the activity and transparency of the CE. In other words, it assesses if the CE is available in all 18 public hospitals from Bucharest (with oncological departments), if each hospital displays information on the CE's activity and if it has an online complaint mechanism.

In Table 14, a number of 2 hospitals out of 18 mentioned the existence of a CE on their website, without publishing any activity report or informing the public about aspects related to internal ethics. Out of the 18 hospitals, 6 have online complaint forms available for patients to fill in. The online complaint form is especially designed for patients and there is no possibility for them to be filled in by medical staff members.²³⁴ In case a medical staff member wants to complain, he/she has to do it via the CE or other internal structures (via the hospital manager, etc). Some of the instructions in the Order of the MPH concerning the existence of the CE are not fully implemented by public hospitals in Bucharest. The absence of reports, website texts on the CE's activity and the online complaint mechanism can affect patients' knowledge of the existence of the CE.

²³³ *Idem*, Art.9 (h), Art.14 (2), op. cit.

²³⁴ The online complaining form is designed for patients only as it requires the number of the patient, the exact day of the medical intervention, details on its diagnosis, its doctor, etc.

Table 14: Transparency of CE in public hospitals in Bucharest

Name of the hospital	Proof of existence of CE (on website, by any available report of the CE or by press conference)	Existence of an online complaining form
1. Spitalul Elias	Yes- mentioned on the website	Yes
2. Spitalul Floreasca	No	No
3. Spitalul Clinic Militar	No	Yes
4. CDT Dorobanti	No existing website	
5. Spitalul Pantelimon	No	No
6. Spitalul Cantacuzino	No	No
7. Spitalul Colentina	No	No
8. CDT Dr.Grozavesti	No existing website	
9. Spitalul Fundeni	No	Yes
10. Institutul Oncologic Bucuresti	No	No
11. Spitalul Gerota	Website in construction	
12. Spitalul Coltea	No	No
13. Spitalul Prof. Dr. Constantin Angelescu	No	No
14. Spitalul Sf. Ioan	No	No
15. Spitalul Bagdasar Arseni	Yes- mentioned on the website	No
16.Spitalul Bolnavilor Cronici si Geriatrie Sf. Luca	No	Yes
17. Spitalul Burghel	No	Yes
18.Spitalul Universitar de Urgenta Bucuresti	No	Yes

Source: Personal table made with data from the websites of the above mentioned 18 hospitals.

V. B. 5.3. Concluding remarks

The matrix of findings assesses the AAAQ (availability, accessibility, acceptability and quality) of the measures discovered within each indicator. Table 15 is a detailed representation containing the most important details discussed in Ch. V A.1.2. The column measuring the overall situation of the AAAQ of the findings is represented by the symbols Y, P, N or n/a (see legend in table 15).²³⁵

In order to better understand the indicators and be able to easily compare them, the Y,P,N,n/a symbols that were attributed to the overall findings were transformed into numbers (Y becomes 1- very adequate measure, P becomes 2- partially good measure and N becomes 3- not adequate measure). The numbers will represent an average between the implementation of the AAAQ criteria and are shown in Figure 3.

The results show that there is one benchmark where the AAAQ is 100% implemented (scored 1): the capacity of the State's legal framework to successfully contain corruption in public hospitals. There are also benchmarks that have been implemented well, but not perfectly (scored 1, 5 or 1, 6), like the capacity of the legal system to protect the patients against damages caused by acts of corruption and the inclusion of the health sector in anti-corruption strategies.

Two of the benchmarks were evaluated without their quality because of the impossibility to prove or confute the criterion (see table 15). The other benchmarks scored between 1,5 and 2 (between very good measure and partially adequate measure).

The benchmark that scored the lowest level of AAAQ is the one concerning the cooperation between the public health sector and the civil society when formulating and implementing decisions and regulations (scored 2,5). This benchmark is situated between partially adequate and not adequate.

²³⁵ Y- yes, the measure (findings) is implemented, P-partially implemented, N- not implemented and n/a- impossible to measure the criterion because of absence of information (either not available, either too new to be measured).

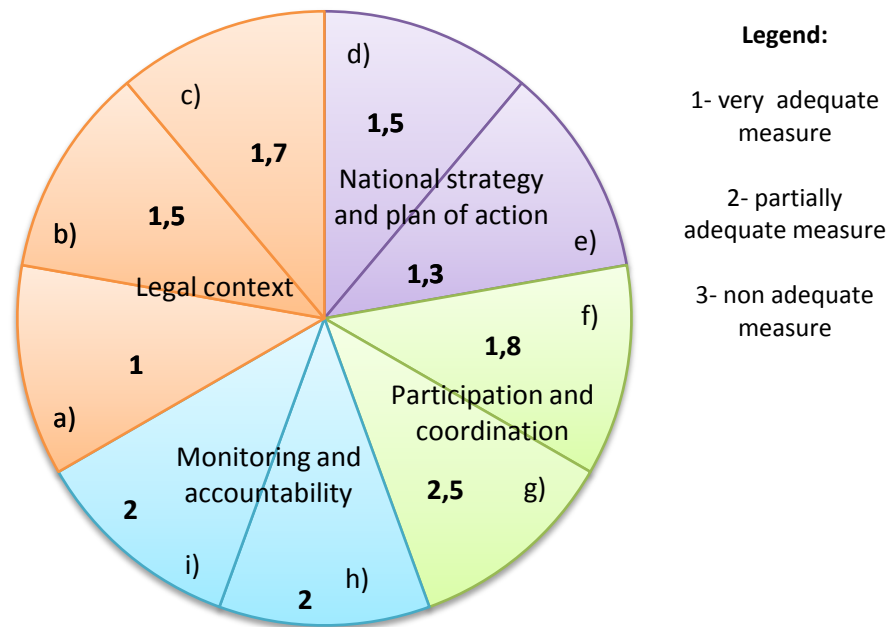
**Table 15: The AAAQ (availability, accessibility, acceptability and quality)
of measures protecting the public health sector against corruption**

		Measurement				Overall	Average Scores
Indicator	Benchmarks	Availability	Accessibility	Acceptability	Quality	AAAQ	1,2,3
Legal context	(a) the capacity of the State's legal framework to successfully contain corruption in public hospitals	yes, through criminal code & AC institutions	yes, allocation of an AC budget and positive result in the past 3 years	yes, criminal code & budget was recently adapted to the present times	yes, the number of court cases has increased, the courts and prosecutors are effective	YYYY	1
	(b) the capacity of the legal system to protect the patients against damages caused by acts of corruption	yes, policy to repair embezzlement damages	partially, 18 to 24 medicines registered discontinuity	partially, the national pharmacy has only been able to distribute 13 types of medicines	yes, medicines are procured by the national pharmacy and verified by the National Agency of the Medicines	YPPY	1,5
	(c) the ability to adjust/reform the legal framework to respond to corruption acts in the public health system.	yes, the new regulation of integrating the private sector in the reimbursement system	no, no public information on how to access the reimbursement policy	yes, policy adapted to the specific corruption concerns	n/a, this information cannot be assessed	YNYn/a	1,7
National strategy and plan of action	(a) the inclusion of the health sector in anti-corruption strategies	yes, the SNA to be implemented in the public health sector	yes, monitoring the implementation and enforcing the plan of action	partially, the SNA is not adapted to the specific corruption cases	partially, the SNA is not well implemented in public hospitals	YYPP	1,5
	(b) the inclusion of anti-corruption measures in health strategies	yes, the NHS contains AC measures	yes, the MPH is monitoring the implementation and enforcing the plan of action	partially, the NHS focuses only on transparency & financial system	n/a, this information cannot be assessed	YYPn/a	1,3

Participation and coordination	(a) the capacity of the civil society to take part in decision-making and monitoring mechanisms in the public health sector	yes, regulations and policies require the presence of the civil society in some activities	partially, the civil society can access the CE depending on the region	yes, the system of the CE was recently adapted (in 2015) for the civil society to access some systems	no, the monitoring mechanisms do not function in all public hospitals	YPYN	1,8
	(b) the cooperation between the public health sector and the civil society when formulating and implementing decisions and regulations	partially, the cooperation depends on the type of the NGO	partially, the cooperation is not compulsory, only at the discretion of the public health institutions	no, no special regulation on the collaboration between civil-society-MPH	no, recommendations and discussions so far did not bring any changes	PPNN	2,5
Monitoring and accountability	(a) the capacity to keep medical staff members' performances and actions under a continuous monitoring system	yes, various monitoring mechanisms are functional	partially, the mixed commissions have specific themes to monitor	partially, the CE cannot be consulted a priori	no, the internal evaluation forms of medical staff are not confirmed by the patient's signature	YPPN	2
	(b) the capacity to hold medical staff members accountable for their actions and for the use of public resources	partially, the CE is not available in every public hospital	partially, the complaint mechanism is not accessible to every patient	partially, the truthfulness of the reporting procedure is not verified	partially, CE does not implement all Orders of the MPH	PPPP	2

Legend	
Y- yes, implemented	1- very adequate measure
N-no, not implemented	2- partially adequate measure
P- partially implemented	3- not adequate measure
n/a- information not assessed	

Figure 3: Assessment on indicators. Representation by average



Legal context	[Legend:
		a) the capacity of the State's legal framework to successfully contain corruption in public hospitals,
		b) the capacity of the legal system to protect the patients against damages cause by acts of corruption
National strategy & plan of action	[c) the ability to reform the legal framework in order to respond to acts of corruption in the health system.
		d) the inclusion of the health sector in anti-corruption strategies
Participation & Coordination	[e) the inclusion of anti-corruption measures in health strategies.
		f) the capacity of the civil society to take part in decision-making and monitoring mechanisms in the public health sector
Monitoring & accountability	[g) the cooperation between the public health sector and the civil society when formulating and implementing decisions and regulations.
		h) the capacity to keep performances and actions/omissions of medical staff members under continuous monitoring
		i) the capacity to hold medical staff members accountable for their actions and for the use of public resources

Source: Personal figure made after the evaluation of findings

Chapter VI

Conclusion

6.1. Findings in brief

This research was designed to evaluate the adequacy of Romanian State's measures to protect the right to health, particularly in the oncological public health sector, against corruption. In other words, the research assesses the AAAQ of four indicators in protecting the public health sector against corruption.

First, Chapter III summarizes the available literature on corruption, the right to health and the correlations (facts and figures) between them. It goes from general matters (part A) to the Romanian specific context (Part B), as it is the country analysed in this thesis. This chapter was essential in proving the logic of a study relating corruption to human rights, especially to the right to health, as it is proven to be a worldwide concern and an internationally debated issue.

Secondly, Chapter IV focuses on a particular background case: corruption in the oncological public health sector in Romania. This case was analysed by using various sources in order to verify if corruption is a matter of concern in the public health sector. This chapter was needed in order to confirm or infirm the need to evaluate the measures protecting the right to health against corruption. If corruption was not a matter of concern in public hospitals, there would not be any need to evaluate the adequacy of Romania's measures to protect the right to health against corruption. Chapter IV revealed that corruption is present in many different forms in the oncological public health sector and analysed how those corruption cases affect the availability, accessibility, acceptability and quality of the right to health. Findings revealed the existence of different types of corruption, such as embezzlement of cancer medicines paid from public funds and resold to patients, or bribery. This confirmed that Romania is confronted with corruption cases in the oncological public health sector and it needs to protect the right to health against corruption (as an international obligation to respect, protect and fulfil human rights).

Chapter V is where it is answered if Romanian State's measures are adequate to protect the right to health in the oncological public health sector against different forms of corruption. The chapter evaluates Romanian's measures using four indicators (equipped with proper benchmarks) such as: the legal context, national strategy and plan of action, the participation and coordination and the monitoring and accountability indicators. Chapter V was concluded by a matrix of findings that assesses the AAAQ of measures. The results show that there is one benchmark where the AAAQ is 100% implemented: the capacity of the State's legal framework to successfully contain embezzlement in public hospitals. There are also benchmarks which are well implemented, but not perfectly: the capacity of the legal system to protect the patients against damages of corruption acts and the inclusion of the health sector in anti-corruption strategies. Also, the lowest AAAQ level was registered in the benchmark concerning the cooperation between the public health sector and the civil society when formulating and implementing decisions and regulations.

When transforming the AAAQ into numbers (on a scale from 1 to 3 where 1-a very adequate measure, 2- a partially adequate measure and 3- not adequate measure) representing the average of the AAAQ criteria, it is shown that each indicator has benchmarks situated between 1 and 2, but there is no indicator that scores 3. No indicator has the status of a non adequate measure; however, no indicator has perfectly adequate measures (only one benchmark from the legal context, but not the entire indicator).

6.3. Recommendations

This subtopic is divided into two parts: on the one hand, it makes recommendations to be taken into account in future researches based on this present paper; on the other hand, it makes recommendations to the Romanian authorities based on the findings of this thesis.

6.3. 1. Recommendations for future researches

The study reflects on measures implemented in or touching upon the public health sector. According to its international definition, the right to health, since it is a socio-economical right in the ICESCR, is guided by the principle of progressive realisation. The findings of the research are not definitive facts, because the measures and their implementation are in continuous evolution and because more indicators need to be evaluated for more complete conclusions. On

this note, this present study can be used as a starting point for future researches that could investigate:

- ❖ the same study based on the evaluation of other indicators in Romania (1),
- ❖ the same indicators applied to a different country with or without the possibility to compare the findings with Romanian State's measures (2),
- ❖ the same indicators applied to a different context such as private health sector (3)
- ❖ or the same study with the same indicators and benchmarks after a long period of time (5-10 years) in order to see the evolution of indicators in protecting the public health sector against corruption (4).

6.3.2 Recommendations for Romanian measures

The analysis of the adequacy of Romanian state's measures to protect the right to health in the oncological public health sector against corruption has offered information on the AAAQ of benchmarks of the established indicators. By carefully looking at each indicator, the following recommendations can be made in order to upgrade each indicator:

The legal context indicator has the highest average score of adequacy of all indicators. However, Romania should consider improving the accessibility and acceptability of the legal system to protect the patients against damages caused by acts of corruption. For instance, concerning the policy on the reparation of damages caused by corruption by distributing free medicines, the authorities should consider distributing a larger variety of medicines and should ensure that all medicines are distributed without discontinuity in public hospitals.

The national strategy and plan of action indicator has a high average of adequacy. Romania could especially consider adapting both the health and the anti-corruption strategy in order to focus on more activities and measures concerning anti-corruption in the public health sector. In addition, the anti-corruption strategy in Romania has not been well implemented in public hospitals so far, therefore there is a need to reconsider the steps in this regard. The causes of the poor quality of the way that the anti-corruption strategy is implemented could be diverse, from financial concerns to a non adequate plan of action.

The indicator on participation and coordination scored the lowest average of adequacy to protect the public health sector against corruption. It was also the indicator where the

cooperation between the public health sector and the civil society and the capacity of the civil society to engage in decisional and monitoring mechanisms in public health sector were not implemented from a qualitative point of view. Romania could reconsider the current practices on how to bring the public health sector and the civil society closer together and regularly achieve collaboration between these two groups. Their communication might increase the level of protection against corruption in the public health sector (as some NGOs and patient associations have already formulated various recommendations regarding the elimination of corruption from public hospitals).

The last indicator on monitoring and accountability has been attributed a partially adequate score. The capacity to keep the performances and actions of medical staff members under a continuous monitoring system is available, yet it's availability and acceptability are (only) partially adequate and where available, the quality of the monitoring mechanisms is not adequate. Moreover, the capacity to hold medical staff members accountable for their actions and for the use of public resources is partially available, partially accessible, partially adaptable and partially qualitative. The small imperfections of the monitoring system, such as not having Council of Ethics in all hospitals, not having complaining mechanisms accessible for every patient, etc..., are a small part of Romania's measures imperfections regarding the protection of the health system against corruption.

6.4. Closing remarks

Every State has a margin of discretion in establishing which measures to implement at the national level for protecting the right to health against corruption. A State evaluates its own needs and has to take steps in solving its own challenges and develop proper measures (health strategy) for specific national circumstances.

The protection of the right to health is an obligation to be implemented by the States (as one of the three levels of States' obligations towards human rights). To protect the right to health means that States have to take measures so that no third party can harm the right to health. The right to health in Romania needs protection against corruption (Chap.IV). In Romania, this sort of protection assessed using the four indicators led to the conclusion that the obligation to protect is implemented, yet not perfectly adequate when assessing the AAAQ of the State's measures.

The indicators evaluated throughout this thesis scored as partially adequate in protecting the public health sector against corruption. However, every measure which is not fully adequate from the point of view of its availability, accessibility, acceptability and quality leaves an open door to the practices of corruption and harms the perfect adequacy of the system to protect the health sector against corruption. Perhaps a perfect system can never be found, but a country needs to become aware of its limitations in order to improve its system.

The positive and negative hypotheses submitted in the introduction are both infirmed.²³⁶ This study leads to the remark that Romanian State's measures analysed using the specific chosen indicators have both strengths and weaknesses. Some measures are more adequate than others. This study has led to an overview of the State's measures pointing out their fluctuations regarding their adequacy. The dissertation can be used by the public authorities in Romania in order to discuss and consider the possibility of renewing or reforming some measures where the indicators scored low in their adequacy. It can also serve as an example of benchmarks for States wishing to provide an adequate protection of any human right against corruption.

²³⁶*Positive Hypothesis: Romania's measures are properly adequate to protect the right to health in the oncological public health sector against corruption because they permit the availability, accessibility, acceptability of the right to health.*

Negative Hypothesis: Romania's measures are not adequate in protecting the right to health in the oncological public health sector against corruption because they do not permit the availability, accessibility, acceptability of the right to health.

Appendix A

Questionnaire

Evaluation of the healthcare services provided by the oncological department of the Hospital X

Purpose

This questionnaire is designed to evaluate the situation and the services provided by the oncological department in different Romanian hospitals. The questions below are about general information concerning hospital services, your satisfaction vis-à-vis their work, the general hygiene, conditions and treatment. It also evaluates the availability, accessibility, acceptability and quality of your right to health in hospitals.

Should you choose to participate, you will be asked to fill in a questionnaire. The expected duration of the questionnaire is around 5-10 minutes. All questions are optional. You have the right to withdraw during the questionnaire at any time.

You can tick the answers yourself on the paper or you can ask the person in charge of the questionnaire to read and fill in the questionnaire with your answers. Please know that this questionnaire is used for research purposes (Master thesis) and that the secrecy of your identity is guaranteed as well as the doctor-patient confidentiality. The questionnaire remains anonymous and your data is protected.

General optional information (for statistical purposes)

Age:

- ☐ < 18 Years
- ☐ 18-29 Years
- ☐ 30-39 Years
- ☐ 40-49 Years
- ☐ 50-59 Years
- ☐ > 60 Years

Occupation:

- ☐ No occupation
- ☐ Public sector
- ☐ Private sector
- ☐ Retired
- ☐ Other: _____

Gender:

- ☐ Male
- ☐ Female

Nationality:

Diagnosis or current health status (if relevant):

1. How often do you come for treatment /consultation at this hospital (hospital's name)?

- ☐ Daily basis
- ☐ 1-3 times a week
- ☐ -1-3 times a month
- ☐ Rarely
- ☐ Other: _____

2. When did you start to be a patient or to be under treatment of the oncological sector of this hospital (hospital's name) ?

- ☐ 0-1 years ago
- ☐ 1-2 years ago
- ☐ 3-5 years ago
- ☐ More than 5 years ago
- ☐ More than 10 years ago
- ☐ Other: _____

3. How would you evaluate the following items related to the hospital?

a. The accessibility of medical staff members of the hospital

Without giving/requesting informal payments or gifts to hospital staff members

Very bad - 1 2 3 4 5 - Very good

I don't know/ Not applicable

When offering informal payments or gifts to hospital staff members

Very bad - 1 2 3 4 5 - Very good

I don't know/ Not applicable

When a hospital staff member is requesting informal payments or gifts

Very bad - 1 2 3 4 5 - Very good

I don't know/ Not applicable

b. The professionalism of doctors and nurses

Without giving/requesting informal payments or gifts to hospital staff members

Very bad - 1 2 3 4 5 - Very good

I don't know/ Not applicable

When offering informal payments or gifts to hospital staff members

Very bad - 1 2 3 4 5 - Very good

I don't know/ Not applicable

When a hospital staff member is requesting informal payments or gifts

Very bad - 1 2 3 4 5 - Very good

I don't know/ Not applicable

c. The availability of medication

Without giving/requesting informal payments or gifts to hospital staff members

Very bad - 1 2 3 4 5 - Very good

I don't know/ Not applicable

When offering informal payments or gifts to hospital staff members

Very bad - 1 2 3 4 5 - Very good

I don't know/ Not applicable

When a hospital staff member is requesting informal payments or gifts

Very bad - 1 2 3 4 5 - Very good

I don't know/ Not applicable

d. The quality of sanitation and hygiene

Without giving/requesting informal payments or gifts to hospital staff members

Very bad - 1 2 3 4 5 - Very good

I don't know/ Not applicable

When offering informal payments or gifts to hospital staff members

Very bad - 1 2 3 4 5 - Very good

I don't know/ Not applicable

When a hospital staff member is requesting informal payments or gifts

Very bad - 1 2 3 4 5 - Very good

I don't know/ Not applicable

4. Tick if you are familiar with any of the above hypothetical situations:

- ☐ The quality or the availability of my treatment/medication depends on my personal relations with the hospital staff members
- ☐ The quality or the availability of my treatment/medication depends on informal payments/gifts I give to the hospital staff members
- ☐ It happened that doctors or nurses asked for informal payments in order to access a service that is normally free of charges at the hospital

5. How would you describe the competences and services offered by the hospital staff members?

- ☐ Highly competent, true professionals

- ☐ Competent with a willing to improve the general services of the hospital
- ☐ Incompetent, unwilling to improve the general services of the hospital
- ☐ Unprofessional, solving issues through corrupt practices
- ☐ Other: _____

6. I give small attentions (gift, small amount of money) to the doctors/nurses to obtain (better) services or (better) medication/treatment:

- ☐ Never
- ☐ Very rarely
- ☐ Sometimes
- ☐ At the end of my consultation/treatment
- ☐ Every time I have the chance

7. How would you evaluate the following items in this hospital (hospital's name):

- ☐ Poor sanitation, hygiene or potable water:
No concern- somehow a concern- important concern
- ☐ Informal payments, bribes and gifts provided to hospital staff members:
No concern- somehow a concern- important concern
- ☐ An adequate and qualitative treatment and drugs:
No concern- somehow a concern- important concern
- ☐ The absence of treatment or drugs in the hospital:
No concern- somehow a concern- important concern

8. Tick if you think that the giving and taking of informal payments or gifts is widespread among the following situations:

- ☐ For doctor consultation
- ☐ For medical assistance and care by nurses
- ☐ For having a surgery or anaesthesia
- ☐ For medication and treatment prescription

9. Doctors or nurses can help you access medication, treatments or medical equipment that are not available (on the market, in the hospitals or in the country) if you provide small attentions such as gifts, informal payments, bribes or other?

- ☐ Yes, always
- ☐ Yes, sometimes
- ☐ No, never
- ☐ I am not aware

10. On a scale from 1 to 5, which of the following items you think the hospital (hospital's name) should improve?

<p>Sanitation and hygiene inspections</p> <p>No need for improvement - 1 2 3 4 5 -Improvement very much needed</p>
<p>Control over the quality and the availability of hospital resources (drugs, medical equipment)</p> <p>No need for improvement - 1 2 3 4 5 -Improvement very much needed</p>
<p>Anti-corruption monitoring systems</p> <p>No need for improvement - 1 2 3 4 5 -Improvement very much needed</p>
<p>Transparency</p> <p>No need for improvement - 1 2 3 4 5 -Improvement very much needed</p>

11. Tick if you experienced at another public hospital in Romania any of the following:

- ☐ Poor sanitation or hygiene
- ☐ Medical staff that requested informal payments or gifts from patients
- ☐ Medical staff that accepted, if offered, any informal payments or gifts from patients
- ☐ The availability of treatment or medication only after informal payments or gifts to medical staff
- ☐ Not applicable

12. Your satisfaction towards the general healthcare services provided by the hospital (hospital's name):

- ☐ I am very satisfied with the hospital healthcare services
 - ☐ I am satisfied with the hospital healthcare services
 - ☐ I am unsatisfied with the hospital healthcare services and I reported irregularities to a competent authority
 - ☐ I am unsatisfied with the hospital healthcare services but I never reported any of my concerns to a competent authority
 - ☐ Other: _____

13. Is it the first time you complete a form regarding the general services of a hospital/ medical care?

- ☐ No, I completed other questionnaire(s) in this regard before
- ☐ I answered some questions for the monitoring experts or national observation mechanisms evaluating the hospitals or the right to health
- ☐ Yes, it is my first questionnaire in this regard
- ☐ Other: _____

14. Please add any additional comments you wish to include:

15. If you would like to receive a follow-up of the questionnaire (outcome) please provide one of the following ways of communication where you can be reached (strictly voluntary):

E-mail:

Post address:

Telephone number:

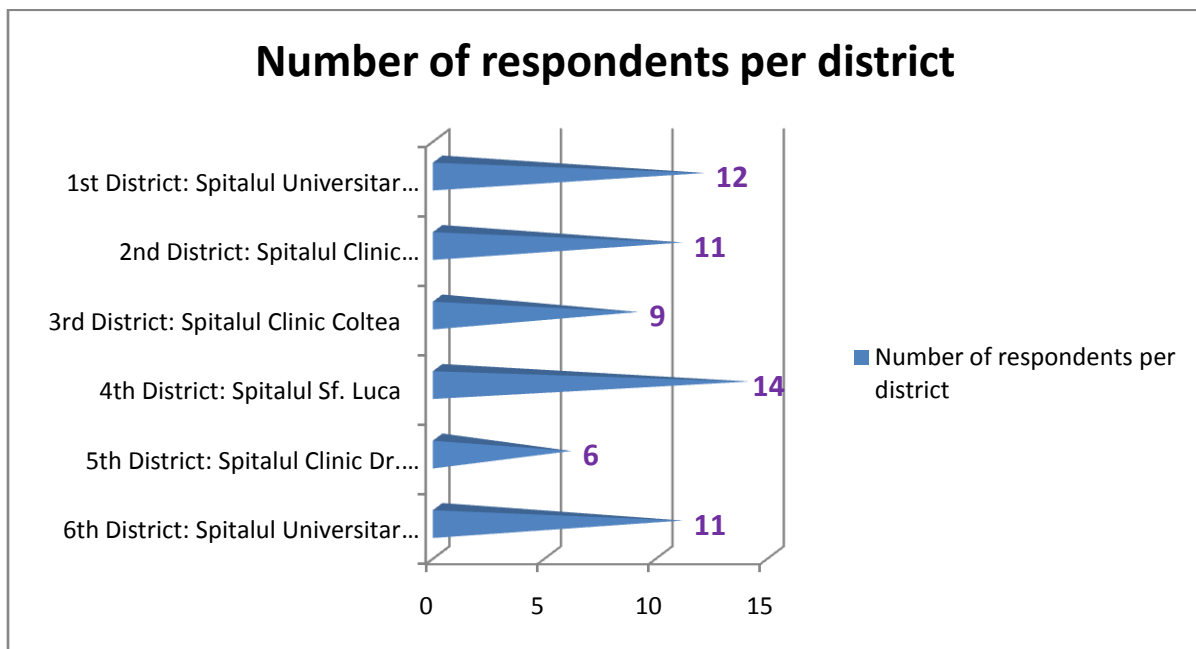
Thank you for your time!

Appendix B

Overall findings of the questionnaire

Evaluation of the healthcare services provided by the oncological department in 6 public hospitals in Bucharest

The questionnaire's findings are based on answers received from 63 patients from one of the 6 public hospitals where the survey took place:



General optional information (for statistical purposes)

Age:

- | | | |
|--------------------------------------|-----------------|-----------------------|
| <input type="checkbox"/> < 18 Years | 0% [0 pers] | |
| <input type="checkbox"/> 18-29 Years | 3,2% [2 pers] | |
| <input type="checkbox"/> 30-39 Years | 4,7% [3 pers] | |
| <input type="checkbox"/> 40-49 Years | 15,9% [10 pers] | |
| <input type="checkbox"/> 50-59 Years | 23,8% [15 pers] | 2 nd Place |
| <input type="checkbox"/> > 60Years | 52,4% [33pers] | 1 st Place |

Occupation:

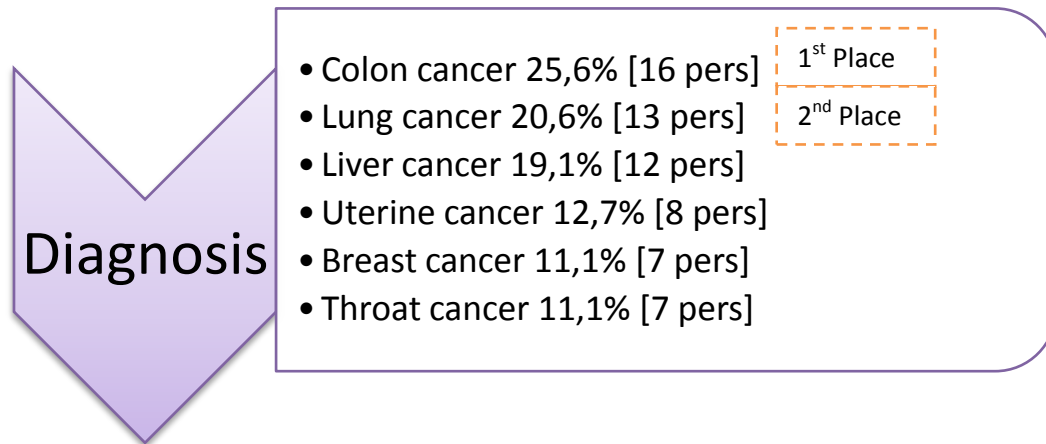
- | | | |
|---|----------------|-----------------------|
| <input type="checkbox"/> No occupation | 3,2% [2 pers] | |
| <input type="checkbox"/> Public sector | 11,1% [7 pers] | 2 nd Place |
| <input type="checkbox"/> Private sector | 9,5% [6 pers] | |
| <input type="checkbox"/> Retired | 76,2 [48 pers] | 1 st Place |
| <input type="checkbox"/> Other:_____ | 0% [0 pers] | |

Gender:

- | | | |
|---------------------------------|-----------------|-----------------------|
| <input type="checkbox"/> Male | 57,1% [36 pers] | 1 st Place |
| <input type="checkbox"/> Female | 42,9% [27 pers] | 2 nd Place |

Nationality: 63 Romanians, where 3 persons declared themselves as belonging to the Hungarian minority

Diagnosis or current health status (if relevant):



1. How often do you come for treatment /consultation at this hospital (hospital's name)?

<input type="checkbox"/> Daily basis	7,9% [5 pers]	
<input type="checkbox"/> 1-3 times a week	9,5% [6 pers]	2 nd
<input type="checkbox"/> -1-3 times a month	79,4% [50 pers]	1 st Place
<input type="checkbox"/> Rarely	3,2% [2 pers]	
<input type="checkbox"/> Other: _____	0% [0 pers]	

2. When did you start to be a patient or to be under treatment of the oncological sector of this hospital (hospital's name) ?

<input type="checkbox"/> 0-1 years ago	9,5% [6 pers]	
<input type="checkbox"/> 1-2 years ago	30,2% [19 pers]	2 nd Place
<input type="checkbox"/> 3-5 years ago	42,8% [27 pers]	1 st Place
<input type="checkbox"/> More than 5 years ago	14,3% [9 pers]	
<input type="checkbox"/> More than 10 years ago	3,2% [2 pers]	
<input type="checkbox"/> Other: _____	0% [0 pers]	

3. How would you evaluate the following items related to the hospital?

a. The accessibility of medical staff members of the hospital

Without giving/requesting informal payments or gifts to hospital staff members

Very bad - 1 2 3 4 5 - Very good

I don't know/ Not applicable

Average: 3,53

Details: 1 pers rating 1, 3 pers rating 2, 30 pers rating 3, 19 pers rating 4 and 10 pers rating 5

When offering informal payments or gifts to hospital staff members

Very bad - 1 2 3 4 5 - Very good

I don't know/ Not applicable

Average: 3,95

Details: 2pers rating 1, 8 pers rating 2, 10pers rating 3, 14 pers rating 4 and 29pers rating 5

When a hospital staff member is requesting informal payments or gifts

Very bad - 1 2 3 4 5 - Very good

I don't know/ Not applicable

Average: 4,23

Details: 0pers rating 1, 4 pers rating 2, 4pers rating 3, 28 pers rating 4 and 27pers rating 5

b. The professionalism of doctors and nurses

Without giving/requesting informal payments or gifts to hospital staff members

Very bad - 1 2 3 4 5 - Very good

I don't know/ Not applicable

Average: 2,68

Details: 12pers rating 1, 19 pers rating 2, 16pers rating 3, 9 pers rating 4 and 7pers rating 5

When offering informal payments or gifts to hospital staff members

Very bad - 1 2 3 4 5 - Very good

I don't know/ Not applicable

Average: 4

Details: 0pers rating 1, 5 pers rating 2, 10pers rating 3, 28 pers rating 4 and 20 pers rating 5

When a hospital staff member is requesting informal payments or gifts

Very bad - 1 2 3 4 5 - Very good

I don't know/ Not applicable

Average: 4,46

Details: 0pers rating 1, 0 pers rating 2, 2pers rating 3, 30 pers rating 4 and 31pers rating 5

c. The availability of medication

Without giving/requesting informal payments or gifts to hospital staff members

Very bad - 1 2 3 4 5 - Very good

I don't know/ Not applicable

Average: 1,28

Details: 49 pers rating 1, 11 pers rating 2, 2pers rating 3, 1 pers rating 4 and 0 pers rating 5

When offering informal payments or gifts to hospital staff members

Very bad - 1 2 3 4 5 - Very good

I don't know/ Not applicable

Average: 4,46

Details: 0pers rating 1, 1 pers rating 2, 5pers rating 3, 21 pers rating 4 and 36pers rating 5

When a hospital staff member is requesting informal payments or gifts

Very bad - 1 2 3 4 5 - Very good

I don't know/ Not applicable

Average: 4,66

Details: 0pers rating 1, 0 pers rating 2, 2pers rating 3, 17 pers rating 4 and 44pers rating 5

d. The quality of sanitation and hygiene

Without giving/requesting informal payments or gifts to hospital staff members

Very bad - 1 2 3 4 5 - Very good

I don't know/ Not applicable

Average: 3,17

Details: 2pers rating 1, 10 pers rating 2, 31pers rating 3, 15 pers rating 4 and 5pers rating 5

When offering informal payments or gifts to hospital staff members

Very bad - 1 2 3 4 5 - Very good

I don't know/ Not applicable

Average: 3,52

Details: 0pers rating 1, 8 pers rating 2, 30pers rating 3, 9 pers rating 4 and 16pers rating 5

When a hospital staff member is requesting informal payments or gifts

Very bad - 1 2 3 4 5 - Very good

I don't know/ Not applicable

Average: 4,60

Details: 1 pers rating 1, 0 pers rating 2, 3pers rating 3, 15 pers rating 4 and 44pers rating 5

4. Tick if you are familiar with any of the above hypothetical situations:

- | | |
|---|--|
| <input type="checkbox"/> The quality or the availability of my treatment/medication depends on my personal relations with the hospital staff members | 0% [0 pers] |
| <input type="checkbox"/> The quality or the availability of my treatment/medication depends on informal payments/gifts I give to the hospital staff members | 90,5% [57 pers]
1 st Place |
| <input type="checkbox"/> It happened that doctors or nurses asked for informal payments in order to access a service that is normally free of charges at the hospital | 9,5% [6 pers] |

5. How would you describe the competences and services offered by the hospital staff members?

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Highly competent, true professionals | 6,4% [4 pers] |
| <input type="checkbox"/> Competent with a willing to improve the general services of the hospital | 25,4% [16 pers] |
| <input type="checkbox"/> Incompetent, unwilling to improve the general services of the hospital | 34,9% [22 pers] 1 st Place |
| <input type="checkbox"/> Unprofessional, solving issues through corrupt practices | 33,3% [21 pers] 2 nd Place |
| <input type="checkbox"/> Other: _____ | 0% [0 pers] |

6. I give small attentions (gift, small amount of money) to the doctors/nurses to obtain (better) services or (better) medication/treatment:

<input type="checkbox"/> Never	3,2% [2 pers]	
<input type="checkbox"/> Very rarely	7,9% [5 pers]	
<input type="checkbox"/> Sometimes	28,6% [18 pers]	2 nd Place
<input type="checkbox"/> At the end of my consultation/treatment	60,3% [38 pers]	1 st Place
<input type="checkbox"/> Every time I have the chance	0% [0 pers]	

7. How would you evaluate the following items in this hospital (hospital's name):

- ☐ Poor sanitation, hygiene or potable water:
No concern- somehow a concern- important concern
 4,7% [3 pers]- 25,5% [16 pers]- 69,8% [44 pers] 1st Place
- ☐ Informal payments, bribes and gifts provided to hospital staff members:
No concern- somehow a concern- important concern
 0% [0 pers]- 7,9% [5 pers]- 92,1% [58 pers] 1st Place
- ☐ An adequate and qualitative treatment and drugs:
No concern- somehow a concern- important concern
 0% [0 pers]-0% [0 pers]- 100% [63 pers] 1st Place
- ☐ The absence of treatment or drugs in the hospital:
No concern- somehow a concern- important concern
 6,4% [4 pers] – 11,1% [7 pers] – 82,5% [52 pers] 1st Place

8. Tick if you think that the giving and taking of informal payments or gifts is widespread among the following situations:

Considered widespread by:

<input type="checkbox"/> For doctor consultation	79,4% [50 pers]	
<input type="checkbox"/> For medical assistance and care by nurses	79,4% [50 pers]	
<input type="checkbox"/> For having a surgery or anaesthesia	84,1% [53 pers]	
<input type="checkbox"/> For medication and treatment prescription	92,1% [58 pers]	1 st Place

9. Doctors or nurses can help you access medication, treatments or medical equipment that are not available (on the market, in the hospitals or in the country) if you provide small attentions such as gifts, informal payments, bribes or other?

<input type="checkbox"/> Yes, always	20,7% [13 pers]	
<input type="checkbox"/> Yes, sometimes	58,7% [37 pers]	1 st Place
<input type="checkbox"/> No, never	7,9% [5 pers]	
<input type="checkbox"/> I am not aware	12,7% [8 pers]	

10. On a scale from 1 to 5, which of the following items you think the hospital (hospital's name) should improve?

<p>Sanitation and hygiene inspections</p> <p>No need for improvement - 1 2 3 4 5 -Improvement very much needed</p> <p>Average: 4,55</p> <p>Details: 0pers rating 1, 1 pers rating 2, 3pers rating 3, 19 pers rating 4 and 40pers rating 5</p>
<p>Control over the quality and the availability of hospital resources (drugs, medical equipment)</p> <p>No need for improvement - 1 2 3 4 5 -Improvement very much needed</p> <p>Average: 4,73</p> <p>Details: 0pers rating 1, 0 pers rating 2, 1pers rating 3, 15 pers rating 4 and 47pers rating 5</p>
<p>Anti-corruption monitoring systems</p> <p>No need for improvement - 1 2 3 4 5 -Improvement very much needed</p> <p>Average: 4,6</p> <p>Details: 1pers rating 1, 1 pers rating 2, 2pers rating 3, 14 pers rating 4 and 45pers rating 5</p>
<p>Transparency</p> <p>No need for improvement - 1 2 3 4 5 -Improvement very much needed</p> <p>Average: 3,25</p> <p>Details: 1pers rating 1, 8 pers rating 2, 31pers rating 3, 20 pers rating 4 and 3pers rating 5</p>

11. Tick if you experienced at another public hospital in Romania any of the following:

<input type="checkbox"/> Poor sanitation or hygiene	79,4% [50 pers]	2 nd Place
<input type="checkbox"/> Medical staff that requested informal payments or gifts from patients	73% [46 pers]	
<input type="checkbox"/> Medical staff that accepted, if offered, any informal payments or gifts from patients	95,2% [60 pers]	1 st Place
<input type="checkbox"/> The availability of treatment or medication only after informal payments or gifts to medical staff	69,8% [44 pers]	
<input type="checkbox"/> Not applicable	4,7% [3 pers]	

12. Your satisfaction towards the general healthcare services provided by the hospital (hospital's name):

- | | | |
|--|-----------------|-----------------------|
| <input type="checkbox"/> I am very satisfied with the hospital healthcare services | 9,5% [6 pers] | |
| <input type="checkbox"/> I am satisfied with the hospital healthcare services | 14,3% [9 pers] | |
| <input type="checkbox"/> I am unsatisfied with the hospital healthcare services and I reported irregularities to a competent authority | 15,9% [10 pers] | |
| <input type="checkbox"/> I am unsatisfied with the hospital healthcare services but I never reported any of my concerns to a competent authority | 60,3% [38 pers] | 1 st Place |
| <input type="checkbox"/> Other: _____ | 0% [0 pers] | |

13. Is it the first time you complete a form regarding the general services of a hospital/ medical care?

- | | | |
|--|-----------------|-----------------------|
| <input type="checkbox"/> No, I completed other questionnaire(s) in this regard before | 3,2% [2 pers] | |
| <input type="checkbox"/> I answered some questions for the monitoring experts or national observation mechanisms evaluating the hospitals or the right to health | 0% [0 pers] | |
| <input type="checkbox"/> Yes, it is my first questionnaire in this regard | 96,8% [61 pers] | 1 st Place |
| <input type="checkbox"/> Other: _____ | 0% [0 pers] | |

14. Please add any additional comments you wish to include:

No comments received on behalf of the respondents

15. If you would like to receive a follow-up of the questionnaire (outcome) please provide one of the following ways of communication where you can be reached (strictly voluntary):

E-mail: Received 6 e-mail addresses on behalf of 6 respondents; this present appendix B has been sent to the 6 respondents as a follow-up of the questionnaire

Post address: No

Telephone number: No

Thank you for your time

Appendix C

List of Indicators and appropriate benchmarks

Indicator	Assess	Benchmarks	
Legal context	(a) the capacity of the State's legal framework to successfully contain corruption in public hospitals	a) Does the State have proper legislation and national institutions to counter embezzlement of public resources or forgery in the public health sector?	Is there a law/policy criminalising forms of corruption? Is the law properly implemented? Has the law been reformed or updated in the past 2-3 years? Is there an independent judicial authority with the power to try ministries/public officials for abuses? What is the efficiency of the activity of the national anti-corruption authorities in the health sector: number of prosecutions, number of arrests of medical staff members for corruption, etc. Does the whistleblower protection apply in the health sector? Financially speaking, are anti-corruption institutions capable of countering corruption? Has the number of these types of activities increased in the past 2-3 years?
	(b) the capacity of the legal system to protect the patients against damages cause by acts of corruption	b) Does the State have a policy to allocate any reparation allowances to patients or any financial resources to replace the assets hindered by corruption (medicines, devices)?	Is the percentage of the reparation policy sufficient to cover the prejudice brought by the embezzlement of medicines?
	(c) the ability to reform the legal framework in order to respond to acts of corruption in the health system.	c) Does the Sate have the ability to adjust/reform the legal framework to respond to corruption acts in the health system?	Did the legislation suffer any modification in order to counter corruption acts in the healthcare system? Are the changes helpful and well received in the healthcare system?

National strategy and plan of action	(a) the inclusion of the health sector in anti-corruption strategies	a) Does the State have a national anti-corruption strategy and plan of action and does it include the public healthcare system?	How do public hospitals implement national the anti-corruption strategy?
	(b) the inclusion of anti-corruption measures in health strategies	b) Does the State have a national health strategy and plan of action regarding the healthcare system and does it include countering corruption or enhancing transparency and integrity?	How do public hospitals implement the national health strategy?
Participation and coordination	(a) the capacity of the civil society to take part in decision-making and monitoring mechanisms in the public health sector	a) Are the representatives of the civil society taking part in decisions and monitoring mechanisms in the public health sector?	Are members of the civil society involved in the decision-making and monitoring process in the MPH or public hospitals? In which structures can civil society be involved in the public health sector?
	b) the cooperation between the public health sector and the civil society when formulating and implementing decisions and regulations	b) Is there a successful cooperation between the public health representatives and the civil society when formulating and implementing decisions and regulations?	Are the messages from the civil society listened to by the public health sector? Is the MPH regularly in contact with the civil society in forums and consultations? Does the MPH accept visits from civil society structures, accept and receive reports from the civil society? Do consultations lead to a fruitful agreement and are the recommendations and reports of the civil society being taken into consideration?

Monitoring and accountability	a) the capacity to keep performances and actions/omissions of medical staff members under continuous monitoring	<p>a) Do public hospitals have internal control policies?</p> <p>b) Are public hospitals controlled concerning the implementation of laws and regulations?</p>	<p>Is the internal control policy fully implemented? Does the internal control policy include controlling transparency, integrity and other measures?</p> <p>Is the monitoring procedure provided by a group of experts? Does it take place regularly? Are reports and follow-up mechanisms issued? Are doctor's medical prescriptions under a control system within a monitoring system?</p> <p>Does the monitoring system control the accuracy of the ratio of the number of medicines in the hospital's storage to the reports and prescriptions of medicines?</p>
	b) the capacity to hold medical staff members accountable for their actions and for the use of public resources	<p>c) Do public hospitals have a reporting procedure regarding the activity of medical staff members?</p> <p>d) Do public hospitals have a complaining system?</p>	<p>Is the reporting procedure verified by a superior commission/authority? Does the reporting procedure include reporting the number of medical prescriptions and patients and any ethics incidents?</p> <p>To whom is the complaining system open? Can patients and medical staff members complain about any type of corruption in public hospitals? Is the complaining system available and accessible? Can medical staff members be verified based on complaints? Do public hospitals collect feedback from patients? Does the MPH undertake questionnaires, check-up or statistics in order to find out the patients' opinion on the quality and services in public hospitals?</p>

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Abstract

To protect the right to health means that States have to take measures so that no third party can harm the right to health. Romania has experienced different types of corruption cases in the oncological public health sector. This issue is presented in a landscape of corruption in its different forms along with its affects on the availability, accessibility, acceptability and quality of patients' right to health. This research will thus assess the adequacy of Romania's measures to protect the right to health against corruption. This type of examination requires a qualitative research method with some quantitative features. Data will be collected through specific indicators: the legal context, the national strategy and plan of action, the participation and coordination and the monitoring and accountability indicators. The adequacy is measured by evaluating the consequences of Romania's measures on the availability, accessibility, acceptability and quality of the right to health.

This study leads to the remark that Romanian State's measures have both strengths and weaknesses. Some measures are more adequate than others. The research can be used by the public authorities in Romania in order to discuss and consider the possibility to reform some measures where the indicators scored low in their adequacy. This thesis can also be used by other States ready to provide an adequate protection of any human right against corruption.

Key words: corruption, right to health, Romania, measures, adequacy.

Das öffentliche Gesundheitswesen Rumäniens hat im Bereich Onkologie bereits verschiedene Arten von Korruptionsfällen erlebt. Diese weitreichenden Probleme der Korruption werden in ihren verschiedenen Formen dargestellt und es wird aufgezeigt, wie sie die Verfügbarkeit, Zugänglichkeit, Akzeptanz und Qualität von Recht auf eine gesundheitliche Versorgung von Patienten beeinflussen. Öffentlich garantierter Schutz für die Gesundheit bedeutet, dass Staaten adäquate Maßnahmen zu treffen haben, sodass Dritte das Recht auf Gesundheit nicht einzuschränken vermögen. Diese Forschung wird daher die Angemessenheit und Tragweite der rumänischen Maßnahmen bewerten, welche das Recht auf Gesundheit gegen die Korruption schützen sollen. Solch eine Art der Untersuchung erfordert eine qualitative Forschungsmethode mit einigen quantitativen Merkmalen. Die hierfür benötigten Daten werden über vier spezifische Indikatoren gesammelt. Diese umfassen den rechtlichen Rahmen, die nationale Strategie und öffentliche Vorgehensweise, die Beteiligung und Koordinierung dieser sowie das Maß an übernommener Verantwortung. Die Angemessenheit der existierenden Maßnahmen wird durch eine Evaluation von Rumäniens Vorgehensweisen bezüglich der Verfügbarkeit, Zugänglichkeit, Akzeptanz und Qualität des Rechts auf Gesundheit beurteilt. Die Auswertung der Untersuchungsergebnisse lässt den Schluss zu, dass aktuelle Maßnahmen des rumänischen Staates sowohl Stärken als auch Schwächen aufweisen, wobei einige Maßnahmen besser geeignet sind als andere. Diese Forschung kann von den Behörden Rumäniens verwendet werden um einige Maßnahmen zu überdenken, welche laut der Ergebnisse und Indikatoren als wenig angemessen erscheinen. Diese Arbeit kann ebenfalls von andere Staaten verwendet werden, welche bereit sind, einen angemessenen Schutz aller Menschenrecht gegen Korruption zu bieten.

Schlüsselwörter: Korruption, Recht auf eine gesundheitliche Versorgung, Rumänien, Maßnahmen, Angemessenheit.