FOR THE RECORD

Published at www.cmaj.ca from Jan. 21 to Feb. 4

Afghanistan's "cancer of corruption"

Doctors and nurses, it seems, command "lower-end" bribes in the Islamic Republic of Afghanistan. Their services typically require bribes of less than US$100, well below the national average of US$158 for most kickbacks and significantly below the grease demanded by judges, prosecutors or customs officers, which generally top US$200 and often exceed US$1000, according to a report by the United Nations Office on Drugs and Crime.

The UN survey, *Corruption in Afghanistan, Bribery as reported by the victims*, also indicates that women pay bribes more frequently than men in the health sector and that in 74% of cases, bribes are paid to speed up procedures. In 28% of cases, they are paid to "receive better treatment" (www.unodc.org/documents/data-and-analysis/Afghanistan/Afghanistan-corruption-survey2010-Eng.pdf).

Doctors were the fifth, and nurses the seventh, largest group who typically demand incentives for their services, behind police officers, municipal/provincial officials, judges and prosecutors. Members of the government squeezed into sixth place.

"It is almost impossible to obtain a public service in Afghanistan without greasing a palm: bribing authorities is part of everyday life," states the report, which surveyed 7600 Afghan citizens in 12 provincial capitals and 1600 villages between August and October 2009. It found that one out of every two Afghan adults had paid at least one kickback over the previous year, at an average US$158, or about one-third of the nation's gross domestic product per capita (US$425). Those who paid bribes typically made payments to an average of 2.4 public officials on two occasions, which translates into a staggering US$2.5 billion in grease shelled out in Afghanistan over a one-year period.

"The cancer of corruption is metastatic in Afghanistan. It will lead to a terminal condition, unless chemotherapy to reduce the chance of further infection (preventive measures) is combined with surgery to remove the biggest infected nodules (the key villains)," states the report.

The survey also indicates that people working in the health sector are themselves not immune from having to pay bribes. In one anecdote, a respondent says: "My cousin runs a medical practice. Some expired and low quality drugs were found in his medical [office] and a procedure was started by the Health Department. Later he bribed the head doctor and his file was clean within a day. My cousin is still selling the expired and poor quality drugs made in Pakistan, under the label of Germany and US Made."

To begin to tackle the scourge, the UN recommended the creation of a "comprehensive monitoring system on corruption," including a sectoral analysis of the working conditions of civil servants and health workers "for the purpose of providing more in-depth and specific information and assist in identifying targeted policy measures." — Wayne Kondro, *CMAJ*

A false pandemic?

The Parliamentary Assembly of the Council of Europe (PACE) will this week conduct a series of sessions on whether the pharmaceutical industry unduly influenced the World Health Organization's decision to declare swine flu a pandemic and recommend mass vaccination campaigns.

Among proposed emergency debates at the assembly's plenary session in Strasbourg, France, is one dealing with a resolution sponsored by Dr. Wolfgang Wodarg, chairman of the PACE Health Committee. It states that "in order to promote their patented drugs and vaccines against flu, pharmaceutical companies influenced scientists and official agencies responsible for public health standards to alarm governments worldwide and make them squander tight health resources for inefficient vaccine strategies, and needlessly expose millions of healthy people to the risk of an unknown amount of side-effects of insufficiently tested vaccines."

Another session will include a Jan. 26 public hearing into whether the WHO's handling of pandemic (H1N1) 2009 influenza was adequately transparent. Issues of transparency and conflict of interest erupted over the past two months after the newspaper *Danish Daily Information* disclosed documents obtained under freedom-of-information law which indicated that vaccine manufacturer GlaxoSmithKline had provided €6.3 million in 2009 to the National Institute for Health and Welfare, the lab of Dr. Juhani Eskola, a Finnish member of the WHO's Strategic Advisory Group of Experts (SAGE), which advises the agency on vaccine use. Further reports indicated that as many as five other SAGE advisers had financial links to the pharmaceutical industry. — Wayne Kondro, *CMAJ*

Scotland worst performer among Britain's "four" National Health Services

Scotland has more doctors and nurses than other countries in the United Kingdom yet has the worst health outcomes, according to a report from the Nuffield Trust, a London, England-based charity that conducts research on health services (www.nuffieldtrust.org.uk/members/download.aspx?f=/ecomm/files/Four_Countries_Report.pdf).

The report, *Funding and Performance of Healthcare Systems in the Four Countries of the UK Before and After Devolution*, sought to examine the health impacts of political devolution of powers in 1999 to the Scottish Parliament and the assemblies of Wales and Northern Ireland, which, de facto, resulted in the emergence of four "different" National Health Services (NHS).

The authors surmise that the differences in health outcomes within each of the four countries are attributable to the fact that each has pursued distinctly different policies, the most significant of which is England's decision to offer "provider competition" in such forms as NHS trusts, NHS foundation trusts, independent sector treatment and private providers. In Scotland and Wales, by contrast, "instead of an emphasis on patients choosing between competing pluralist providers, these governments favour a publicly owned NHS run by authorities that are integrated with providers."

Among other factors that may play a role are historical differences in funding levels or individual policy measures, such as Scotland's provision of free personal care for the elderly, or Wales decision to abolish charges for prescriptions.

The report states that Scotland "appears to perform less well than anywhere else on almost every measure examined." Those include highest levels of poor health, low rates of "activity" (outpatient appointments, inpatient admissions and day cases) and lowest rates of productivity for doctors and nurses in hospitals.

By contrast, England, which spends less on health care and has fewer doctors, made good use of its resources and provided more and better health services, the report states. In the United Kingdom as a whole, health care providers enjoyed large funding increases since 1999, the report states, but this "feast" period is likely over and may soon be followed by a period of "famine."

"The Government in England used the years of 'feast' to reduce long waiting times, and governments in other countries may find it hard to catch up with performance in England during the years of 'famine'," the report states.

It cautions, though, that the findings have limitations. The report "does not claim to offer a complete rounded assessment of NHS performance across the four countries, instead the aim was to report comparative longitudinal analysis of key statistics on funding, staffing, outputs, crude productivity, hospital waiting times and ambulance response times to emergency calls." The report adds that the differences in those statistics, though, "raise troubling questions about performance, governance and accountability." — Roger Collier, *CMAJ*

Health and science winners in Obama budget

United States President Barack Obama's blueprint for fiscal year 2010/11 has proposed a US$1 billion increase, to US$32 billion, in funding for the National Institutes of Health Research (NIH).

Obama's blueprint proposes to spend US$900.8 billion on health and human services, with the bulk of that money (US$818 billion) for Medicare and Medicaid, which cover health services for the poor and the elderly. The "discretionary" portion of the Department of Health and Human Services budget will rise to a projected $US82.8 billion in 2011, including the increase for the NIH, which received its largest budget hike in eight years.

The budget states that NIH investments "will focus on priority areas including genomics, translational research, science to support health care reform, global health, and reinvigorating the biomedical research community. The Budget includes $6,036 million to support a range of bold and innovative cancer efforts, including the initiation of 30 new drug trials in 2011, and a doubling of the number of novel compounds in Phase 1–3 clinical trials by 2016" (www.whitehouse.gov/omb/budget/fy2011/assets/budget.pdf).

It also proposes that US$222 million be spent on research and treatment of autism and that over US$3 billion be allocated to HIV/AIDS prevention and treatment. The Agency for Healthcare Research and Quality's budget rose to US$611 million from US$400 million. Some $US286 million of that is ticketed for comparative effectiveness research (*CMAJ* 2009. DOI:10.1503/cmaj.109-3140).

Obama's budget also proposes to increase support for global health programs to US$8.5 billion in fiscal year 2010/2011 from US$7.8 billion. But critics, including the Center for Global Health Policy, said that the specific increases for many of the programs are inadequate given demand for treatment. The organization noted, for example, that Obama's budget proposes a US$50-million cut in support for the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Obama's proposals must still meet the stern test of Congress approval. — Wayne Kondro, *CMAJ*

Inmates urge needle-exchange programs

At Nova [Institution for Women in Truro, Nova Scotia], there were mostly pills, like Valium, Oxycontins and Dilaudids. People snorted and injected the pills. About 70 percent of the prison population was using drugs, and 10 percent were injecting. I used Oxycontins and Dilaudids.

I started snorting, but I progressed to injecting about a year into my sentence. It was the first time I ever injected drugs. The girls there told me the high was more intense and the drugs would work faster if I injected, and they were right. That was the start of my life on needles. I would inject drugs about twice a day.

We got needles from the nurse's station, from the dirty needle container. We would take them from there. Or someone would bring in the occasional needle. About five or six girls would share one needle. We did not clean the needle with bleach first, but we did use hot water to rinse it out. We only got one new needle every five or six months.

I've seen a needle so used that when I injected with it, it would rip my skin off.

I knew I could get HIV and hepatitis C from sharing a needle, but I didn't think about that because I wanted to

get high. After a while, I got addicted to the needle itself.

We did not have access to methadone while I was at Nova. We did have access to bleach, but it was too time consuming to bleach the needles first, and the guards would always start asking questions if the bleach was gone.

They would search our cell if they were suspicious. If they found a needle, we would get charged. It happened to a girl I knew. Someone told the guards this girl had a needle, so without telling her, they searched her room, found it, and charged her with possession of contraband. She was sent to Springhill Institution [in Springhill, Nova Scotia],

maximum security, for a month ….

Sometime in 1999, three other girls and I broke into the nurse's station to get a box of clean needles. We got caught, and we got charged with a break-and-enter. Another six months were added to my sentence.

I was diagnosed with HIV and hepatitis C in 1999, when I was in Nova. I am 100 percent sure I got infected from sharing used needles, because I didn't have sex inside and I didn't get tattoos. I didn't do anything else that would put me at risk. I lost my mind when I found out. CSC put me in segregation after that, because I flipped out. They told me to take a while to think about it. — "Kate," 49, Halifax, Nova Scotia

Such accounts are altogether the norm in Canadian prisons, according to the Canadian HIV/AIDS Legal Network. The tale is also one of dozens of first-person accounts documenting drug use or the sharing of needles inside Canadian prisons presented in the network's latest report, *Under the Skin* (www.aidslaw.ca/EN/index.htm).

The network argues that the accounts demonstrate the need for needle-exchange programs within Canada's prisons. But while a risk–benefit review of prison needle exchange programs conducted for the Public Health Agency of Canada indicated that such programming for injection drug users in prisons reduces the need for health care interventions, the Conservative government said sterile syringes aren't needed to control the spread of AIDS and hepatitis C in cellblocks (*CMAJ* 2007.DOI: 10.1503/cmaj.070018). — Wayne Kondro, *CMAJ*

DOI:10.1503/cmaj.109-3177