Exposing medical fraud: "one of the last taboos in society"

It seems there are lessons to be learned from various national medical fraud units. The first would be that there is no valid reason to think that any country in the world is exempt from medical fraud.

The second? Don't sweep it under the rug. Denial is not the solution.

The third? It's not a zero sum game. Countries that have aggressively pursued health care fraudsters have found that enormous savings accrue which can be pumped back into their health care systems.

Several of the world's medical fraud experts, including Dr. David Evans, director of the Department of Health Systems Financing at the World Health Organization (WHO), are also of the opinion that not only is the extent of health care fraud vastly underestimated around the world, it's probably going to get worse because of the global financial crisis. "It seems that during periods of economic downturn the cost of fraud frequently increases," Evans writes in an email.

With many countries facing times of austerity, tackling health fraud is becoming a necessity and the first step in doing so is to admit they have a problem, says Jim Gee, director of counter fraud services at the United Kingdom–based accounting firm PKF and chair of the Centre for Counter Fraud Studies at the University of Portsmouth.

"For some people at senior levels in health organizations and in ministries of health internationally, they are unwilling to actually acknowledge that they may have a significant financial problem and they think the reputational damage of acknowledging that they have a problem actually outbalances the financial benefits that would be obtained by tackling that problem," says Gee, who headed the UK's National Health Service's (NHS) Counter Fraud Service between 1998 and 2006 and helped to craft one of the world's first comprehensive strategies to combat health care fraud.

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The nature and structure of a nation's health care system affect both the nature and degree of fraud within its borders. In some countries, such as China, identification theft is the major problem.

Gee's unit started with a budget of £210 000 and a staff of three, while being told to root out fraud from the NHS, with a budget of £40 billion and 1.2 million employees. "By the end of the eight year period, we had delivered £811 million worth of financial benefits," at an investigatory cost of £67 million, or a 12:1 return on investment.

"I was very clear from the start that we needed to know what the nature and the scale of the problem was before we rushed off to develop a solution, so we gradually measured the cost of fraud in each of the streams of expenditure involved. By the end I think we'd covered 70% of £80 billion pounds of expenditure," says Gee, who has worked with 30 different countries to develop their fraud detection capabilities and who created a primer, *Fraud loss measurement: a short guide to the methodology and approach, on measuring fraud* (www.pkf.co.uk/pkf/publications/guide_to_fraud_loss_measurement#).

Gee was unable to provide a breakdown of the types of fraud that the British unit discovered, other than to later note in an email that it was committed by a "dishonest minority within each group: medical professionals, staff and managers, patients and contractors. We didn't find that there was a preponderance of fraud in any one group."

Nor would he indicate whether the level of financial fraud varied by group, as it has in the United States, where physicians have often been heavily involved in fraud cases involving staggering amounts of money (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4346). "We measured the cost of fraud to a very high level of accuracy (+or-1%) and statistical validity (95% statistical confidence) and the accurate information about the nature and scale of the problem enabled us to invest a sufficient resource in the right solution, and to cut the cost by up to 60%," he writes. "For example, pharmaceutical fraud fell by 60%, dental fraud by 48% and optical fraud by 38%. The areas where the cost of fraud was greatest were the areas of greatest expenditure — payroll and procurement expenditure — as they tend to be in any organisation. The numbers of

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prosecutions don't reflect the prevalence of fraud, because they are only what has been detected, and detection rates for fraud, even in well performing organisations are low. The potential for effective detection also varies from area to area."

But investments in good fraud detection procedures and units can generate savings that can be plowed back into health care systems, Gee argues. It can also yield the benefit of improved public perception of accountability. "We went through that pain barrier in 1998 and 1999 in the UK and I think the NHS's reputation was actually much stronger because we actually point to the fact that health care resources weren't being wasted on fraud," he says.

But many countries are in denial that they've a problem with fraud, notes Paul Vincke, president of the Brussels, Belgium–based European Healthcare Fraud & Corruption Network, which believes that about €56 billion is lost annually on the continent to fraud and corruption.

Only 11 of Europe's 46 nations are members of the international not-for-profit organization, and many either do not see the need (believing "there is no sense of urgency"), or assert that they can't afford the high start-up costs of establishing antifraud units, Vincke says.

There also societal obstacles, Vincke noted in a preface to a report, *The Financial Cost of Healthcare Fraud* (www.ehfcn.org/media/documents/The-Financial-Cost-of-Healthcare-Fraud-Report-2011.pdf). "Reasons are that there is little transparency and there are powerful lobbies of stakeholders. Exposing the phenomenon of healthcare fraud is one of the last taboos in society. Healthcare professionals are organized in powerful lobbies with a high corporatist reflex when confronted with evidence of abuse and fraud committed by peers. Patients do not understand the substantial impact of this fraud on the affordability of healthcare."

The report, which assessed data from six nations (the UK, US, France, Belgium, the Netherlands and New Zealand), projected the percentage loss of health care expenditures due to fraud and error was between 3% and 15.4%, or an average 7.29%. Globally, that translates into about US$415 billion per year, the report added. "This is the equivalent of more than twice the budget for the entire UK NHS or enough to build more than 2,300 new hospitals (at developed world prices) and more than the entire national GDP of all but 29 of more than 190 countries across the world."

What's also clear is that the nature and structure of a nation's health care system affect both the nature and degree of fraud within its borders.

In China, for example, considerable fraud occurs as a result of identity theft, particularly by those who lack adequate health coverage. "There is not a universal medical insurance system for all citizens. Because of inequality of healthcare and medical services between family members, some enjoy [a] high percentage medical insurance refund, some of them have lower, or even null, so the most popular [type of fraud] was that a large number of family members use the highest medical card to buy medicine," Dr. Jiye Hu, associate professor at the China University of Political Science and Law in Beijing, writes in an email. In response, the government has introduced legislation requiring patients to present both an insurance and an identification card when seeking health services, adds Hu, whose studies have concluded that fraud losses could top RMB $31 billion (about $5 billion) annually in China.

In other nations, it appears that the nature of health care fraud is evolving. In South Africa, for example, a recent survey indicated that while the overall level of health care fraud had declined between 2007–2009, the number of instances of service-provider fraud involving code manipulation increased from 15 489 (32.57%) in 2007 to 26 913 (52.36%) in 2009, while the number of instances of "services not rendered" fell from 17 308 (36.39%) to 12 453 (23.76%) over the same time period (www.kpmg.com/ZA/en/IssuesAndInsights/ArticlesPublications/General-Industries-Publications/Documents/MC7143%20Anti%20Fraud%20Survey.MR.PDF).

"Investigators are seeing more and more syndicate-type fraud," Lynette Swanepoel, manager of the Healthcare Forensic Management Unit at the Board of Healthcare Funders of Southern Africa, writes in an email.

Among the major obstacles in fighting fraud is a lack of supportive legislation and a failure to pump recovered monies back into the health care system, Swanepoel adds. "Statutory bodies are still too lenient on offenders and this often leaves medical schemes out of pocket as the fines imposed on offenders benefit the statutory bodies and not the medical schemes."

"The problem, however, is compounded as many medical scheme members have a sense of entitlement and are often in cahoots with the unethical healthcare providers," Swanepoel writes. "From discussions with my international counterparts, the same types of fraud are being perpetrated globally. A fee for service system, as is operational in South Africa, is at the root of the problem."

Rooting out the problem, some believe, will also require far more international collaboration, exchange of best practices and improved training for fraud investigators. To that end, representatives of more than 20 nations gathered in October for the second annual Global Health Care Fraud Prevention Summit.

Identified as needs were a global directory of experts in the field in health care fraud, new educational degrees and professional recognition for health care counterfraud specialists and more international exchange of information, Gee says. "It's important to recognize that if somebody doesn't have a solution in your own country, maybe somebody in another country does." — Adam Miller, *CMAJ*

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Editor's note: Third of a three-part series.

Part I: **White coats and white collar crime** (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4346).

Part II: **Medical fraud north of the 49th** (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4358).

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