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Counter fraud

The financial cost of Healthcare fraud

What data from around the world shows

By Jim Gee, Mark Button and Graham Brooks

With a foreword by Paul Vincke, President, European Healthcare Fraud
and Corruption Network.



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Foreword



European Union countries spend more than 1 trillion Euros a year on providing healthcare for their citizens. This Report shows that 56 billion Euros of these healthcare budgets are lost to fraud in Europe annually and 180 billion Euros globally. The European Healthcare Fraud and Corruption Network (EHFCN) exists to help European healthcare organisations identify and reduce these losses so that more money can be better spent on patient care; similar Networks exist in the United States, and Canada and counterparts are being created in other continents.

Europe is a big place and there are certainly differences between us - differences in the size of our countries; differences in politics; differences in economies and differences in healthcare systems. However, whether we come from Lisbon or Vilnius, Oslo or Nicosia, what we all have in common is that we want and need to be healthy.

We have healthy people who fear ill health, sick people who yearn to be well, old people who want to enjoy their later years and young people who need the foundations of life long good health.

Unfortunately we also have a fraudulent or corrupt minority who is prepared to divert

or misuse funds which are intended to keep us all well. Let's not pretend, this minority exists in all our countries. No country is immune and none of us can afford to pretend that we have no healthcare fraud.

Every cent lost drains the lifeblood from our healthcare systems and undermines their capacity to provide essential treatment. We need to join together and mobilise the honest majority, we need to do this across Europe and we need to do it urgently.

There are three main reasons why we need to work together. Firstly, wherever a problem arises we can all learn from it together rather than the same lesson being learnt many times in different countries; secondly, by agreeing common high standards for countering fraud and corruption in healthcare we can make sure that no-one is in any doubt about what action is required for success; and thirdly, we can support each other. None of us have this problem beaten but those who have progressed furthest can help those with the furthest to go.

In this work every Euro lost to fraud or corruption means that someone, somewhere is not getting the treatment that they need. They are ill for longer, and in some cases

they simply die unnecessarily. Make no mistake - healthcare fraud is a killer.

There is no time to waste. This Report provides credible, accurate information about the financial cost of healthcare fraud. We need to join together to tackle this destructive problem.

Paul Vincke
President
European Healthcare Fraud and
Corruption Network

Introduction

In November 2009, MacIntyre Hudson LLP and the Centre for Counter Fraud Studies at University of Portsmouth published, for the first time, an in-depth 'Financial Cost of Fraud' Report¹ collating the latest, accurate, statistically valid information from around the world about the real financial cost of fraud and error.

That Report considered and analysed 132 exercises to measure losses to fraud (and error) which have been undertaken around the world during the last ten years. The exercises were implemented across 32 types of expenditure, to accurately measure the financial cost resulting from fraud and error.

66 of those exercises measured losses in healthcare organisations and this Report undertakes a further analysis in this specific area. The reasons for and basis of this work were clearly stated in 'The Financial Cost of Fraud' Report, however, it is important to restate them here.

What is fraud?

The measurement of losses to fraud (and error) is an essential first step to successful action. Once the extent of fraud losses is known then they can be treated like any other business cost – something to be reduced and minimised in the best interest of the financial health and stability of the organisation concerned. It becomes possible to go beyond reacting to unforeseen individual instances of fraud and to include plans to pre-empt and minimise fraud losses in business plans.

The Report doesn't just look at detected fraud or the individual cases which have come to light and been prosecuted. Because there is no crime which has a 100% detection rate, adding together detected fraud significantly underestimates the problem. It is also the case that if detected fraud losses go up, does that mean that there is more fraud or that there has been better detection; equally, if detected fraud losses fall, does that mean that there is less fraud or worse detection?

¹*'The Financial Cost of Fraud' Report 2006*

The starting point for civil law definitions of fraud is the case of **Derry v. Peek 1889** (UK House of Lords). Here, Lord Herschell, giving judgement on the case, defined 'fraud' to include a false statement "made knowingly, or without belief in its truth, or recklessly, careless whether it be true or false".

This definition covers a number of possibilities, ranging from where:

- a person admits knowledge that a statement is untrue (through to...)
- where it can be demonstrated from evidence that they knew the statement to be untrue (even if this is not admitted) (through to)
- where it can be demonstrated from evidence that they did not care whether the statement was true or untrue - or in other words, that they knew it was possible that the statement might be untrue

In 2005 the Swiss Institute of Comparative Law provided the following definition, which broadly follows the UK law:

"Civil fraud is the use or presentation of false, incorrect or incomplete statements and/or documents, or the non-disclosure of information in violation of a legally enforceable obligation to disclose, having as its effect the misappropriation or wrongful retention of funds or property of others, or their misuse for purposes other than those specified".

Where error has been measured in the exercises reviewed in this Report, this is non-medical internal or external 'error' which has resulted in incorrect expenditure.

The Report also doesn't rely on survey-based information where those involved are asked for their opinions about the level of fraud. These tend to vary significantly according to the perceived seriousness of the problem at the time by those surveyed. While they sometimes represent a valid survey of *opinion*, that is very different from a valid survey of *losses*.

The financial and economic damage resulting from fraud (and error) is surely the worst aspect of the problem. Yes, fraud is unethical, immoral and unlawful; yes, the individuals who are proven to have been involved should be punished; yes, the sums lost to fraud need to be traced and recovered. However, these are actions which take place after the fraud losses have happened – after the resources have been diverted from where they were intended and after the economic damage has occurred.

Fraud as a business cost

In almost every other area of business life, organisations know what their costs are – staffing costs, accommodation costs, utility costs, procurement costs and many others. For centuries, these costs have been assessed and reviewed and measures have been developed to **pre-empt** them and improve efficiency. This incremental process now often delivers quite small additional improvements.

Fraud and error costs, on the other hand, have only very rarely had the same focus. The common position has been that organisations have either denied that they had any fraud or planned only to **react** after fraud has taken place. Because of this, fraud is now one of the great unreduced business costs.

However, a cost can only be reduced if it can be measured, and a methodology to do this accurately has only been developed and implemented over the last decade.

Now that we can measure fraud and error losses, we can make proper judgements about the level of investment to be made in reducing them. Now that we can measure these losses, we can measure the financial benefits resulting from their reduction.

The size of the prize

In the current macro-economic climate, reducing these losses are one of the least painful ways of reducing costs. This Report identifies what the financial cost of healthcare fraud and error has been found to be and thus, the 'size of the prize' to be achieved from reducing them.

Of course, there is always more research to be done and any organisation should consider what its own fraud and error costs are likely to be, however, the volume of data which is already available from exercises covering over £300 billion, points clearly to losses usually being found in the range of 3-8%.

We will continue to monitor data as it becomes available and publish further Reports as appropriate.

Jim Gee
Director of Counter Fraud Services,
MacIntyre Hudson LLP and Chair of
the Centre for Counter Fraud Studies

Overview

This Report has reviewed 69 exercises, to accurately measure healthcare fraud and error losses, undertaken in 33 organisations from 6 countries. 66 of those exercises were successfully completed covering expenditure totalling over £300 billion. The value of the expenditure examined has **not** been updated to 2009 values.

It is important to be clear about the basis for this Report. It is based on extensive global research, building on previously established direct knowledge, to collate information about relevant exercises. The data was then analysed electronically. Exercises were considered from Europe, North America and Australia and New Zealand. None were found in Asia or Africa.

The Report has **excluded** guesstimates, figures derived from detected fraud losses, and figures resulting from surveys of opinion. It has also excluded some loss measurement exercises where it is clear that they have not met the standards described below.

Statistically valid

It has **included** exercises which:

- have considered a statistically valid sample of income or expenditure
- have sought and examined information indicating the presence of fraud, error or correctness in each case within that sample
- have been completed and reported
- have been externally validated
- have a measurable level of statistical confidence
- have a measurable level of accuracy.

However, there are a number of caveats.

Some of the exercises have resulted in estimates of the healthcare fraud frequency rate, some of the percentage of expenditure lost to healthcare fraud, and some have measured both.

It is also the case that, some exercises have separately identified measured healthcare fraud and error and some have not.

In some cases, there have been repeated exercises to measure fraud and error losses in a single area of expenditure. To avoid skewing the overall results by including a disproportionate quantity of data from one source, only the results from the first and most recent exercises have been included. In most of these instances, fraud and error losses have been significantly reduced since the initial measurement exercises

Transparency is a key factor

Sometimes, once such exercises have been completed, the organisations concerned have, mistakenly in the view of the authors of this Report, decided not to publish their results. Transparency about the scale of the problem is a key factor in its solution, because attention can be focused and a proportionate investment made.

In some cases, those directly involved in countering fraud have decided, confidentially, to provide information about unpublished exercises for wider consideration. In those cases, while the overall figures have been included in the findings of this Report, no specific reference has been made to the organisations concerned.

The authors of this Report are also aware of a very small number of other exercises which have been completed, but which have not been published and where nothing is known of the findings.

Finally, it is important to emphasise that this research will never be complete. More evidence becomes available each year. However, the preponderance of the evidence does point clearly in one direction, as is explained later.

While it is necessary to make these caveats clear, the importance of the evidence collated in this Report should not be underestimated. The evidence shows healthcare fraud and error losses can be measured – they have been successfully measured many times, in many different organisations and across the world.

However, even more important is that the evidence shows that losses to healthcare fraud and error are significant and seriously undermine the quality and extent of patient care which can be provided.

The data which has been analysed

The six countries in which the authors are aware that fraud loss analysis exercises have taken place are:

- the UK
- the United States
- France
- Belgium
- the Netherlands
- New Zealand.

By value of income or expenditure measured, the United States has undertaken the greatest amount of work in this area. This is a direct reflection of the Improper Payments Information Act of 2002 (IPIA) which requires designated major U.S. public authorities to estimate the annual amount of payments made where fraud and error are present, and to report the estimates to the President and Congress with a progress report on actions to reduce them.

The guidance relating to the IPIA states "The estimates shall be based on the equivalent of a statistical random sample with a precision requiring a sample of sufficient size to yield an estimate with a 90% confidence interval of plus or minus 2.5%"². Many U.S. agencies undertake work to the higher standard often found in the UK and Europe – 95% statistical confidence and +or- 1%.

A growing understanding

In other countries, while there has not hitherto been any legal requirement, there is a growing understanding that the key to successful loss reduction is to understand the nature and scale of

the problem. For example, in Europe, the European Healthcare Fraud and Corruption Declaration of 2004, agreed by organisations from 28 countries called for "The development of a European common standard of risk measurement, with annual statistically valid follow up exercises to measure progress in reducing losses to fraud and corruption throughout the EU."³

The range of types of income and expenditure where losses have been measured include fraud (and error) involving patients, healthcare professionals, staff and managers, and contractors.

The specific areas where losses have been measured include:

- the fraudulent provision of sickness certificates
- prescription fraud by pharmacists
- prescription fraud by patients
- fraud and error concerning capitation payments to general practitioners
- fraud and error concerning payments made to doctors to manage a patients medical care
- the evasion of dental charges by patients
- fraud and error by opticians concerning the provision of sight tests
- fraud and error concerning employees of healthcare organisations
- fraud and error concerning payments for in-patient hospital services
- fraud and error concerning long term care

- fraud and error concerning home and community based services
- fraud and error concerning the provision of services and supplies
- fraud and error concerning health insurance for children.

²Appendix C to Office of Management and Budget Circular A-123

³European Healthcare Fraud and Corruption Declaration 2004

The nature of the figures

Two types of figures have been produced:

- a percentage loss rate (PLR - i.e. the proportion of expenditure lost to fraud and error)
- a fraud frequency rate (FFR - i.e. frequency of fraud and error)

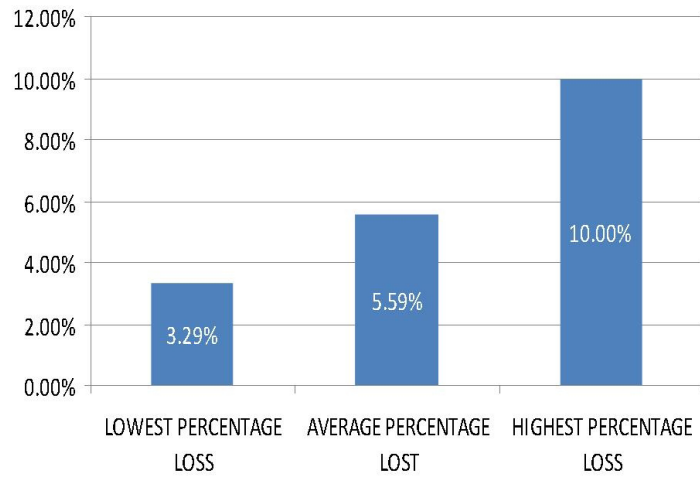
The same exercise can produce different PLR and FFR figures. For example, one hundred items of expenditure out of a thousand worth £100,000 might be found to be fraudulent. This would produce an FFR of 10%. However, the particular ten items might have a value of £12,000 producing a PLR of 12%.

The items of expenditure where fraud is found to be present may be either greater or less than the average value of all of the items of expenditure. For example, it may be that fraud tends to affect items of expenditure that are higher than the average value - this will result in the PLR being higher than the FFR. Indeed, to some extent the findings of this research, in general, show just that.

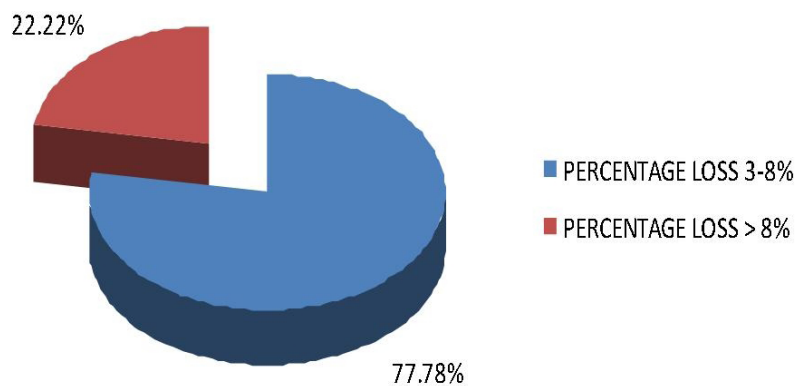
There is more research still to be done and it is intended that this Report will be updated on a regular basis.

Healthcare fraud and error losses

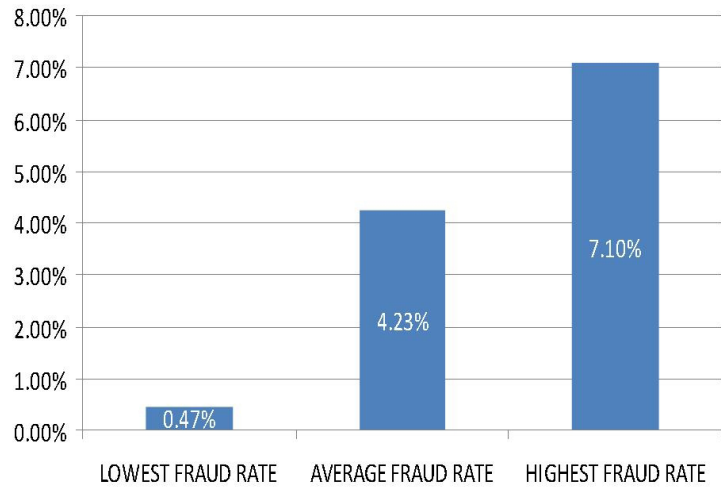
The range of percentage losses (PLR) was found to be between 3.29% and 10.00% with an average PLR of 5.59%.



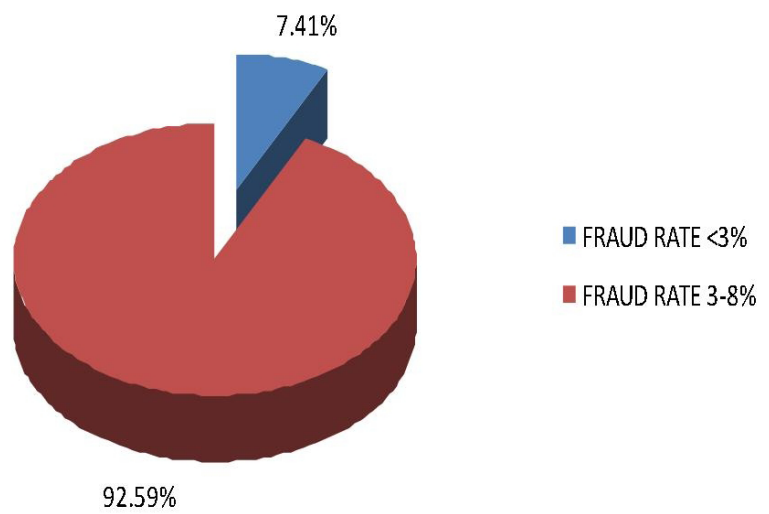
All of the PLR figures were more than 3% with more than one fifth showing losses of more than 8%.



The range of fraud frequency rates (FFR) was found to be between 0.47 and 7.1% with an average FFR of 4.23%.



92% of the exercises showed FFR figures of between 3% and 8%.



On the basis of the evidence, it is clear that healthcare fraud and error losses in any organisation should currently be expected to be at least 3%, probably more than 5% and possibly as much as 10%.

Separate research, analysing 28 key aspects of counter fraud arrangements across many organisations, continues. By combining the data which underpins this report and organisation-specific information about counter fraud arrangements, MacIntyre Hudson is able, for the first time, to predict the likely scale of losses, the key improvements which would reduce them and the related cost, for client organisations.

You can go to the webpage to get a free prediction concerning the likely scale of losses in your organisation at either.

www.macintyreHUDSON.co.uk/services/counter_fraud.html

or

www.ehfcN.org

Conclusion

This Report, for the first time, publishes accurate information about the extent of losses to healthcare fraud and error. It proves that it is possible to measure the nature and extent of the problem. It may be embarrassing for some organisations to find out just how much they are losing but it is possible to do this.

Because of the direct, negative impact on human life of healthcare losses, it is never easy to admit they take place. However, the first step to reducing losses is to stop being in denial about them. If an organisation is not aware of the extent or nature of its losses, how can it apply the right solution and reduce them?

Where losses have been measured, and the organisations concerned have accurate information about their nature and extent, there are examples where losses have been substantially reduced. These include the UK's National Health Service (the second largest organisation in the world) between 1999 and 2006 where losses were reduced by up to 60%, and by up to 40% over a shorter period⁴.

Three things are clear:

- losses to healthcare fraud and error can be measured – and cost effectively;
- on the basis of the evidence it is likely that losses in any healthcare organisation and any area of expenditure will be at least 3%, probably more than 5% and possibly as much as 10%;
- and with the benefit of accurate information about their nature and extent, they can be reduced significantly.

This Report shows just how much is being lost. The average loss found, across such a wide range of healthcare expenditure, was 5.59%. The World Health Organisation's latest estimate of global healthcare expenditure is US\$4.7 trillion (3.3 trillion Euros or £2.9 trillion).

Thus, it is likely that around 180 billion Euros (£160 billion or US\$260 billion) is lost globally to fraud (and error). This is the equivalent of one and a half times the

budget for the entire UK NHS or enough to build more than 1,500 new hospitals (at developed world prices) and more than the entire national GDP of 157 of the world's 195 countries.

Countering fraud effectively would reduce these losses and free up massive resources for better patient care. The authors of this Report hope that it focuses attention on this problem and the potential benefits to be derived from starting to solve it.

⁴ *UK NHS Counter Fraud and Security Management Service – 1999 – 2006 Performance Statistics*

Appendix 1

Examples of healthcare fraud

Below are some examples from across the world of healthcare fraud:

Fraud by managers and staff

- Payroll fraud: Managers or staff employed by healthcare providing organisations (public or private health insurers, national health funds, etc.) obtaining employment or advancing their careers by claiming false employment histories or qualifications;
- Misdirection of resources: One finance manager was found to have placed their family on the payroll of the healthcare organisation that they worked for;
- Personal impropriety: One Chief Executive Officer of a healthcare organisation was found to have overclaimed on his mileage allowance by 55,000 miles;
- Hospitals: Hospitals have been found to falsely claim that they have undertaken surgical procedures to attract extra payments.

Fraud by healthcare professionals

- Doctors: Two doctors were found to have claimed a Government improvement grant for their surgery and to have subsequently spent the money on creating a car import/export business;
- Doctors: It was reported from Taiwan that three doctors who admitted to conspiring with patients to defraud insurance companies of almost NT\$80 million have had their licenses revoked for the first time in Taiwan's medical history. A syndicate of medical personnel had been

falsely diagnosing patients with cancer – going as far as performing breast removal surgeries and chemotherapy in disease-free bodies – since 2003 to file multiple insurance claims;

- Dentists: Dentists have been found to have claimed for dental work which has not been undertaken; to have claimed for gold fillings which were actually mostly composed of nickel; and to have claimed fees for re-opening their surgeries out of normal hours without actually doing this;
- Opticians: Opticians have been found to have claimed fees for undertaking sight tests on people who were subsequently found to have been dead or non-existent; or to have been paid for providing replacement glasses without doing so;
- Pharmacists: Pharmacists have been found to deliberately divide up prescriptions into small packages in order to claim additional fees.

Fraud by the public and patients

- Organised criminals: criminals have been found to establish bogus medical clinics in order to bill insurers for healthcare treatments that were never provided and to have stolen confidential patient data for use in credit card fraud;
- Patients: Patients have been found to lie about their economic circumstances in order to obtain free healthcare treatment, to pretend that they are resident in particular countries where they were entitled to free treatment and to claim expenses for journeys to hospital which they never made;

Fraud by contractors and suppliers

- Pfizer Inc., the drugs giant, was ordered to pay \$2.3 billion in America's largest healthcare fraud settlement, for making false claims about four prescription medications. 11 whistleblowers became so concerned that the company was asking them to break the law and mis-sell the drugs that they informed the authorities;
- Drug companies: Drug companies have been found to organise cartels to restrict the supply of key drugs and to artificially raise the price; they have also been found paying bribes to medical professionals to prescribe their drugs;
- Equipment companies have been found to supply counterfeit diagnostic equipment and there is a serious global problem concerning the supply of counterfeit drugs.

It should be emphasised that there is a vast honest majority of managers, staff, professionals, patients and contractors but the dishonest minority causes significant financial losses which have a serious effect on the quality of patient care.

About the authors

Jim Gee is Director of Counter Fraud Services at MacIntyre Hudson LLP and Chair of the Centre for Counter Fraud Studies

Jim Gee is one of the leading counter fraud specialists in the UK. His accomplishments include leading the team which cleaned up London Borough of Lambeth in the mid to late 1990s; advising Right Honourable Frank Field M.P. during his periods as Chair of the House of Commons Social Security Select Committee and Minister for Welfare Reform; and being Director-General of the European Healthcare Fraud and Corruption Network between 2004 and 2006.

He was also a senior adviser to the Attorney-General concerning the Government's Fraud Review which has started to professionalise this country's approach to fraud. Gee's work in the NHS reduced fraud-related losses by up to 60%, delivering financial benefits to the tune of more than £800 million and achieving a 12:1 return on the costs of the work.

Mark Button is a Reader at University of Portsmouth and Director of the Centre for Counter Fraud Studies

Mark Button is a Reader in Criminology and Associate Head Curriculum at the Institute of Criminal Justice Studies, University of Portsmouth. He has also recently founded the Centre for Counter Fraud Studies of which he is Director.

He has written extensively on counter fraud and private policing issues, publishing many articles, chapters and completing four books with one forthcoming: *Private Security* (published by Perpetuity Press and co-authored with the Rt. Hon. Bruce George MP), *Private Policing* (published by Willan), *Security Officers and Policing* (Published by Ashgate), *Doing Security* (Published by Palgrave), and *Understanding Fraud: Issues in White Collar Crime* (to be published by Palgrave in early 2010 and co-authored). He is also a Director of the Security Institute, and Chairs its Academic Board, and a member of the editorial advisory board of 'Security Journal'.

Mark founded the BSc (Hons) in Risk and Security Management, the BSc (Hons) in Counter Fraud and Criminal Justice Studies and the MSc in Counter Fraud and Counter Corruption Studies at Portsmouth University and is Head of Secretariat of the Counter Fraud Professional Accreditation Board (CFPAB). Before joining the University of Portsmouth he worked as a Research Assistant to the Rt. Hon. Bruce George MP specialising in policing, security and home affairs issues.

He completed his undergraduate studies at the University of Exeter, his Masters at the University of Warwick and his Doctorate at the London School of Economics. Mark is currently working on a research project funded by the National Fraud Strategic Authority and ACPO looking at victims of fraud.

Graham Brooks is a Course Leader at University of Portsmouth

Graham Brooks is Course Leader for the Counter Fraud and Corruption MSc. at the University of Portsmouth. He was previously the Course Leader for the Counter Fraud and Criminal Justice Studies BA from June 2007 to March 2009, and Head of Secretariat for the Counter Fraud Professional Accreditation Board from September 2007 to March 2009. He is also a member of the Centre for Counter Fraud Studies at the University of Portsmouth.

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We provide a comprehensive range of services and specialist advice, including audit and assurance, tax planning and compliance for both corporate and individual clients, payroll and VAT, corporate recovery, business strategy, counter fraud services and outsourcing. Other parts of the MacIntyre Hudson Group provide specialist advice on corporate finance and professional training.

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The Centre for Counter Fraud Studies

The University of Portsmouth's Centre for Counter Fraud Studies (CCFS) was founded in June 2009 and is one of the specialist research centres in the University's Institute of Criminal Justice Studies. It was founded to establish better understanding of fraud and how to combat it through rigorous research. The Institute of Criminal Justice Studies is home to researchers from a wide cross-section of disciplines and provides a clear focus for research, knowledge transfer and educational provision to the counter fraud community. The Centre for Counter Fraud Studies makes its independent research findings available to support those working in counter fraud by providing the latest and best information on the effectiveness of counter fraud strategies.

www.port.ac.uk/departments/academic/icjs/CentreforCounterFraudStudies/

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The European Healthcare Fraud and Corruption Network

The European Healthcare Fraud and Corruption Network (EHFCN) exists to help its members combat fraud and corruption in the healthcare sector across Europe. Its aim is **to assist in improving European healthcare systems by reducing losses to fraud and corruption.**

EHFCN provides information, tools, training and assistance in fighting fraud and corruption as well as a platform for its members to exchange information and ideas. The Network also aims to collaborate with European and international bodies who have an influence on healthcare in Europe, such as the European Union, Council of Europe, and the World Health Organisation.

EHFCN is a non-profit organisation financed through subscription fees. Its members are healthcare and counter fraud organisations from across Europe.

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