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Healthcare Fraud in the new NHS market – a threat to patient care

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Contents

Introduction and Executive Summary

1. This report sets out the risks posed to patient care as a result of fraud and embezzlement in the new marketised National Health Service in England. It identifies the prospects for fraud in the NHS as a result of the increased use of private providers to deliver key NHS services, and analyses the government's current approach to counter fraud policy. It finds that the issue of healthcare fraud in England has not been adequately addressed by policy makers in the new NHS market created by the Health and Social Care Act 2012 and that a reduction in resources for the counter fraud function has taken place, whilst a weak legal structure for tackling fraud remains in place. It looks at the experience of fraud in the US, where healthcare fraud is estimated to cost the US taxpayer between $ 80 and $98 billion each year, and at the strategies used by the US government to counter this. It notes that many of the same companies which have engaged in fraudulent activity in the US are at the heart of the new NHS market. Finally, it proposes a number of policy responses for dealing with the likely increase in fraud in the new NHS market.

2. The report concludes that a failure to deal with healthcare fraud in the new NHS is likely to result in reduced services to patients as funds are diverted away from the delivery of healthcare services to illegitimate income generation by private healthcare providers.

Quantifying the prospects of Fraud in the new NHS

The theory

...across all healthcare systems fraud accounts for an average of around **5.59%** of all health care expenditure. In the NHS this would translate to **£3.35 billion** a year lost to patient care.

3. The economic and political science literature suggests that government should expect that fraudulent activity will increase as health care services are 'contracted out' from the state to the private sector. A basic assumption within 'principal-agent' theory is that any organisation contracted to deliver goods or services is self-interested and motivated to 'shirk' its obligations under the contract. This is also a basic assumption of proponents of the use of 'quasi' or competitive markets in the delivery of public services, who recognise that because of this motivation to shirk and cheat there are often significant costs in monitoring contracts with private sector organisations and ensuring contract compliance.[1]

4. These opportunities to shirk contractual obligations are more likely where there are asymmetries of information– that is, where the supplier of goods or services contracted for knows more than the purchaser about their cost, quality or quantity. The more complex the goods and services which are being provided the greater the opportunity for cheating and hence for fraud. Healthcare services delivered under contract between the state and the private sector are particularly susceptible to cheating because of their highly complex nature, and because effective monitoring of the performance of contracts is liable to be prohibitively expensive.

What do we know so far about healthcare fraud in the UK prior to the 2012 Health and Social Care Act?

5. Quantifying the extent of healthcare fraud is problematic. However, the best data available suggest that across all healthcare systems fraud accounts for between 3.29% and 10% of all health care expenditure, with an average of around 5.59%.[2] In the NHS this would translate to £3.35 billion a year lost to patient care, counting only the £60bn worth of services to be commissioned by clinical commissioning groups. Even before the large scale contracting out of healthcare services to the private sector, fraud within the NHS has been substantial, partly as a result of the contracts which have been struck with private organisations to deliver healthcare services and products.

The National Fraud Authority estimates that around £2.4 billion a year is lost through fraud when the government enters into contracts with the private sector.

6. Thus, according to the latest figures available, in 2009 the NHS Counter Fraud Service estimated that around £100 million in prescription fraud occurred every year, £18.9 million in optical fraud, and £36.3 million in dental fraud.[3] In addition, in any instance in which the NHS currently procures services from the private sector, the National Fraud Authority estimates that around 1% of what is spent will be lost to fraudulent behaviour. Under current arrangements between government and the private sector for the delivery of all forms of public service, the, the National Fraud Authority estimates that around £2.4 billion a year is lost through fraud when the government enters into contracts with the private sector.[4]

Healthcare fraud in the new NHS market in England – lessons from the US

7. The US healthcare system provides interesting lessons for the prospects of health care fraud in the NHS in England and what an appropriate policy response may be for three reasons:

- The US healthcare system relies on a myriad of contracts between the government and private healthcare providers to deliver healthcare services to the population, similar to the situation envisaged under the Health and Social Care Act 2012;
- A number of those companies which have settled major fraud cases in the US are currently engaged in the delivery and commissioning of healthcare services in the UK (as indicated below) and are seeking greater roles in the future;
- The US federal government has dedicated significant resources – both legal and bureaucratic – to dealing with healthcare fraud.

8. In the US the most prevalent form of healthcare fraud is private healthcare providers overcharging insurers, including the federal Medicaid and Medicare programmes, by invoicing for healthcare treatments they have not delivered, or by 'upcoding', that is, categorising patients as having more severe conditions than they actually have and so attracting higher rates of payment. It is widely acknowledged that such 'false accounting' is endemic in the US healthcare system.

The FBI estimates that healthcare fraud in the US totals $80 bn a year

9. Estimates of the scale of healthcare fraud in the US vary widely because of the intrinsic difficulty of detecting it and the different definitions of fraud used in different studies.[5] The FBI estimates that healthcare fraud in the US totals $80 bn a year,[6] while as long ago as 2009 the White House Office of Management and Budget estimated improper healthcare payments alone at $98 bn annually, of which $54 bn came from Medicare and Medicaid.[7]

10. These patterns of corporate behaviour are not always a matter of criminal, or even necessarily unethical, behaviour on the part of the corporate executives concerned, though they can be and often are both. Exploiting opportunities to increase revenues through 'gaming' the system are entirely rational for those seeking to maximise returns for investors and are likely to be perceived as part of a range of legitimate tactics – including tax avoidance measures – to boost profit margins.

11. Opportunities for illegitimate income generation through "upcoding" have existed in the English NHS as a result of the Payment by Results scheme whereby hospital providers bill Primary Care Trusts (PCT) for the treatment that they have provided to patients. In a study conducted by the Audit Commission in 2006 a 'relatively high level of clinical coding error' was found, leading to inaccurate payments across the hospitals examined: an incorrect price was being charged in nearly 12% of all treatments and diagnoses given.[8] While in some cases the Commission found that hospitals were undercharging, they also found that there was 'evidence of trusts actively working to optimise their coding to maximise income'. They were particularly concerned that 'in one trust the clinical coding team reports to the director of finance, and is involved in discussions about the financial impact of coding changes on a regular basis', 'increasing the likelihood of manipulation.'

12. The last (2010) estimate by the Audit Commission of 'coding errors' or false invoicing was 11% of all NHS transactions.[9] This average may be an underestimate. A review of the bills from one London hospital in respect of the patients referred from one GP practice in 2008-09 found that the hospital had overbilled the PCT in respect of these patients to the tune of at least 40%. The PCT stopped checking the results after confirming this figure, because to check more would have consumed too many staff resources. It contented itself with securing a repayment from the hospital of £323,000 out of total billings for the year of £801,000.[10]

13. However, it should be stressed that when NHS hospitals maximise income by overcharging their behaviour is not driven by the financial interest of shareholders, or of the staff involved, and while it leads to serious misallocation of resources, and needs to be dealt with, the funds do not leave the NHS. The case is different if there is overbilling by private providers.

14. Both the incentives to 'cheat' the system in this way and the opportunities for doing so are likely to increase as for profit companies are used to deliver healthcare services in the NHS. A study published in the *Journal of Health Economics* found that the rate of 'upcoding' in the US health care system was twice as high in for-profit hospitals as in non-profit hospitals.[11] The study also found that the likelihood of upcoding increased still further if the clinical staff had a financial stake in the earnings of the hospital. In this respect, it is relevant to note that one of the recent entrants to the UK healthcare market, Circle Health, which runs Hitchingbrooke NHS Trust, prides itself on the fact that the clinicians and other staff members of Circle own 49% of the company's shares.[12]

15. The risks to the English NHS are increased by the fact that some companies entering the new NHS market have settled major fraud cases in the US. These include the following:

- **UnitedHealth**. In 2000 UnitedHealth paid $2.9 m for billing the US government for patients it falsely claimed were in nursing homes.[13] In 2009 the company paid $50 m for systematically reducing insurance payments, and $350 m to settle class actions for non-payment of benefits.[14]

  Until recently, United Health was involved in the provision of GP primary care services for the NHS (owning 6 GP practices in England), but has decided to switch its focus to supporting clinical commissioning groups which, if it is successful, will put it at the heart of the new NHS market.[15] This builds on the position that it has previously established working with all levels of the NHS and with over 60 Primary Care Trusts. For example in 2009 it 'assumed responsibility for commissioning £107m of acute and specialised services with 17 London Providers'[16]

- **McKesson**: in 2009 McKesson was forced to repay insurers and patients $350 m for overcharging for drugs.[17] In the same year the company's former chairman was jailed, and shareholders were repaid $1.2 billion for losses caused by the misrepresentation of corporate assets.[18]

  In England McKesson is the prime contractor for the NHS Electronic Staff Record, implementing an integrated pay and HR system for 1.2 million NHS Staff.[19]

- **Aetna**: in 2003 Aetna paid $170 m to settle charges of failure to pay doctors for services to Aetna patients, and for overriding doctors' treatment decisions.[20]

  In England, Aetna, like UnitedHealth, is involved in providing support for the commissioning of NHS health care by Clinical Commissioning Groups, and in reconfiguring health services in Birmingham.

- **HCA**: in 2003 the US parent company of HCA UK admitted 14 felonies and paid over $1.7 billion in settlements for a range of frauds against the government, Medicare and Medicaid, doctors and patients.[21]

  In England, HCA has set up HCA NHS Ventures, which is at the centre of several NHS private patient units. It operates six hospitals in London and 20 clinics or diagnostic centres around England. This includes private cancer centres in the NHS University College Hospital, in Queens Hospital Romford (part of the NHS' Barking, Havering and Redbridge Trusts) and the Christie Clinic at the Christie NHS Foundation Trust in Manchester.[22]

- **GlaxoSmithKline**: in 2011 the British company GSK paid $3 bn to settle a series of criminal and civil investigations into its marketing of products in the US and for alleged fraud against Medicare.[23] GSK is a major supplier of drugs to the NHS.

16. A third lesson from the US experience of healthcare fraud is that the huge amount of fraudulent activity which is perpetrated each year occurs in spite of the well resourced legal and regulatory systems that are in place to combat it. The majority of prosecutions against healthcare fraud have come under the US False Claims Act. This Act, substantially amended under the Obama administration, imposes liability upon anyone who knowingly or with "deliberate ignorance" or "reckless disregard" of the truth submits, or conspires with another to submit, a false claim or related false record for payment from the US Government or from any entity administering government funds, or to avoid or decrease an obligation to pay the US Government.

17. The Act gives individuals the right, backed by a very large financial incentive (15-30% of any funds recovered) to initiate lawsuits against companies they believe are defrauding public agencies. This provides a significant incentive for 'whistleblowers' to come forward with evidence of fraud against the companies that they work for.[24] When it is clear that a case has merit it is usually joined by federal and/or state prosecutors, with adequate resources to pursue it, and the ability of the courts to impose treble damages means that there is an incentive for public law agencies to pursue cases, as they are likely to be recompensed for the cost of their investigations. Civil fines of about US$11,000per false claim (i.e. per billing item) are also imposed and companies convicted of offences under the FCA can be barred from involvement in government programmes, though some companies appear to have circumvented this by shifting liability to subsidiary corporate entities. Between 1987, when the Act was significantly updated, and 2008, $22 bn have been recovered under the provisions of the Act.[25] $2.5 billion were recovered in healthcare fraud claims in 2010.[26] Relative to the total sums estimated to be lost to healthcare fraud alone this is not a large figure, but the existence of the False Claims Act presumably acts as something of a deterrent.

The need for a new counter-fraud infrastructure for the new NHS market in England

...across all healthcare systems fraud accounts for an average of around **5.59%** of all health care expenditure. In the NHS this would translate to **£3.35 billion** a year lost to patient care.

In 2011–12 the NHS Counter Fraud and Management Service managed to recover just £3.44 million in fraudulent payments.

In 2011, when the NHS Counter Fraud and Management service was transferred to NHS Protect, the number of staff was reduced by 21%

18. The approach to counter fraud in the US - both legal and bureaucratic - should be contrasted with the approach taken in the UK, and in England in particular. Whilst the UK Fraud Act 2006 does make it a criminal offence to engage in dishonest acts, the provisions of the 1998 Public Interest Disclosure Act to incentivise 'whistleblowers' to come forward with evidence of fraudulent behaviour are relatively weak, nor is there any specific prohibition on defrauding the state, as is the case under the US False Claims Act.[27]

19. The current NHS counter-fraud infra-structure is built upon a central unit within NHS Protect, plus counter-fraud specialists based in NHS bodies drawn from in-house staff, audit consortiums and other parts of the private sector.[28] Traditionally most of the investigative work has focussed on fraud by individuals, such as nurses working for agencies while supposed to be off sick, midwives submitting false overtime claims, dentists exaggerating treatments administered or consultants abusing their entitlement to do private work. In 2010 the NHS Counter Fraud and Management Service which undertook NHS counter fraud work prior to the establishment of NHS Protect had a staff of just over 200 and a budget of around £20 million. In 2011-12 the Service managed to recover just £3.44 million in fraudulent payments.[29] In 2011, when the service was transferred to NHS Protect, the number of staff was reduced by 21%, from 209 to 165.[30]

20. The new healthcare market will pose a new challenge to the NHS of having to deal with potential fraud by major corporations with substantial resources to defend themselves from both criminal and civil actions.[31] Indeed one of the few attempts to take on major corporate bodies engaged in fraud in the NHS, 'Operation Holbein', ended with mixed success. In 2008 the criminal case brought by the Serious Fraud Office (SFO) collapsed after an 8-year investigation. The case centred on an alleged £120 million of fraud by pharmaceutical companies fixing prices. The SFO investigation was estimated to have cost between £25 to £40 million.[32] The NHS Counter Fraud Service, however, did achieve some success through civil actions and out of court settlements through parallel cases brought between 2002 and 2007, yielding around £46 million paid in compensation by five pharmaceutical companies.[33] This case was pursued at the height of the NHS Counter Fraud Service's resources and influence; since 2007 there have been reviews and the reduction in staff already referred to.

21. The SFO, which takes the lead on major cases fraud, has been ineffective in several other high-profile cases, and a government-backed review exposed many weaknesses.[34] There has been little evidence of a substantial improvement in its performance, with the 2012 collapse of the investigation into the Icelandic

bank and the Tchenguiz brothers. The reality is that criminal prosecutions in complex cases involving large sums of money against opponents with the resources to pay for high quality lawyers are very expensive and have a high risk of failure due to legal technicalities or bewildered juries.

22. The American experience offers several clues to what is needed to address the future challenges in the NHS. Combined with the False Claims Act, discussed above, the US has many tools for dealing with the problem, above all adequately-resourced teams with a capacity to utilise all sanctions – criminal, civil and regulatory – and to switch between them as cases unfold.[35] The use of Deferred Prosecution Agreements, where corporations agree to accept additional monitoring, introduce reforms, co-operate with the investigation and pay compensation in return for non-prosecution, is also common.

23. To confront the challenge of fraud that the new NHS market in England makes likely the following should be considered:

- An appropriately resourced unit dedicated to corporate fraud should be created within NHS Protect, with appropriate staff capable of pursuing all possible sanctions and with experience of successfully doing so.
- Deferred Prosecution Agreements, which are to be introduced in the UK,[36] should also become a major tool for dealing with the likely problems, based on a recognition that criminal prosecution – although desirable – is not always the most viable option.
- Consideration should also be given to passing a UK equivalent of the False Claims Act to encourage the exposure of fraud and malpractice by private corporate bodies in receipt of public funds, and to legislation to ban the award of a contract by any NHS body to any company, or subsidiary of a company, which has been convicted of, or settled, a criminal charge.
- Consideration should also be given to preventing companies or subsidiaries of companies found guilty of healthcare fraud in the UK from providing NHS services in the future, and to providing for the imposition of punitive fines on the scale necessary to provide a deterrent to multi-billion pound enterprises.

Conclusion

24. The introduction of for profit providers of healthcare services in the English NHS is likely to substantially increase the amount of health care fraud in the UK. This is for two reasons. First, for-profit providers have significant incentives to 'cheat' the system in order to increase their revenues and maximise returns to investors, and are likely to seek to do so in the knowledge that the opportunities for detection are weak and the penalties for breaking the law, if found out, are insubstantial. The use of 'payment by results' contracts with private providers in the new NHS market, provides significant opportunities for 'upcoding' and making other fraudulent claims, as has already been shown by the activities of some publicly-owned hospital trusts. Second, some of the private companies which are significantly involved in the new NHS market have experience of engaging in healthcare fraud in the US.

25. At this stage, policy makers have not devoted any attention to this issue, either during the discussion of the passage of the Health and Social Care Act, nor subsequent to this. This is likely to be because at this stage healthcare fraud is not currently endemic within the UK NHS, primarily because up until this point the use of contracts with private providers to deliver healthcare services has been limited. However, it is also unlikely that politicians pushing for increased marketisation of the NHS would be willing to raise publicly the very real threat of increased corporate healthcare fraud, which is a likely consequence of any private market in healthcare provision. In creating this new market policy makers will need to address this threat quickly and develop a set of tools, both legal and operational, sufficient to challenge corporate healthcare fraud when and where it emerges.

26. As the US experience shows, the impact of fraudulent behaviour on patient care is likely to be significant. The diversion of funds away from patient care as a result of fraud will mean fewer resources available for patient care at a time when questions are already being asked about the continued 'affordability' of the NHS. On this basis alone, policy makers should be compelled to act.

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