United Nations A/72/137

General Assembly

Distr.: General
14 July 2017

Original: English

Seventy-second session
Item 73 (b) of the provisional agenda*
Promotion and protection of human rights: human rights questions, including alternative approaches for improving the effective enjoyment of human rights and fundamental freedoms

Right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Note by the Secretary-General

The Secretary-General has the honour to transmit to the General Assembly the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Dainius Puras, submitted in accordance with Human Rights Council resolutions 6/29 and 24/6.

* A/72/150.

17-11954 (E) 240817

Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Summary

Corruption can have a devastating effect on good governance, the rule of law, development and the equitable enjoyment of all human rights, including the right to health. In many countries health care is among the most corrupt sectors, threatening the sustainability of health-care systems worldwide. Corruption originates from power imbalances and asymmetries, is perpetuated by non-transparent decision-making and reinforces ineffective and harmful policymaking and health services provision. The present report is focused not only on those forms of corruption that are legally defined as breaking the law and should be brought to justice, but also on those practices which undermine principles of medical ethics and social justice, as well as effective and transparent health-care provision. The right to health provides a valuable normative framework and constitutes a legally binding imperative to analyse and address corruption affecting the right to health and occurring in and beyond the health sector.

Contents

Page

I. Introduction . . . 3

II. Corruption and the right to health: key issues and trends . . . 4

III. Corruption and the normative framework of the right to health . . . 8

A. The right to health as a legally binding obligation . . . 8

B. Available, accessible, acceptable and good-quality health care . . . 10

C. Underlying and social determinants of the right to health . . . 11

D. Participation, transparency and accountability . . . 12

E. Role and responsibilities of non-state actors . . . 15

IV. Issue in focus: corruption and the right to mental health . . . 16

V. Conclusions and recommendations . . . 20

A. Conclusions . . . 20

B. Recommendations . . . 20

I. Introduction

1. Corruption can have a devastating effect on good governance, the rule of law, development and the equitable enjoyment of all human rights, including the right to health. Corruption has been the subject of international legal commitments as well as recent political commitments. The 2030 Agenda for Sustainable Development and the Sustainable Development Goals (targets 16.5 and 16.6) stipulate that corruption and bribery, in all their forms, should be substantially reduced by 2030 and that effective, accountable and transparent institutions should be developed at all levels.

2. While corruption manifests at many levels within societies and States, the present report focuses on the links between corruption and the enjoyment of the right to the highest attainable standard of health. Corruption in government, institutions and society at large is a significant obstacle to the enjoyment of the right to health of individuals and groups. In countries with a higher level of perceived national corruption, there is a much higher prevalence of poor health.[1] Corruption in Government and society can reduce the ability of the government to raise resources for health and other social sectors through putting off investors or donors or as a result of tax evasion.

3. In many countries health is among the most corrupt sectors.[2] Health sector corruption, including for example the bribing of health officials and unofficial payments to health-care providers, obstructs the ability of States to fulfil their right to health obligation and to guarantee available, accessible, acceptable and good quality health services, goods and facilities.[3] Yet corruption affecting health also occurs in other sectors and industries, for example, the water sector, and the food and beverages, tobacco and other industries. Moreover, corruption has significant implications for equality and non-discrimination since it has a particularly marked impact on the health of populations in situations of vulnerability and social exclusion, in particular those living in poverty and children.[4]

4. The right to health provides a valuable normative framework and constitutes a legally binding imperative to analyse and address corruption affecting health and occurring in and beyond the health sector. The framework reflects notions of good governance, transparency, accountability and participation, which are key when it comes to combating corruption. It places legal obligations on States to guarantee access to health-related goods and services for all, including individuals and groups in situations of vulnerability, and this requires them to take actions to curb corruption where it occurs.

5. The present report is the result of extensive consultations among a wide range of stakeholders, including representatives of relevant United Nations agencies, civil society and academic experts. In May 2017, the Special Rapporteur convened an

[1] Margot I. Witvliet and others, “Sick regimes and sick people: a multilevel investigation of the population health consequences of perceived national corruption”, *Tropical Medicine and International Health*, vol. 18, No. 10, pp. 1240-1247; Angela Maria Pinzon-Rondon and others, “Association of rule of law and health outcomes: an ecological study”, *BMJ Open* (2015), vol. 5, No. 10.

[2] Transparency International, *Global Corruption Report 2006*, part one, Corruption and health, pp. 3-22.

[3] Brigit C.A. Toebes, “Human rights and health sector corruption”, in *Global Health and Human Rights*, John Harrington and Maria Stuttaford, eds. (London and New York, Routledge, 2010), pp. 102-134.

[4] Witvliet and others, “Sick regimes and sick people”, pp. 1245-1246; see also Mogens Justesen and Christian Bjørnskov, “Exploiting the poor: bureaucratic corruption and poverty in Africa”, World Development, vol. 58, No. C (2014), pp. 106-115.

expert consultation in Bangkok and is very grateful to those who participated and provided valuable inputs for the present report.

II. Corruption and the right to health: key issues and trends

6. Corruption is generally defined as "the misuse of public or entrusted power for private gain".[5] In relation to health, in many countries varying degrees of responsibility for public roles is entrusted to private actors, including private health professionals, pharmaceutical companies and health insurance companies. Corruption occurs in both the public and private sectors.

7. A distinction is frequently made between "grand" and "petty" corruption. Grand or "high-level" corruption refers to acts committed at a high level of government that distort policies of the central government, for example a health minister "skimming" money off a loan from a foreign country. Petty or "administrative" corruption is smaller-scale everyday corruption by low- and mid-level public officials in their interaction with citizens, for example an informal payment from patient to doctor.[6]

8. Other definitions distinguish between types of corruption, which among other forms include political and institutional corruption. "Political corruption" means manipulation by political decision makers of, for example, policies and rules of procedure in the allocation of resources, such as a government accepting a bribe in exchange for the construction of a large private hospital in the capital. "Institutional corruption" results from the normalization of behaviours that compromise truth-seeking and lead to the formation of perverse incentive structures, and thus addresses the behaviour of actors who exploit their institutional positions to influence institutional processes and actions.[7]

9. All in all, corruption is a multidisciplinary phenomenon demanding a response from many fields of study. From a legal perspective, the United Nations Convention against Corruption (General Assembly resolution 58/4, annex) lists five acts of corruption, which can be translated as follows to the health context:

(a) The bribery of national and foreign public officials in exchange for an undue advantage;

(b) Embezzlement, misappropriation or other diversion of funds from the health budget by a public official;

(c) Trading in influence;

(d) Abuse of functions;

(e) Illicit enrichment.[8]

10. There are many other manifestations of corruption in the health sector and beyond. The present report focuses on several non-exhaustive, illustrative examples.

11. Both corruption occurring in society at large (general corruption), as well as corruption specifically occurring in the health or other health-related sectors, have a negative impact on the enjoyment of the right to health. These forms are

[5] Transparency International, "Frequently asked questions on corruption". Available from www.transparency.org/whoweare/organisation/faqs_on_corruption#defineCorruption.

[6] Transparency International, "How do you define corruption?". Available from https://www.transparency.org/what-is-corruption/#define.

[7] Lawrence Lessig, "'Institutional corruption' defined" foreword, *Journal of Law, Medicine and Ethics*, vol. 41, No. 3 (2013). Available from https://ssrn.com/abstract=2295067.

[8] Toebes, "Human rights and health sector corruption".

intertwined. Corruption in society at large may affect the regulatory environment and the efficiency of State institutions. It hinders economic growth and sustainable development as well as equitable distribution of resources.[9] It undermines public confidence in the State and may obstruct attainment of the commitments made through Sustainable Development Goal 16 to create effective and accountable institutions.

12. Corruption is particularly detrimental in that it increases mistrust on the part of all stakeholders, especially users of services, not only in the health-care system but also in the abilities and performance of local and national authorities in general. While little research has been done on the impact of corruption on health outcomes, it is suggested, for example, that countries with higher levels of corruption have higher levels of child mortality.[10]

13. Alongside general corruption, health sector corruption is widespread and has serious consequences for the enjoyment of the right to health on the basis of equality and non-discrimination. The most common forms of corruption in the health sector are selling government posts, absenteeism, bribes, procurement corruption, theft or misuse of property, fraud, and embezzlement of user fee revenue, as well as informal payments to health-care providers.[11] A range of stakeholders may be implicated in these and other corrupt practices in the health sector affecting the enjoyment of the right to health. These include but are not limited to health ministers, parliaments, accrediting and licensing bodies, public and private insurers, hospitals, health professionals and health professional associations, community health workers, pharmacists, pharmaceutical companies and biotechnology companies, medical researchers and medical research groups and patients and patient support groups.[12] As will be argued below, they all bear responsibilities with regard to the right to health.

14. Corruption is a significant challenge to the delivery of quality health care, which is central both to the right to health and to the commitment under Sustainable Development Goal 3 to universal health coverage. The health sector is extremely vulnerable to corruption at all levels — grand and petty, political and institutional — and occurring in both the public and private sectors. It is estimated that every year 180 billion euros are lost to fraud and corruption in health care globally.[13] Health sector corruption negatively affects the (financial) resources available for health care; resources that are drained through embezzlement and procurement fraud are no longer available for paying salaries, funding health-care delivery or maintenance.[14] For example, there is evidence suggesting that health sector corruption has a negative

[9] Marie Chêne, “The impact of corruption on growth and inequality” (Transparency International, March 2014); and Kwabena Gyimah-Brempong, “Corruption, economic growth, and income inequality in Africa”, Economics of Governance, Springer-Verlag, No. 3: (2002), pp. 183-209.

[10] Sanjeev Gupta and others, “Corruption and the provision of health care and education services”, International Monetary Fund working paper, June 2000, p. 8; see also Witvliet and others, “Sick regimes and sick people”, p. 1245.

[11] Taryn Vian, “Review of corruption in the health sector: theory, methods and interventions”, *Health Policy and Planning* (2008), vol. 23, No. 2, pp. 83-94; and U4 Anti-Corruption Training Course. Available from www.bu.edu/actforhealth/CorruptionInHealthforce/Reader%201.pdf.

[12] Transparency International, *Global Corruption Report 2006*, pp. 4-13.

[13] University of Portsmouth, Centre for Counter Fraud Studies and MacIntyre Hudson, “The financial cost of healthcare fraud”, available from www.macintyrehudson.co.uk/sites/www.macintyrehudson.co.uk/files/The%20Financial%20Cost%20of%20Healthcare%20Fraud%20-%20Report.pdf.

[14] U4 Anti-Corruption Training Course.

effect on cancer care and care for HIV/AIDS.[15] While these trends are visible in countries at all levels of development, it is evident that lower-income countries are more deeply affected by health sector corruption and a lack of transparency. In some countries, the health sector is considered to be the most corrupt sector of all.

15. The lesser form of corruption, namely, petty corruption, is quite common in the health sector and includes informal payments from patient to health-care provider, absenteeism of health personnel and preferential treatment. These forms of corruption are also sometimes called "survival corruption", as they are exacerbated by a lack of resources in health-care settings, poor working conditions, low pay, and hierarchical structures, which drive people to engage in such acts. There is evidence that this "microform" of corruption has a particularly negative effect on the poor in society, as they are often unable to pay the bribes necessary for a certain service.[16]

16. Three main characteristics make the health sector particularly vulnerable to corruption: (a) power asymmetries or an imbalance of information, inter alia, between health-care provider and patient and between government, the private sector and rights holders; (b) uncertainty inherent in selecting, monitoring, measuring and delivering health-care services; and (c) the complexity of health systems: the large number of parties involved makes it more difficult to generate and analyse information in a transparent manner.[17] A fourth problem, sometimes termed "provider moral hazard", is that health professionals, public officials or private actors may choose to act in their own interests rather than in the interests of the rights holders towards whom they bear duties. Moreover, where health systems lack transparency, participation and accountability, a fertile breeding ground is created for corruption.

17. Health reforms introduce organizational changes that can mitigate corruption but may also open new channels for abuse. As discussed during the expert consultation held in Bangkok, transferring responsibility for public health facilities from national to local governments may make them more accountable and less corrupt, but it can also create opportunities for local officials to divert resources for personal gain. Deregulation can eliminate requirements that are exploited by public officials to charge bribes, but it can also eliminate rules and oversight that are necessary to protect the public against unscrupulous actors. Permitting doctors to combine public and private practices is often justified as assuring staffing of public facilities, but may create situations where patients cannot obtain treatment to which they are entitled in public facilities, either because doctors are unavailable or because they encourage patients to see them privately.

18. The Special Rapporteur is concerned that there is a "normalization of corruption" in health care; corruption can be so pervasive that it becomes accepted as "normal".[18] Yet these practices lead to groups and individuals being disadvantaged and to the infringement of human rights, such as access to health care on the basis of equality and non-discrimination. Changing views and perceptions in institutions and society of corruption as normal, unavoidable and justified is an important element in addressing the problem of corruption. Informal payments can be reduced by engaging with the public in a debate about the adverse consequences of corruption, with a view to changing cultural values in relation to corruption.

[15] Saskia Mostert and others, "Corruption in health-care systems and its effect on cancer care in Africa", *Lancet Oncology*; vol. 16, No. 8 (August 2015), pp. 394-404, and Willa Friedman, "Corruption and averting AIDS deaths", Center for Global Development, working paper No. 395, February 2015.

[16] Justesen and Bjørnskov, "Exploiting the poor: bureaucratic corruption and poverty in Africa".

[17] Transparency International, *Global Corruption Report 2006*, p. xvii.

[18] Transparency International, *Diagnosing corruption in healthcare* (2016), foreword.

Codes of conduct and ethics, training and education can also be used to support responsible conduct among professionals, including avoiding corrupt behaviour, although they may not be sufficient alone for behaviour change where it is most needed. States should also take action to address other trigger factors such as low or unpaid salaries, cumbersome administrative procedures and excessive red tape,[19] as well as enhancing transparency, participation and accountability.

19. Beyond the health sector, corrupt practices that have a direct impact on the right to health have occurred in other private sector companies, including private water companies, tobacco manufacturers, food and beverage manufacturers, car manufacturers and the natural resources extraction industry.[20] Such practices include, for example, bribery of public officials and the manipulation of scientific research practices.[21] In his previous reports, the Special Rapporteur has highlighted how power asymmetries have given rise to the widespread prioritizing of specialized medicine over primary care and public health interventions, including poverty reduction, labour conditions and early childhood services (see A/HRC/35/21, paras. 21-26). Such asymmetries generate preferences for physical health care over mental health care; biomedical interventions over non-biomedical interventions; the prioritization of certain disciplines that promote expensive biomedical technologies over social sciences in public health research agendas; and limited space for civil society participation in health policymaking.

20. Although many everyday practices in health-related services may not be considered as corruption, legally speaking, their accumulation and their acceptance by various stakeholders have a detrimental cumulative effect on the performance of health-care systems and, indirectly, on individual and societal health. It is for that reason that the present report is focused not only on those forms of corruption that are legally defined as breaking the law and should be brought to justice, but also on those practices which undermine principles of medical ethics, social justice, as well as effective and transparent health-care provision. When such practices are not properly addressed, they pave the way to non-transparent decisions at all levels of policymaking, policy implementation and services provision and thus lead to corrupt environments and foster institutional corruption.

21. Mindful that the nature of corruption means that it is often difficult to distinguish intentional malfeasance from inefficiencies, errors, and differences in judgments and in priorities,[22] the Special Rapporteur underlines that enhancing transparency is particularly important not only to address clearly corrupt practices but also to address these harmful phenomena, which obstruct the enjoyment of the right to health.

22. In the context of universal health coverage, as one of the important global commitments under the 2030 Agenda, it is critical to strengthen health-care systems so that all segments of population trust primary care and primarily use this level of services for most health conditions. This would be an effective anti-corruption

[19] Jon S.T. Quah, “The normalization of corruption: why it occurs and what can be done to minimize it”, Department of Economic and Social Affairs, Division for Public Administration and Development Management, Singapore, December 2015.

[20] See https://www.transparency.org/topic/detail/water; Transparency International, Policy Position No. 2, 2008, “Linking the corruption, water and environmental agendas to combat climate change”, 15 February 2008.

[21] Pascal A. Diethelm, Jean-Charles Rielle and Martin McKee, “The whole truth and nothing but the truth? The research that Philip Morris did not want you to see”, *Lancet*, vol. 366, No. 9479 (2 July 2005), pp. 86-92.

[22] William Savedoff, Amanda Glassman and Janeen Madan, Center for Global Development, policy paper No. 86, “Global Health, Aid and Corruption: Can We Escape the Scandal Cycle?”, 2016, p. 9.

measure to help decrease the prevailing tendency whereby users of health services prefer to bypass primary care and use specialized health-care services. The Special Rapporteur welcomes recent initiatives developed and replicated in some countries through which medical doctors educate the general population against wasteful or unnecessary use of medical tests, treatments and procedures in health care. Such initiatives, inter alia, "choosing wisely", "realistic medicines" or "preventing over-diagnosis", should be supported by States as effective measures to develop rational health-care services and thus prevent unnecessary and costly use of specialized interventions.

III. Corruption and the normative framework of the right to health

A. The right to health as a legally binding obligation

23. The right to health is recognized in the Constitution of the World Health Organization (WHO) and protected by the Universal Declaration of Human Rights and international human rights treaties which are binding on States parties, including the International Covenant on Economic, Social and Cultural Rights, the International Convention on the Elimination of All Forms of Racial Discrimination, the Convention on the Elimination of All Forms of Discrimination against Women, the Convention on the Rights of the Child, the Convention on the Rights of Persons with Disabilities and the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families. Additionally, regional human rights treaties and many domestic constitutions protect the right to health. These international treaties and domestic laws obligate States to take action to respect, protect and fulfil the right to health and to address corruption where it interferes with their right-to-health obligations. They should inform responses to corruption alongside other legal instruments, such as the United Nations Convention against Corruption.

24. The right to health gives rise to obligations that provide a framework for action for duty bearers, as well as a framework of reference for monitoring and accountability. The right to health is subject to progressive realization.[23] This means that many aspects of the right to health do not have to be realized immediately; rather, States must take effective and targeted measures towards the progressive realization of the right to health. However, States also have some immediate obligations, including core obligations such as the equitable distribution of health facilities, goods and services; the provision of essential medicines; access to minimum essential food, basic shelter, safe and potable water and sanitation; and the adoption of a national health strategy and plan of action on the basis of epidemiological information.[24] The Committee on the Rights of the Child has also highlighted that universal health coverage is a core obligation (see the Committee's general comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health, para. 72). States must adopt and enforce legislative, regulatory and policy measures to ensure that corruption does not impede the fulfilment of their progressive and core obligations.

[23] International Covenant on Economic, Social and Cultural Rights, art. 2.1; Convention on the Rights of the Child, art. 4.

[24] Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000) on the right to the highest attainable standard of health, para. 43.

25. Corruption undermines the State's obligation to realize the right to health "to the maximum of its available resources".[25] Notably, embezzlement diverts financial resources from their intended purpose. Corruption also reduces the ability of governments to generate maximum resources, including through international cooperation, in the first place by making countries less attractive to donors and investment,[26] and may support tax evasion. Measures to prevent and protect against corruption offences are therefore an essential component of this obligation.

26. Moreover, since the right to health includes not only a right to health care but also to the determinants of health, it offers a road map and tools for addressing corrupt action in the health sector as well as corruption affecting the social, environmental and other determinants of health. Measures to address the right to health should be holistic and integrated, go beyond the provision of health services and be underpinned by cross-departmental commitment (see A/HRC/32/32, para. 37). It requires the improvement not only of outcomes but also of processes, for example with governance and health systems required to operate on the basis of principles including transparency, participation, accountability and non-discrimination, all of which have a particular importance for addressing corruption.

27. In recent years, a number of United Nations human rights bodies have acknowledged the negative impacts of corruption on the enjoyment of human rights.[27] By its decision 2002/106, the Sub-Commission on the Promotion and Protection of Human Rights appointed a Special Rapporteur on the impact of corruption on human rights, in particular economic, social and cultural rights. In her reports, the Special Rapporteur established that the enjoyment of both civil and political and economic, social and cultural rights are seriously undermined by corruption.[28] In a report published in 2015, the Advisory Committee to the Human Rights Council explained that a human rights perspective on the impact of corruption can move the victims to the centre of the fight against corruption by highlighting the negative impacts of corruption on the individuals and groups concerned. The human rights perspective also reveals that the State bears the ultimate responsibility for such acts. Establishing the links between corruption and human rights can promote access to human rights mechanisms to combat corruption, thus creating new opportunities for monitoring and litigation (see A/HRC/28/73, paras. 27-28 and 32).

28. When it comes to addressing corruption and a lack of transparency, the right to health is closely related to and dependent upon other human rights and fundamental freedoms that are critical to the fight against corruption, including the right to life; freedom of expression including the right to seek, receive and impart information; freedom of association; and the right to a fair trial.[29] For example, freedom of expression offers a basis for protecting whistle-blowers, which is of key importance in combating corruption, while the right to information is vital to access information including on financial transactions and decision-making processes that may reveal corruption. The promotion and protection of these rights will also therefore be vital tools to address corruption affecting health.

[25] Magdalena Sepúlveda, *The Nature of the Obligations under the International Covenant on Economic, Social and Cultural Rights* (Intersentia, 2003), p. 315.

[26] Maureen Lewis, "Governance and Corruption in Public Health Care Systems", working paper No. 78 (Center for Global Development, 2006), p. 8.

[27] Office of the United Nations High Commissioner for Human Rights, "The human rights case against corruption", March 2013. Available from www.ohchr.org/EN/NewsEvents/Pages/HRCaseAgainstCorruption.aspx; and A/HRC/28/73.

[28] See E/CN.4/Sub.2/2004/23 and E/CN.4/Sub.2/2005/18

[29] Toebes, "Human rights and health sector corruption".

B. Available, accessible, acceptable and good-quality health care

29. The right to health requires that health-care goods, services and facilities be available in adequate numbers; financially and geographically accessible, as well as accessible on the basis of non-discrimination; acceptable, that is, respectful of the culture of individuals, minorities, peoples and communities and sensitive to gender and life-cycle requirements and of good quality, thus meeting all the criteria of availability, accessibility, acceptability and quality (AAAQ).[30]

30. Petty and grand corruption and institutional and political corruption can have a negative impact on the availability, accessibility, acceptability and quality of health care. When money that has been allocated to the health sector is embezzled, the availability of health services and goods is affected.

31. Corruption can also arise when States fail in their obligation to ensure that there is an adequate number of health professionals receiving domestically competitive salaries[31] as petty corruption is often used by health professionals or other local officials to make up for inadequate, or unpaid salaries, although it should also be noted that bribes and illicit charges also occur where health professionals earn adequate salaries. As well as competitive salaries, reward for correct performance can also help to tackle corruption. Absenteeism of health service staff also negatively affects availability.

32. As to physical accessibility, health sector corruption can lead to choices that are less favourable to the community, for instance as a result of bribes, health-care facilities may be built in urban or wealthy areas rather than in locations accessible to poor or rural populations.

33. In terms of affordability, health-care providers can make health-care services more expensive by demanding payments (informal or under-the-table payments), which can put treatment out of reach and be a matter of life or death, contribute to morbidity or impoverish patients and their families. The payment of bribes by patients for privileged care is common in many countries and results in discriminatory access to care, with wealthier patients likely to access care more easily than those that are too poor to pay bribes.[32] As a result of bribery in procurement processes, medicines may be more expensive.

34. In terms of information accessibility, a lack of information about rights in the health system can provide a smokescreen for corruption. Moreover, patients are vulnerable due to the so-called “information imbalance” in the health sector, with doctors being more knowledgeable about the health-care services that they provide than the receivers.

35. Corruption also infringes medical ethics, which are an essential component of acceptable health care. Lastly, in terms of quality, corruption can affect the quality of medicines, for example, when regulators are bribed to carry out less rigorous checks, or when hospital administrators purchase medicines of unknown quality.[33] Quality can also be compromised where bribes are extorted or accepted in decisions on hiring staff, or accrediting, licensing or certifying facilities,[34] in deciding which

[30] Committee on Economic, Social and Cultural Rights, general comment No. 14, para. 12. See also A/71/304, para. 17.

[31] Committee on Economic, Social and Cultural Rights, general comment No. 14, para. 12 (a).

[32] Transparency International, *Global Corruption Report 2006*, p. 10.

[33] Brigit Toebes, “Health Sector Corruption and Human Rights: A Case Study”, in *Corruption and Human Rights: Interdisciplinary Perspectives*, Martine Boersma and Hans Nelen (eds.) (Antwerp/Cambridge/Portland, Intersentia, 2010), pp. 91-123.

[34] Transparency International, *Global Corruption Report 2006*, p. xviii.

medicines to include on essential medicines lists,[35] or to market unregulated medicines, which can increase mortality and morbidity among those affected,[36] as well as hampering disease control efforts. Nepotism, cronyism and other forms of favouritism can also compromise the quality of health and health-related services.

36. The right to health requires that States take action, including policy, legislative and budgetary action, to prevent corruption from impeding the available, accessible, acceptable and good-quality health care.

C. Underlying and social determinants of the right to health

37. Corruption compromises the ability of the State to guarantee the underlying and social determinants of health including safe drinking water, safe and nutritious food and a healthy environment, and exacerbates the discrimination and inequalities that prevail in societies throughout the world.

38. To take the example of water, around 10 per cent of water sector investment is lost to corruption. Corruption can make water inaccessible and unaffordable and affect the quality of water. In some low-income countries, corruption can add an estimated 30-45 per cent to the price of connection to a water network.[37] The increasing role played by private sector actors in water services requires the State to adopt an appropriate regulatory framework.

39. The harmful effects of the tobacco industry and unhealthy foods industry has been covered up by manufacturers and industry lobbyists, including through sponsoring research to downplay links to health problems. Misinformation, pressure and bribery from private sector actors, including the food and beverage and breast-milk substitute industries[38] and the tobacco and the polluting industries, can interfere with the obligation of governments to adopt an appropriate legislative, regulatory and policy framework to promote and protect public health.

40. Discrimination encompasses any distinction, exclusion or restriction that has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise by all persons, on an equal footing, of all rights and freedoms. Non-discrimination and equality are human rights obligations which are fundamental to realizing the right to health. Not only must health and other goods and services be available to all on the basis of non-discrimination, but broader promotion and protection of equality and non-discrimination are vital in guaranteeing the equitable enjoyment of the right to health.

41. There is ample research indicating that corruption and a lack of transparency exacerbate socioeconomic deprivation. Lower social groups carry a heavier burden in a society rife with corrupt elements.[39] In turn, the equal enjoyment of the right to health is deeply affected by poverty and income inequality.[40]

42. In the health sector, low-income and other groups in vulnerable situations are affected the most by corruption and a lack of transparency. Lower-income groups

[35] Mostert and others, p. 396.
[36] U4 Anti-Corruption Resource Centre, “Corruption in the health sector”, U4 issue 2008, No. 10, p. 18.
[37] See https://www.transparency.org/topic/detail/water.
[38] See A/HRC/32/32 and joint statement by the Special Rapporteur and others on breastfeeding. Available from www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=20871&LangID=E.
[39] Witvliet and others, p. 1246.
[40] Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016) on the right to sexual and reproductive health, para. 8.

have the most difficulty affording the informal payments that are often required to receive the medical treatment they need. In health-care settings that face a high level of corruption, the poorer sections of the population and those who live in rural areas may suffer longer waiting periods at public health clinics and are also more frequently denied vaccines than rich and urban sections of the population.[41] Health sector corruption can also lead to discrimination more directly when health-care providers and professionals treat patients differently according to their income and their contact with the medical profession.

43. There are several intersecting groups in society that suffer from corruption on other grounds. There is, for example, evidence that corruption does not affect rural areas in the same way as it affects urban areas. Women can often be particularly affected by health sector corruption. In many countries, they are more likely to use health care than men, a pattern partly explained by their increased use of services during their reproductive years. They may thus be disproportionately affected by the effects of health sector corruption, for example when they lack the money to afford informal payments necessary for assistance around childbirth. Women may also be more vulnerable to informal payments where they lack economic means, for example where they do not participate equally in the paid labour force or do not have equal access to or control of financial resources within the household. Furthermore, women constitute a large proportion of health-care personnel, and can thus be disproportionately affected when health sector corruption negatively affects the timely payment of proper wages.[42]

D. Participation, transparency and accountability

44. Meaningful participation of people in decisions that affect their health and socioeconomic well-being is a key component of the right to health and crucial when it comes to combating corruption in health care and in society at large. States' obligations under article 12 of the International Covenant on Economic, Social and Cultural Rights require that the right to participate in decision-making processes affecting their health and development must be an integral component of any relevant policy, programme or strategy.[43] Sustainable Development Goal target 16.7 stipulates the duty to ensure responsive, inclusive, participatory and representative decision-making at all levels.

45. Participation in health decision-making leads to improved health outcomes and is essential for ensuring the distribution of policies and programmes to broader segments of the population, thus making governance more accountable. Participation goes beyond merely being educated, informed or consulted. It implies a human right to actively engage individuals and groups in the development, implementation and review of policies, standards, indicators, benchmarks or legislation, particularly aimed at including the voices and needs of more vulnerable or otherwise underrepresented and especially affected populations.[44]

46. Key elements of meaningful participation with the aim of preventing and controlling corruption are the active disclosure of important health-related

[41] Transparency International, *Global Corruption Report 2006*, pp. 37-39.

[42] Toebes, "Human rights and health sector corruption", pp. 106-134.

[43] See A/HRC/32/32, para. 53; see also Committee on Economic, Social and Cultural Rights, general comment No. 14, para. 11.

[44] See also Helen Potts, "Participation and the Human Right to the Highest Attainable Standard of Health" (University of Essex, Human Rights Centre, 2007), available from http://repository.essex.ac.uk/9714/1/participation-right-highest-attainable-standard-health.pdf; Marlies Hesselman, Antenor Hallo de Wolf and Brigit Toebes, *Socio-Economic Human Rights in Essential Public Services Provision* (Routledge, 2017), p. 317.

information and the participation of relevant stakeholders in health decision-making, including in health sector plans, in the annual budget process and in review processes for health laws, policies and programmes.[45] In the context of budgets, participation involves the engagement of a variety of stakeholders in determining the allocation of funding, as well as monitoring expenditure. Methods for realizing participation include forums and conferences, local health committees and teams, citizens' juries, public meetings, but also institutional participation, for example in hospital boards.[46] Key stakeholders include, but are not limited to, national health assemblies, community-based and grass-roots organizations, professional associations and other non-governmental bodies and civil society organizations.

47. Patients' organizations and other more empowered interest groups may exert influence on health decision-making by lobbying in favour of the prescription and reimbursement of expensive drugs or particular programmes or treatments in a health service at the expense of other treatments or programmes. Paradoxically, these activities can reinforce imbalances and power asymmetries, as they too often result in undue pressure on policymakers to invest in specialized care and vertical programmes of treatment for certain diseases at the expense of primary care and holistic medicine. Thus participation has to be carefully planned, balanced and accompanied by open and transparent planning mechanisms to ensure representation of a broad range of civil society and other key stakeholders.

48. Where there is opacity surrounding decisions at the political, macro or micro levels, corruption can flourish, go undetected and occur with impunity. Transparency unveils corruption and is inextricably linked to the right to access information, participation and accountability. Access to information and transparency laws provide a framework for addressing corrupt practices, while the regulations and monitoring arrangements are also vital. Transparency can often be enhanced by the participation of rights holders and civil society organizations in decision-making processes that may be prone to corrupt practices.

49. There are particular challenges to transparency in the health sector. Asymmetric information between providers, payers and users leads to provider or user moral hazard. Information is divided between a multitude of different actors, including regulators, payers, providers, users and suppliers, which reduces transparency. There are many varying ways to improve transparency depending on the context. For example, transparency in procurement is enhanced through public access to procurement bidding results, monitoring of the prices paid and analysis of bids.[47] Transparency in recruitment can be supported through the publication of criteria. Transparency through the promotion of information that sets out the services and treatments to which individuals are entitled and how these services are reimbursed can help minimize inequalities in access to care through corrupt practices. The publication of transparent waiting lists can negate the practice of bribery to access more rapid treatment.

50. There is a significant demand from civil society for accountability of Governments and other institutions.[48] Sustainable Development Goal 16 includes a commitment to create effective, transparent and accountable institutions at all levels. Accountability is at the heart of human rights and central to the fight against corruption. Human rights-based accountability for corruption helps reveal where

[45] U4 Anti-Corruption Resource Centre, "Addressing corruption in the health sector", U4 issue, January 2011, No. 1.

[46] Potts, "Participation and the Human Right to the Highest Attainable Standard of Health", p. 20.

[47] Transparency International, *Global Corruption Report 2006*, p. 59.

[48] Independent Accountability Panel, "2016: old challenges, new hope: accountability for the global strategy for women's, children's and adolescents' health" (2016), p. 7.

corruption has taken place and resulted in human rights abuses. Effective accountability processes are also important for the reason that they can have a deterrent effect in relation to corruption. It is therefore troubling that research suggests that accountability for corruption is rare,[49] indicating a need for governments to take concerted steps to strengthen accountability mechanisms and processes.

51. Accountability comprises three elements: monitoring ("what is happening, where and to whom (results) and how much is spent, where, on what and whom (resources)"), review ("analysing whether pledges, promises and commitments have been kept by countries, donors and non-state actors")[50] and remedies and action.[51] The rule of law, transparency and access to information, including on decision-making processes, budgets and financial transfers in both the public and private sectors, provide vital conditions which help to strengthen accountability.

52. Health systems are complex and a wide range of monitoring and review processes have a role to play in enhancing accountability for the right to health in the context of corruption. In terms of monitoring, budget monitoring, effective and accurate accounting, audits and public expenditure tracking surveys are ways of monitoring how funds have been allocated and whether they have been distributed as intended, or whether corruption may have occurred. Yet in many low-income countries, Governments lack financial and technical capacity to operate such systems in an effective way.[52] As well as monitoring of funds, monitoring of health professionals' practice and supplies is also important. The establishment of well-resourced and independent anti-corruption and fraud agencies to prevent and detect corruption, including in the health sector, can also support the monitoring dimension of accountability.[53]

53. Judicial, quasi-judicial, political and administrative mechanisms at the local, national and international levels can all play an important review function.[54] It is essential that rights holders are aware of their entitlements and that complaints procedures are simple and accessible. Independent complaints procedures are often valuable. Rights holders must be able to participate in review procedures carried out by quasi-judicial, political or administrative bodies. Moreover, whistle-blower protection in the public and private sectors for individuals in procurement bodies, health authorities, health service providers and suppliers of medicine and equipment supports review through encouraging the reporting of corruption.[55] Domestic human rights bodies, such as national human rights institutions, as well as international mechanisms such as the United Nations treaty bodies and the universal periodic review, can provide an important contribution to enhancing accountability for the right to health, including in the context of corruption.

54. Governments must take action where monitoring and review have revealed corrupt practices. Not only should sanctions be applied, but remedies must also be awarded and implemented. Accountability should not be exclusively equated with a blame and punishment model that puts front-line workers in the firing line. Rather it is better understood as reinforcing the rule of law, including the promotion and protection of the right to health in the health system. Court judgments, as well as

[49] Lewis, "Governance and Corruption in Public Health Care Systems", pp. 20 and 40.
[50] Commission on Information and Accountability for Women's and Children's Health, *Keeping Promises, Measuring Results*, p. 7.
[51] Independent Accountability Panel, "2016: old challenges, new hopes", p. 12.
[52] U4 Anti-Corruption Resource Centre, "Corruption in the health sector", p. 11.
[53] Transparency International, *Global Corruption Report 2006*, p. XXI.
[54] Helen Potts, *Accountability and the Right to the Highest Attainable Standard of Health* (University of Essex, 2008).
[55] See Transparency International, *Global Corruption Report 2006*, p. XX.

recommendations from other review bodies, can lead to actions by governments and other duty bearers producing transformative changes in the health sector.[56]

E. Role and responsibilities of non-state actors

55. Under the Universal Declaration of Human Rights, all organs of society have human rights responsibilities. It is now widely acknowledged that, while States parties are ultimately accountable for the right to health, all members of society, including health professionals and the private business sector have responsibilities regarding the realization of the right to health.[57] As indicated in the Guiding Principles on Business and Human Rights: Implementing the United Nations "Protect, Respect and Remedy" Framework, private actors have the responsibility to "respect" human rights.[58]

56. Private hospital and insurance boards and other institutions responsible for the financing and provision of health care or underlying determinants have an important role to play in combating corruption and lack of transparency within their organizations. They must ensure that they comply with national laws and regulations regarding corruption and human rights. They may adopt an anti-corruption strategy, including internal regulations aimed at prohibiting and preventing the diversion of budgets, medicines or medical supplies for personal advantage; the acceptance of informal payments by their health personnel; preferential treatment for well-connected individuals; the use of hospital equipment for private business; the improper referral of public hospital patients to private practices; and illegitimate absenteeism of medical personnel while being paid. When it comes to preventing informal payments, the creation of individual contracts with personnel and increased pay scales while sanctioning poor performance are recommended.[59] In the case of whistle-blowers, hospital boards and other actors should refrain from punitive actions and provide adequate protection and guarantees to safeguard their personnel and services.

57. Organizations administering health insurance schemes and insurance regulators have a responsibility to prevent embezzlement, theft and illicit enrichment from the health insurance budget and bias in favour of certain procedures, medical professionals or products due to conflicts of interests. They should avoid adverse selection practices leading to patients being refused on the basis of their health status, age, financial capacity or other factors.[60]

58. The medical profession has a responsibility to abstain from unethical and unprofessional behaviour under its professional codes, which often emphasize a commitment to integrity and non-corrupt behaviour.[61] Among other acts, the medical profession is to refrain from favouritism and other forms of preferential treatment for well-connected individuals; accepting bribes; using hospital equipment for private business; and referring public hospital patients to their private practices. They should remain independent from outside organizations that have vested

[56] Independent Accountability Panel, "2016: old challenges, new hopes", p. 11.
[57] See Committee on Economic, Social and Cultural Rights, general comment No. 14, para. 42.
[58] See *Guiding Principles on Business and Human Rights: Implementing the United Nations "Protect, Respect and Remedy" Framework* (United Nations publication, Sales No. HR/PUB/11/04, chap. II).
[59] Taryn Vian, "Corruption in hospital administration", in Transparency International, *Global Corruption Report 2006*, pp. 49-55.
[60] Maureen Lewis, "Governance and corruption in public health care systems", Center for Global Development, working paper No. 78, January 2006.
[61] See World Medical Association, International Code of Medical Ethics, last amended in 2006.

interests in their clinical activities. They should avoid conflicts of interest that compromise their decisions regarding the care of patients.

59. Education in the health-care sector is one important element in that regard. The doctrine of the "five-star doctor" needs to be reaffirmed to translate modern values and scientific evidence into everyday medical practice. Modern medical doctors need to be not only good clinicians but also effective community leaders, communicators, decision makers and managers. That philosophy should be complemented by a strong human rights-based approach and evidence gained from the modern public health approach.

60. While medical doctors and other health-care workers are accountable and responsible for ethical conduct and non-corrupt behaviour, it is crucial that corrupt practices and institutional corruption do not affect decisions made at the level of academic medicine. Medical schools that train future medical doctors and carry out medical research and university hospitals that provide a tertiary level of health-care services and use expensive biomedical technologies have a key role in preventing corruption in the rest of the health-care system. It is very important to use the principle of academic autonomy in a responsible way. The academic medical elite has enormous power over decision-making and when they advise policymakers on how to invest resources proper accountability mechanisms need to be in place.

61. Within the health sector, the pharmaceutical industry stands out as being particularly prone to corruption. Corrupt practices take place at all stages of the pharmaceutical value chain, including during research and development, manufacturing, registration, distribution, procurement and marketing. The key problems are a lack of objective data and understanding of corruption in the pharmaceutical sector, a weak legislative and regulatory framework, potential undue influence from companies and a lack of leadership committed to anti-corruption efforts.[62]

62. While governments have the primary duty to regulate and oversee the pharmaceutical sector, the pharmaceutical industry has a responsibility to engage with governments on the issue of corruption. It has an independent responsibility to prevent corruption throughout its value chain, inter alia, through institutional checks and balances, protection and security of medicines and the adoption of monitoring and accountability procedures such as audits and whistle-blowing mechanisms for all staff in the company.[63]

IV. Issue in focus: corruption and the right to mental health

63. The Special Rapporteur has raised the issue of the global burden of obstacles (see A/HRC/35/21) that persists in mental health-care systems globally and how this hinders the realization of the right to health. Obstacles include the overuse of biomedical model and biomedical interventions, in particular psychotropic medications; power asymmetries; and the use of biased evidence. The Special Rapporteur advocated for a shift in mental health policies and services.

64. Existing evidence shows that mental health policies and services are especially prone to ineffective and corrupt practices, as well as the use of biased evidence. These obstacles, if not properly addressed, divert mental health policies and services from the effective realization of the right to health and hinder implementation of Sustainable Development Goals, including Goal 3 and a very important target: to promote mental health and well-being.

[62] Transparency International UK, *Corruption in the Pharmaceutical Sector* (June 2016), p. 28.
[63] Ibid., p. 27.

65. Mental health policies and services illustrate how lack of transparency and accountability in the relationships between the pharmaceutical industry and academic medicine can lead to institutional corruption and have a detrimental effect on mental health policies and services, not only on a national or regional scale but also at the global level.

66. As mentioned above, institutional corruption occurs when an organization or institution is no longer sufficiently independent to pursue its stated goals or mission effectively. It occurs when systematic practices develop within an institution that are legal, accepted and normative, but nonetheless undermine its integrity. Thus, institutional corruption results from the normalization of behaviours that compromise truth seeking and from perverse incentive structures (e.g., promotions; peer-reviewed publications) that reward problematic behaviour. It is a solution-, not blame-, oriented framework — a "bad barrel" rather than a "bad apple" problem.[64]

67. Representatives of academic psychiatry and other mental health researchers can have significant and long-lasting ties to drug manufacturers yet believe that they are immune to explicit or implicit bias, provided that they disclose these ties. Similarly, journal editors can have financial ties to the same drug companies and publish these studies, also believing that their judgment is not compromised. However, there are decades of research demonstrating that scientists are not immune to guild interests and implicit bias and that transparency or disclosure of financial conflicts of interest is an insufficient solution.

68. Thus, the framework of institutional corruption highlights both the harm done and what is lost, namely, harm to patients; loss of public trust and confidence in the integrity of academic medicine; and distortion of the scientific evidence base. It exposes the economies of influence that contribute to those harms and losses and it is a call for action to neutralize those influences. Below, the Special Rapporteur reviews three main areas in the mental health field using this framework, namely, the process of development and promotion of diagnostic categories for mental health conditions, psychotropic drug research and clinical practice guidelines.

69. Because of its global reach, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) has been referred to as the "bible" of psychiatric diagnosis and is used worldwide in psychiatric research. However, over the last decade there have been increasing concerns that the interconnected needs of the pharmaceutical industry and the psychiatric community may have played a role in the development or expansion of questionable diagnostic categories.

70. A 2006 study found that the majority of DSM-IV (fourth edition of the Manual) panel members had financial ties to drug companies and that 100 per cent of the Mood Disorders work group and the Schizophrenia and Psychotic Disorders work group had commercial ties to the companies that manufacture antidepressants and antipsychotics. Despite a disclosure policy implemented by the American Psychiatric Association one year later, the majority of individuals serving on the DSM-5 (fifth edition of the Manual) still had such ties and, as with the DSM-IV, the most conflicted panels were those for which pharmacological treatment was the first-line intervention.[65]

71. The widening of disease boundaries has medicalized normal human experience (e.g., "social anxiety disorder"), resulting in expanded markets for treatment and

[64] Lawrence Lessig, *Republic, Lost: How Money Corrupts Congress — and a Plan to Stop It* (New York and Boston, Twelve, 2011).

[65] Joel Lexchin and others, "Pharmaceutical industry sponsorship and research outcome and quality: systematic review", in *British Medical Journal*, vol. 326 (May 2003), pp. 1167-1170.

diverting attention away from the cultural, socioeconomic and political context of emotional distress.

72. Studies have revealed that commercially funded trials are up to four times more likely to report industry-friendly results than trials without such financial conflicts of interest.[66] In addition, there is clear evidence of publication bias in psychotropic drug trials; research demonstrating the ineffectiveness of a drug can be suppressed or written in a way that conveys a positive result.[67] Such publication biases result in an inflated perception of efficacy and an underestimation of the harms of psychotropic medications.

73. The Special Rapporteur observes that pharmaceutical companies have a vested interest in finding a new indication (namely, a new disorder) for their drugs when a patent expires since this allows the drug manufacturer to obtain an additional three years of exclusivity for the drug in question. Pharmaceutical companies have used "exclusivity" as an informal mechanism to effectively extend patent protection for that time period.

74. The inclusion of new disorders in DSM-5 referred to above have led some to question whether the updated edition inadvertently functioned as a vehicle for high-profit patent extensions. It was found that in the majority of clinical trials testing drugs for new DSM disorders (e.g., "Binge-eating disorder"), there were commercial ties between DSM-5 panel members and the pharmaceutical companies that manufactured the drugs that were being tested for these new disorders.[68] This is not to suggest any wrongdoing on the part of DSM panel members, but rather to emphasize the economies of influence at play and that transparency alone is an insufficient measure for systemic problems.

75. The Special Rapporteur is seriously concerned that treatment guidelines for mental health conditions are particularly vulnerable to industry capture because the absence of biological markers for mental health conditions increases clinical uncertainty and subjective judgments. Bias in such guidelines creates the potential to expose patients to harm from unnecessary treatment or from treatment that is not evidence-based and leads to a drain on resources.

76. When guidelines are produced by medical specialty groups, especially those with strong and pervasive industry ties, these groups tend to recommend market-driven treatment options (e.g. pharmacotherapy) when less expensive and safer (e.g., lifestyle change or psychosocial support) approaches are available.[69] For example, meta-analyses,[70,71] re-analyses of antidepressant clinical trial data[72,73] and

[66] Ibid.

[67] Erick Turner and others, "Selective publication of antidepressant trials and its influence on apparent efficacy", *New England Journal of Medicine*, vol. 358, No. 3 (2008), pp. 252-260.

[68] L. Cosgrove and others, "Tripartite conflicts of interest and high stakes patent extensions in the DSM-5", *Psychotherapy and Psychosomatics*, vol. 83 (2014), pp. 106-113.

[69] Lisa Cosgrove and others, "From caveat emptor to caveat venditor: time to stop the influence of money on practice guideline development", *Journal of Evaluation in Clinical Practice*, vol. 20 (2015), pp. 809-812.

[70] Irving Kirsch and others, "Initial severity and antidepressant benefits: a meta-analysis of data submitted to the Food and Drug Administration", *PLOS Medicine*, vol. 5, No. 2 (2008).

[71] Jay Fournier and others, "Antidepressant drug effects and depression severity: a patient-level meta-analysis", *Journal of the American Medical Association*, vol. 303, No. 1 (2010), pp. 47-53.

[72] Toshi A. Furukawa and others, "Comparative efficacy and acceptability of first-generation and second-generation antidepressants in the acute treatment of major depression: protocol for a network meta-analysis", in *BMJ Open*, vol. 6, No. 7 (2016).

[73] Joanna Le Noury, "Restoring study 329: efficacy and harms of paroxetine and imipramine in treatment of major depression in adolescence", in *British Medical Journal*, vol. 351 (2015), p. 802).

narrative reviews[74] have explicitly concluded that because of the risk benefit profile, antidepressants should not be used as a first-line intervention for mild depression, as this may result in overtreatment. Nonetheless, some guidelines produced by industry-funded psychiatry specialty organizations continue to use a predominately biological framework and recommend antidepressant medication as a first-line intervention for even mild depression.[75]

77. Institutional corruption in the mental health system has several consequences. One of them is the medicalization of human diversity and misery, which expands the number of patients labelled with mental illness. According to WHO, more than 300 million people of all ages globally suffer from depression, and depression is the leading cause of disability worldwide.[76] However, some researchers have raised serious questions about the reliability of these disease burden estimates. One study concluded that poor-quality data limit the interpretation and validity of global burden of depression estimates. They warn that uncritical application of these estimates to international health-care policymaking could divert scarce resources from other public health-care priorities.[77] While industry certainly profits from a biological approach that emphasizes these disease burden estimates, the attainment of the right to health globally becomes ever more elusive.

78. It is the global burden of such obstacles, rather than the global burden of mental disorders, that should be addressed as a priority in mental health policies and services. In that connection, corruption in mental health research, education and services should be addressed as one of the most important concerns or obstacles.

79. Indeed, institutional corruption in mental health has reinforced the medicalization of emotional distress and has thereby undermined the ability of decision makers to focus on the underlying and social determinants of health and address the way in which the health of socially disadvantaged groups is determined by exposures to societal and environmental risks and resources.[78]

80. Certainly, many people are in need of mental health services and often they do not have access to them. However, all stakeholders, especially policymakers and the leadership of the psychiatric profession, must address the fact that overdiagnosis and overtreatment of milder forms of anxiety, depression, inattention, age-related cognitive decline and the like unnecessarily creates pathological identities in people and exposes individuals to the iatrogenic effects of labelling and the side effects of treatments without offering them benefit to offset the harm. Individualizing, decontextualizing and medicalizing emotional distress reinforces health disparities by reducing the capacity of health systems to serve those with more severe mental health problems — the ones, often from disadvantaged groups, who need the care the most.

81. The medicalization of the public mental health field is driven by a lack of transparency and accountability in medical education and research and leads to

[74] Baumeister H., “Inappropriate prescriptions of antidepressant drugs in patients with subthreshold to mild depression: time for the evidence to become practice” in *Journal of affective disorders*, vol. 139, No. 3 (2012), pp. 240-243.

[75] L. Cosgrove and others, “Conflicts of Interest and the Presence of Methodologists on Guideline Development Panels: A Cross-Sectional Study of Clinical Practice Guidelines for Major Depressive Disorder”, *Psychotherapy and Psychosomatics*, vol. 86, No. 3 (2017), pp. 168-170.

[76] WHO, “Depression”, fact sheet, 2017, available from www.who.int/mediacentre/factsheets/fs369/en/.

[77] Petra Brhlikova, Allyson M. Pollock and Rachel Manners, “Global burden of disease estimates of depression — how reliable is the epidemiological evidence?”, *Journal of the Royal Society of Medicine*, vol. 104, No. 1 (2011), pp. 25-34.

[78] David R. Williams, Naomi Priest and Norman Anderson, “Understanding associations among race, socioeconomic status, and health: patterns and prospects”, *Health Psychology*, vol. 35, No. 4 (April 2016), pp. 407-411.

biased evidence being translated into practice worldwide. This is an unacceptable tendency and must be addressed by States and international organizations, with a view to ensuring that mental health policies nationally and globally are driven by non-biased evidence and a human rights-based approach. The obvious crisis in academic psychiatry,[79] influenced by a doubtful relationship with the pharmaceutical industry, has contributed to what could be called the "corruption of knowledge" in mental health and represents a warning signal not only to mental health-care practice and research but to the health sector as a whole.

V. Conclusions and recommendations

A. Conclusions

82. **Corruption has a devastating effect on good governance, the rule of law and equitable access to public goods and services. Corruption is a human rights concern and it has a particularly damaging effect on the enjoyment of the right to health. The health sector is especially prone to corruption, which threatens the sustainability of health-care systems worldwide.**

83. **The right to health offers a valuable normative framework and a legally binding imperative to address corruption in and beyond the health sector. The framework embraces the principles of good governance, transparency, accountability and participation. The right to health is closely related and dependent on other human rights, which are also important for combating corruption, including freedom of expression, which gives guarantees to whistle-blowers.**

84. **All forms of corruption at all levels have a negative impact on realization of the right to health. Many of these forms originate from power imbalances and asymmetries, which are widely prevalent in the health sector. Such asymmetries are perpetuated by non-transparent decision-making and reinforce ineffective and harmful policymaking and health services provision.**

85. **In accordance with their legal obligations under international human rights law, as well as high-level political commitments made in the Sustainable Development Goals to address corruption and develop effective, accountable and transparent institutions by 2030, States should provide leadership to confront the domestic and global causes of corruption and its impact on the right to health through legal, policy and programming measures in the health and related sectors.**

86. **Applying a human rights-based approach to health and related policies and avoiding selective approaches to human rights and the production and use of evidence in the realization of the right to health are the most effective measures for combating corruption.**

B. Recommendations

87. **The Special Rapporteur urges States to:**

(a) **Implement the United Nations Convention against Corruption and to explicitly criminalize the corrupt acts identified in that treaty and which are also prevalent in the health sector;**

[79] Arthur Kleinman, "Rebalancing academic psychiatry: why it needs to happen — and soon", *The British Journal of Psychiatry*, vol. 201, No. 6 (December 2012), pp. 421-422.

(b) **Ensure the integration of the right to health as a standard in anti-corruption laws and policies aimed at regulating the health sector;**

(c) **Provide for comprehensive whistle-blower protection for those reporting corruption offences in the health sector and beyond, which includes guaranteeing the anonymity and protection of whistle-blowers;**

(d) **Progressively build resilient health systems, with a special focus on health promotion and primary care, so as to root out the problem of systemic incentives for corruption in health sector;**

(e) **When elements of a health sector are decentralized or handed over to the private sector, to ensure that there are sufficient checks and balances to ensure that this transition addresses corruption and, at the least, does not lead to more corruption. There must be adequate oversight, transparency and monitoring of private sector and decentralized provision;**

(f) **Raise awareness among the actors in the health sector, including health-care providers, insurers and the providers of medicines and medical equipment about the harmful effects of corruption on the right to health and insist on their responsibilities under the right to health;**

(g) **Raise awareness among the general population about the negative impact of all forms of corruption in the health sector on individual and societal health and well-being. National human rights institutions can play a role in such awareness-raising and this may include the establishment of corruption-reporting hotlines;**

Participation, transparency and accountability

(h) **Guarantee the right to participation of the population in all actions aimed at combating corruption in health, such as through the disclosure of important health-related information, as well as in the design and delivery of health programmes;**

(i) **Engage a variety of stakeholders, such as community organizations, professional organizations and civil society organizations, including those representing groups in vulnerable situations, in determining the allocation of funding, as well as in monitoring budget expenditure at the national, local and institutional levels;**

(j) **Ensure monitoring and accountability in the health sector and related sectors through the establishment of well-resourced and independent anti-corruption and fraud agencies, as well as accessible and effective accountability procedures for health system users who encounter corrupt practices;**

(k) **Ensure judicial and other forms of review of violations of anti-corruption legislation; and effective remedies where corruption leads to a violation of the right to health;**

Corruption in health-care provision

(l) **Address petty corruption by health professionals by guaranteeing decent living wages and working conditions, job security and reward for good performance and conduct;**

(m) **Prevent misuse of dual practices whereby health-care providers inappropriately refer patients to their own private practices; and take measures to reduce theft and improper billing in hospitals;**

(n) **Create awareness among health-care providers that preferential treatment of well-connected individuals is unethical and at odds with the main principles for realization of the right to health;**

(o) **Develop non-biased and evidence-based treatment guidelines to reduce opportunities for corruption;**

(p) **Create awareness, for example through the development of ethical guidelines, among health-care providers that they should remain independent from outside organizations and avoid conflicts of interest with the best interests of their patients;**

(q) **Create awareness among health system users of their rights as well as identifying and reporting corrupt acts;**

(r) **Support initiatives that prevent excessive and unnecessary use of diagnostic and treatment interventions and involve users of services in shared decision-making with medical doctors.**

88. **The Special Rapporteur also urges other relevant stakeholders to:**

(a) **Take into account the Human Rights Guidelines for Pharmaceutical Companies in relation to Access to Medicines (A/63/263, annex);**

(b) **Address, through legal, policy and other measures, corrupt practices taking place in all stages of the pharmaceutical value chain, including during research and development, manufacturing, registration, distribution, procurement and marketing of medicines;**

(c) **Strengthen measures to address corruption and unethical practices in the process of generation of knowledge through research, dissemination of such knowledge through medical education and the development of guidelines for diagnostics and treatment of health conditions;**

(d) **Strengthen those elements in the medical education curriculum of future medical doctors that strengthen their knowledge and skills in order to prevent them from becoming involved in corrupt acts, unethical behaviour, reliance on excessive and unnecessary medical interventions, disease mongering, favouritism, informal payments and other practices that are either corrupt or increase the risk of corruption;**

(e) **Address the production and dissemination of biased outcomes of research in psychiatry and prevent, through transparent changes in medical education, research and practice, institutional corruption in psychiatry and mental health care;**

(f) **Enhance transparency and avoid misusing the principle of academic autonomy when investments in health and health care are addressed, so that the integrity of academic medicine and its commitment to the realization of the right to health is not undermined.**