

The financial cost of healthcare fraud 2015

What data from around the world shows

Jim Gee and Professor Mark Button



Foreword by Joseph Kutzin, Coordinator, Health Financing Policy at the World Health Organisation

Preface by Dr Simon Peck, Founder, Health Insurance Counter Fraud Group

**“ in order to develop
a solution, it is first
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and understand the
nature of the problem ”**

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Foreword

I am pleased to contribute a Foreword to this report. The World Health Organisation (WHO) has cited fraud as one of the ten leading causes of inefficiency in health systems, and it is good that this report provides detailed information about its extent. In particular, the volume of the health expenditure where losses have been measured, and the variety of types of expenditure covered, make the report's conclusions – that an average of more than 6% of expenditure is lost - convincing.

Fraud is an important problem for health systems around the world. The authors of the report are to be congratulated for their research – over 17 years – into this issue. WHO has previously recognised the importance of countries improving the efficiency of their health systems, thereby releasing resources that could be used to cover more people, with more services of high quality. In short, fraud constrains progress towards Universal Health Coverage (UHC).

However, having credible information about the problem of losses to health systems is not a goal in itself. The most important reason to know about the problem is to be better able to apply the right solutions - informing the prioritisation of work to counter fraud, the level of investment to be made and where best to focus action.

The data revealed by the report shows that one off, large scale frauds are unusual, but widespread low value fraud is common. This makes it harder to detect more than a small proportion and means that an emphasis needs to be placed on pre-empting fraud, rather than reacting to it after it has occurred. Fraud which is visible and which has been detected is only a small element of the total cost.

Fraud in the health system has a direct negative impact on human life – patient care is diminished in the quality and quantity which can be made available. It also prevents appropriate forms of health promotion and prevention that allows people to take control of their own health.

The report highlights examples where real gains have been made by reducing the cost of fraud – with up to a 40% reduction possible within 12 months. This is obviously good news and with health systems under financial pressure, cutting the cost of fraud can be a significant additional source of progress towards UHC, for example by putting the “recovered” resources towards increased coverage of services for health promotion, disease prevention, treatment, rehabilitation and/or palliative care.

It is important that those leading health systems – wherever they are in the world – read this report. They need to make sure that their systems are properly protected against fraud rather than simply responding after it does occur and losses have been incurred. As with the protection of health more generally, proactive, pre-emptive action has an important role to play.

JOSEPH KUTZIN

Coordinator, Health Financing Policy at the World Health Organisation.

Preface

"I was very pleased to be asked to contribute an updated preface to this renewed version of the 'Financial Cost of Healthcare Fraud' report.

I have spent a significant part of my career looking at this particular problem. For many years it was a problem which most people were unwilling to discuss or acknowledge. The public perception has always been that healthcare workers are dedicated individuals whose only concern is patients' welfare and that is, to a large extent, true. But hiding among them is a small number who are involved in healthcare for entirely the wrong reasons and, for them, the trust that society invests in them and the confidentiality which rightly preserves patients' privacy, also provides a convenient smokescreen behind which to hide criminal activity.

Patients, of course, can also be responsible for fraud, although it is with the providers and those working in the industry where the opportunity is greatest.

I have studied the subject of healthcare fraud wastage and abuse for something approaching two decades now and have seen huge changes. Most people – or at least those I meet - now acknowledge that, just as in every other area of human enterprise, there are those who could commit fraud. What still surprises me is that, outside of the USA (which has both a serious problem and some very well established and effective solutions), there is so little published about the cost and nature of that fraud.

About 15 years ago, I was one of the founders of the Health Insurance Counter Fraud Group - an initiative to tackle fraud and abuse in the private healthcare market. Since then I have often been asked to give advice or assistance by various organisations in setting up anti-fraud programmes. I have always been happy to give such advice and assistance as I can. Many of the people who ask me are considering investing in expensive software or high tech solutions. These things work well and have an important place but the most important thing is to start with the basics. The first piece of advice I always give, which is echoed in this report, is that, in order to develop a solution, it is first necessary to quantify and understand the nature of the problem. Once the problem is understood, only then is it possible to develop a framework of policies, procedures, controls and solutions needed to minimise and design out the risk.

Quantification has another important role too – in this day and age we all have to justify our existence and, in the 21st century, it is very difficult, if not impossible, to persuade organisations to invest in solutions to a problem, the size and scope of which is unknown. It also makes it extremely difficult to judge whether a solution is working or not, unless the problem is understood.

I would like to end by suggesting that if there are any readers who still have doubts, they should read the website for the US Government Office of the Inspector General <http://oig.hhs.gov/>. It has a whole area devoted to healthcare fraud and makes for some sobering reading and it speaks for itself.

DR SIMON PECK

Dr Simon Peck is a founder and former chair of the Health Insurance Counter Fraud Group. He works in the health insurance industry.

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Introduction

- 1.1. This Report renews research first undertaken in 2009 and repeated in 2011 and 2013, collating the latest, accurate, statistically valid information from around the world about the real financial cost of healthcare fraud (and error).
- 1.2. 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 develop business strategies to pre-empt and minimise fraud losses.
- 1.3. 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 also raises the question as to whether, if detected fraud losses go up, does that mean that there has been more fraud or just a higher level of detection? Equally, if detected fraud losses fall, does that mean that there has been less fraud or a lower level of detection?
- 1.4. 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.
- 1.5. The financial and economic damage resulting from healthcare 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 damage to the quality of patient care has occurred.
- 1.6. In almost every other area, healthcare 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.
- 1.7. 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 healthcare costs.
- 1.8. 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.
- 1.9. 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. We can also measure the financial benefits resulting from their reduction.
- 1.10. In the current macro-economic climate, reducing these losses is one of the least painful ways of reducing costs. Using global research, 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 it.
- 1.11. 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 now covering more than £2.9 trillion of healthcare expenditure, points clearly to losses usually being found in the range of 3-8%.
- 1.12. We will continue to monitor data as it becomes available and publish further reports as appropriate.

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Overview

2.1 Building on previous research, this 2015 Report takes account of loss measurement data from 1997 to 2013 and reports on a total of 107 exercises. The research published in this Report now covers 14 different types of healthcare expenditure totalling over £2.91 trillion (\$4.44 trillion), in 33 organisations from 7 countries. The value of the expenditure examined has not been updated to 2015 values. The losses referred to are expressed as a percentage loss of expenditure.

2.2 The Report is based on extensive global research, building on previously established direct knowledge, to collate information about relevant exercises. The data has then been analysed electronically. Exercises have been collated from Europe, North America and Australia and New Zealand. No data was available from Asia or Africa, although the authors are aware of developments which should lead to data being available in the near future.

2.3 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.

2.4 It has included exercises which have:

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

2.5 There are a number of caveats:

- Some of the exercises have resulted either in estimates of the fraud frequency rate, or the percentage of expenditure lost to fraud, and some have measured both;
- It is also the case that some exercises have separately identified measured fraud (and error) and some have not;
- Sometimes, once such exercises have been completed, the organisations concerned have, mistakenly in the view of the Report's authors, decided not to publish their results. Transparency about the scale of the problem is a key factor in its solution, because attention can be focussed and a proportionate investment made to reduce the level of loss;
- 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;

and

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

2.6 While it is necessary to make these caveats clear, the importance of the evidence collated in this Report should not be underestimated. It shows that losses to fraud (and error) in the healthcare sector represent a significant, damaging and, crucially, unnecessary business cost.

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The nature of the data which has been analysed

3.1 The seven countries in which the authors are aware that healthcare loss analysis exercises have taken place are:

- the UK;
- the United States;
- France;
- Belgium;
- The Netherlands;
- Australia; and
- New Zealand.

3.2 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) (followed by the more recent Improper Payments Elimination and Recovery Act of 2010) 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.

3.3 The guidance relating to the IPIA stated “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%”. Many U.S. agencies undertake work to the higher standard often found in the U.K. and Europe – 95% statistical confidence and + or - 1%.

3.4 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. In Europe, as long ago as 2004, the European Healthcare Fraud and Corruption Declaration, 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.”

3.5 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.

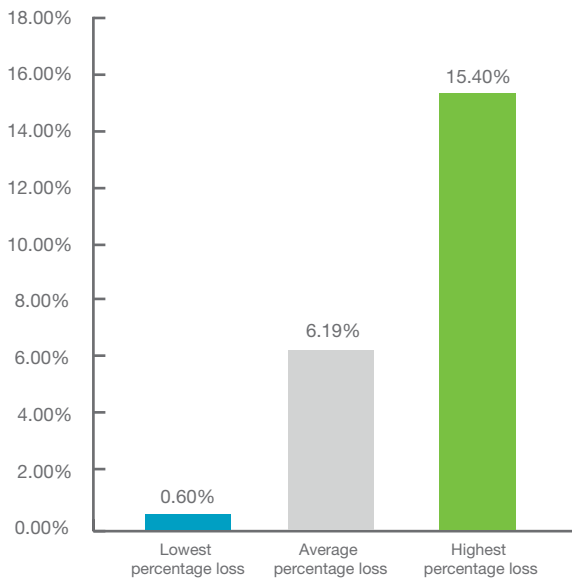
3.6 The specific areas where losses have been measured include:

- 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 patient’s 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;
- fraud (and error) concerning foster care; and
- fraud (and error) concerning child care.

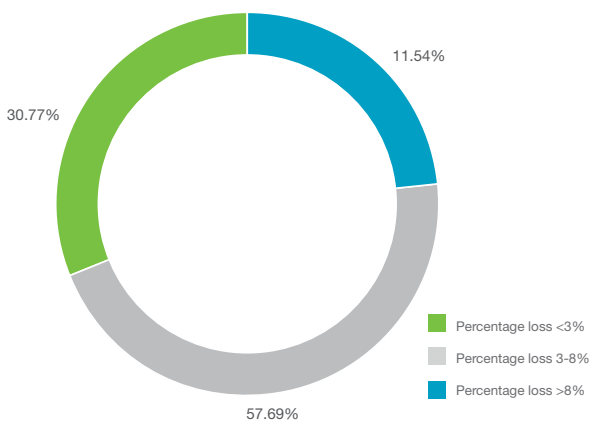
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Healthcare fraud (and error) losses

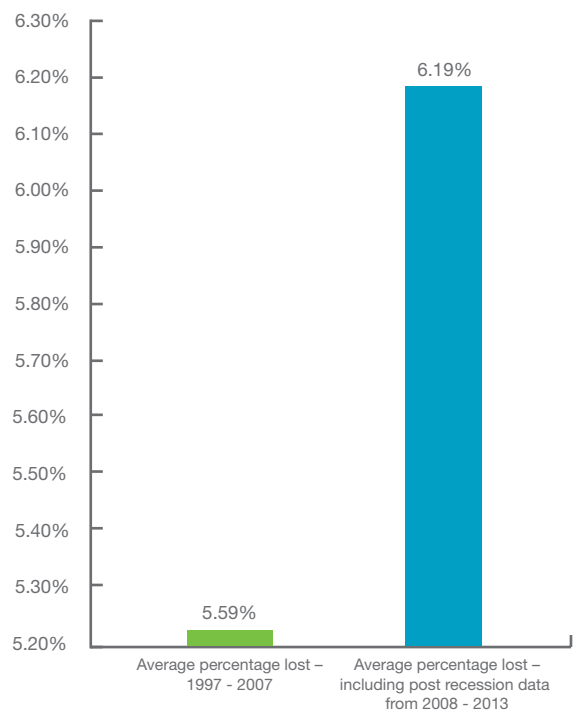
4.1 The range of percentage losses across all the exercises reviewed between 1997 and 2013 was found to be between 0.6% and 15.4% with average losses of 6.19%.



4.2 Over 88% of the loss measurement exercises showed losses figures of more than 3%.



4.3 Average losses have increased by 10.7% since 2007.



4.4 It is clear that fraud remains a significant problem and one which involves a larger cost than previously thought. Where organisations have undertaken repeated exercises to measure their losses in the same areas of expenditure, then the evidence also shows that this has helped to reduce them.

4.5 The current global average loss rate of 6.19% - a running average taking account of 17 years of data - when expressed as a proportion of global healthcare expenditure for 2013 (\$7.35 trillion, £4.83 trillion or €5.65 trillion), equates to £299 billion (\$455 billion or €350 billion).

- 4.6 This sum equates to:
- more than three times the NHS's total budget of £109.7 billion¹ for 2013-2014;
 - more than twice the total healthcare expenditure of Canada for 2013; and
 - almost fifteen times the total healthcare expenditure of South Africa for 2011.
- 4.7 It represents around a sixth of the United States total healthcare expenditure for 2013 and more than a quarter of European Union countries total healthcare expenditure for the same period.
- 4.8 This is an enormous sum which is diverted from the provision of patient care.
- 4.9 If healthcare organisations reduced these losses by 40% - which individual organisations have achieved - it would free up more than £120 billion (\$182 billion or €140 billion).
- 4.10 On the basis of the evidence, it is clear that fraud (and error) losses in any organisation should currently be expected to be at least 3%, probably more than 5% and possibly more than 10%. It would be wrong to go too much further in terms of predicting where in this range losses for an individual organisation will be, without some organisation-specific information about the strength of arrangements to protect it against fraud (its 'fraud resilience').
- 4.11 PKF Littlejohn and the CCFS, in parallel research, have developed Europe's most comprehensive database of fraud resilience information, with data recorded concerning over 1100 organisations. By combining the data which underpins this report and organisation-specific information about fraud resilience, we are able, for the first time, to
- predict the likely scale of losses;
 - the key improvements which would reduce them; and
 - the related cost.
- 4.12 We can also accurately measure losses or train client organisations to do this. The practical experience of PKF Littlejohn specialists, combined with the academic rigour of CCFS researchers, provides an unparalleled expert resource.

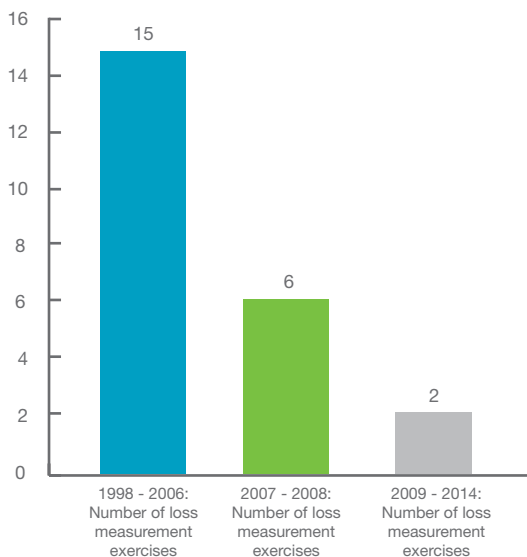
¹ The NHS Confederation

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What this means for the NHS

5.1 It should be emphasised that this report is the product of global research to produce a global average percentage figure for losses in healthcare. Whilst the data reviewed includes outcomes from NHS loss measurement exercises, it is much broader than that. An important question is what do the global trends and averages tell us about likely levels of loss in the NHS?

5.2 The NHS used to have a programme of measuring the cost of fraud (and error). Between 1998 and 2006 fifteen loss measurement exercises took place. A further six exercises took place in 2007 – 2008. Only two exercises took place between 2009 and 2014.



5.3 There are two key questions:

- What did these NHS-specific exercises show the cost of fraud (and error) in the NHS to be?
- and
- Is there any evidence that losses in the NHS are likely to be any different from those found globally?

What did these NHS-specific exercises show the cost of fraud (and error) in the NHS to be?

5.4 Below it is possible to see the number of NHS loss measurement exercises and what they found.

NHS loss measurement exercises	Range
1998 - 2001: Ten loss measurement exercises	5.1% - 6.72%
2002 - 2006: Five loss measurement exercises	1.6% - 3.9%
2007 - 2008: Six loss measurement exercises undertaken	2.0% - 9.3%
2009 - 2014: Two loss measurement exercises undertaken	2.94% - 3.49%

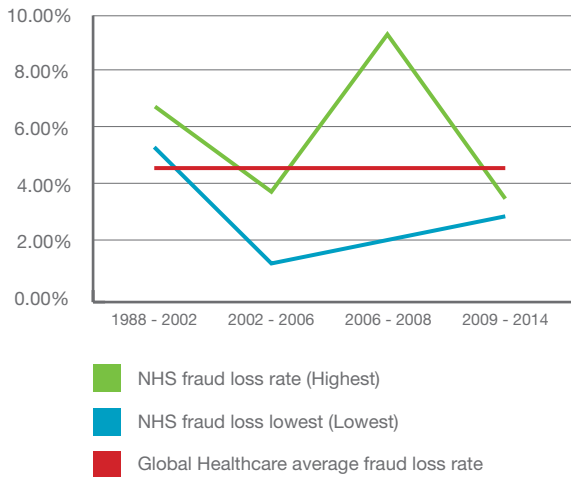
Is there any evidence that fraud losses in the NHS are likely to be any different from those found globally?

5.5 As discussed above, the current, running healthcare global average loss rate (for fraud (and error)) is 6.19%. Where healthcare loss measurement data is available to distinguish between fraud (and error), the split averages 73.8% fraud / 26.2% error. Thus it would be expected that the healthcare global average fraud loss rate would be $6.19\% \times 73.8\% = 4.57\%$ ('the healthcare global average fraud loss rate').

5.6 If we compare the results from the NHS exercises with the global running average, it can be seen that the latter is directly comparable with what has been found in the NHS.

	1998 - 2002	2002 - 2006	2007 - 2008	2009 - 2014
NHS loss rate (highest)	6.72%	3.90%	9.30%	3.49%
NHS loss lowest (lowest)	5.10%	1.60%	2.00%	2.94%
Global healthcare average fraud loss rate	4.57%	4.57%	4.57%	4.57%

5.7 A line graph shows this point even more clearly.



5.8 What does this mean for the NHS? Rather than simply looking at a global figure – the global average fraud loss rate applied to NHS expenditure (£109.7 billion was spent on the NHS in England in 2013/14²) would mean that £5.01 billion was lost annually – let us look at what the component elements of these losses would look like.

5.9 As with all fraud, the greatest losses are usually to be found where there is the greatest expenditure. The figures below are for 2013 – 2014:

- Payroll expenditure £32.66 billion³
- Procurement expenditure £20.6 billion⁴
(2011-2012) = £21.9 billion
(2013-2014 after inflation⁵)
- General Practice £7.63 billion⁶
- General Dental Services £3.01 billion⁷
- Pharmaceutical Services £2.1 billion⁸
- General Optical Services £0.523 billion⁹

5.10 This expenditure represents a total of £67.8 billion or 61.8% of the total NHS expenditure for 2013-2014.

5.11 Fraud also affects the income which the NHS should receive in patient charges. These are prescription, dental and optical charges.

5.12 The next part of this Report examines each of these areas to outline what types of fraud can occur and what losses might be incurred in each area. All the figures quoted represent the annual loss to the NHS.

Payroll expenditure

5.13 NHS payroll expenditure has been reported to be £32.66 billion for 2013-2014. The NHS undertook a loss measurement exercise examining payroll expenditure in 2003-2004 across the total payroll budget. Expenditure of this type at that time was £26.8 billion. The exercise found that the cost of fraud represented 1.7% of the expenditure but that the fraud prevalence rate was 3.4%. This indicates that most fraud of this type is high volume, low value.

5.14 While very few ghost employees were found, there were significant loss rates in the following areas:

- incorrectly received allowances (3.2%);
- incorrectly claimed employment histories (6.8%); and
- incorrectly claimed qualifications (6.8%).

5.15 Applying the 1.7% figure to 2013 payroll expenditure would equate to fraud losses of £555 million. If we apply the healthcare global average fraud loss rate (4.57%) then the figure would be £1.49 billion.

Procurement expenditure

5.16 NHS procurement expenditure has been reported to be £21.9 billion for 2013-2014. As there has never been a successful NHS loss measurement exercise looking at procurement expenditure, there is no NHS-specific loss percentage which can be applied. However, such exercises have been completed successfully in other sectors and have generally shown higher than usual loss rates in this area of expenditure. The lowest percentage fraud loss figure which has been found is 5.8%.

5.17 The nature of procurement fraud has mostly been found to be where goods or services are under-provided in terms of quality or quantity or over charged. Sometimes the goods or services are not provided at all. Where procurement fraud losses have been measured in other organisations, a key weakness has been found to be the lack of consistent data and communication between those procuring goods or services, those receiving or benefitting from them and those paying for them.

² The NHS Confederation

³ The Health Foundation – January 2015

⁴ Better Procurement Better Value Better Care – Department of Health – August 2013

⁵ Bank of England inflation calculator applied

⁶ NHS Payments to General Practice – HSCIC – February 2015

⁷ NHS England Annual Report – 2013 - 2014

⁸ NHS England Annual Report – 2013 - 2014

⁹ NHS England Annual Report – 2013 - 2014

5.18 Examples of procurement fraud range from that of two NHS managers, John Leigh and Deborah Hancox, who masterminded a 5-year procurement fraud worth £229,000 against a health authority in the North West, and who were jailed for over five years in total, to the more common high volume, low value fraud which can easily become 'embedded'.

5.19 Applying the 5.8% percentage figure to 2013 procurement expenditure would equate to fraud losses of £1.27 billion. If we apply the healthcare global average fraud loss rate then the figure would be £1 billion.

General Practice

5.20 According to the Health and Social Care Information Centre in 2015, £7.63 billion was paid to general practice service providers in 2013-2013. As there has never been a successful NHS loss measurement exercise looking at expenditure on general practice, there is no NHS-specific loss percentage which can be applied.

5.21 Examples of fraud include that of Dr Thirumurugan Sundaresan, a Rochdale doctor who stole over £62,000 from the NHS by falsifying 1,700 patient records. Fraud also takes place in the following ways:

- Creating ghost patients;
- Claiming for services provided to ghost employees including production of false prescriptions;
- Claiming for services not provided (enhanced services);
- Raising false prescriptions for self-medicating; and
- Accepting bribes to register overseas visitors.

5.22 The best estimate of the cost of fraud in this area therefore has to be based on the healthcare global average fraud loss rate. If we apply this figure then fraud losses would equate to £348 million.

General Dental Services

5.23 According to the NHS England Annual Report for 2013-2014, £3.01 billion was spent on General Dental Services (GDS). There have been six NHS loss measurement exercises considering the cost of fraud in GDS. The average loss rate is 4.03%.

5.24 Examples include that of Joyce Trail, the Birmingham dentist jailed for 7 years in 2012 for stealing £1.4 million from the NHS and dentists have also been found to claim for higher numbers of Units of Dental Activity than actually provided.

5.25 If we apply this 4.03% percentage to GDS expenditure, fraud losses would equate to £121 million. If we apply the healthcare global average fraud loss rate, then this figure would be £137 million.

Pharmaceutical Services

5.26 According to the NHS England Annual Report for 2013-2014, £2.1 billion was spent on Pharmaceutical Services (PhS). There have been six NHS loss measurement exercises considering the cost of fraud in PhS. The average loss rate is 3.97%.

5.27 Examples include a case where a pharmacist purported to dispense a much greater volume of drugs than was actually the case, thereby wrongfully obtaining over £200,000. Fraud also takes place where pharmacists claim for services not provided and fail to declare prescription charges which have been collected.

5.28 If we apply this 3.97% percentage to PhS expenditure, fraud losses would equate to £83 million. If we apply the healthcare global average fraud loss rate, then this figure would be £96 million.

General Optical Services

5.29 According to the NHS England Annual Report for 2013-2014, £0.523 billion was spent on General Optical Services (GOS). There have been nine NHS loss measurement exercises considering the cost of fraud in GOS. The average loss rate is 2.47%.

5.30 Examples include opticians claiming NHS allowances for individuals who are not entitled, creating ghost patients and claiming for the provision of phantom sight tests.

5.31 If we apply this 2.47% percentage to GOS expenditure, fraud losses would equate to £12.9 million. If we apply the healthcare global average fraud loss rate, then this figure would be £23.9 million.

Patient charges – prescription charge fraud

5.32 The NHS last undertook a loss measurement exercise concerning prescription charges in 2013-2014. The report concerning this exercise has not been published but was referred to in the media¹⁰ on 30 December 2014. The media article states 'The Department of Health estimates 29.4 million prescriptions were wrongly handed out for free last year at a cost of £237million.' and then goes on to quote the health minister Dr Daniel Poulter. The figure of £237 million compares to a figure of £47 million in 2003.

¹⁰ The Daily Mail – 30 December 2014

5.33 It is not known how the Daily Mail obtained this information but there is no record of it having been challenged by the Department of Health. It would therefore not be unreasonable to accept this figure of loss for 2013-2014.

Patient charges – dental charge fraud

5.34 The NHS has not undertaken a loss measurement exercise concerning dental charge fraud since 2007-2008. The report concerning this exercise reveals losses of £36.3 million and a loss rate to fraud of 3.8%.

5.35 If we use the Bank of England inflation calculator these losses equate to £43.9 million in 2013-2014 (assuming that no other factors have caused this figure to rise or fall).

Patient charges – optical charge fraud

5.36 The NHS has not undertaken a loss measurement exercise concerning optical charge fraud since 2007-2008. The report concerning this exercise reveals losses of £18.9 million and a loss rate to fraud of 3.0%.

5.37 If we use the Bank of England inflation calculator these losses equate to £22.9 million in 2013-2014 (assuming that no other factors have caused this figure to rise or fall).

NHS losses

5.38 If we take these figures together:

- Payroll expenditure £555 million - £1.49 billion
- Procurement expenditure £1 billion - £1.27 billion
- General Practice £348 million
- General Dental Services £121 million - £137 million
- Pharmaceutical Services £83 million - £96 million
- General Optical Services £12.9 million - £23.9 million

They represent losses in these areas of expenditure of between £2.12 billion - £3.36 billion.

5.39 The areas of **expenditure** which have been studied (above) represent 61.8% of NHS expenditure for 2013-2014. If we extrapolate these figures across the totality of NHS expenditure then the losses would be between £3.43 billion - £5.44 billion.

5.40 It is then necessary to add the figure for lost **income** from patient charges:

- Prescription charge fraud £237 million
- Dental charge fraud £43.9 million
- Optical charge fraud £22.9 million

These three areas of fraud represent total losses of £303.8 million.

5.41 If we add losses to expenditure and income then **total losses to the NHS would be between £3.73 billion - £5.74 billion.**

5.42 Several points arise from this analysis:

- The NHS's own loss measurement exercises (now sadly almost completely curtailed) do not show significantly different loss rates from those found globally in other healthcare organisations (and highlighted in previous reports of this type);
- The level of loss is significant and is likely to undermine the NHS's capacity to provide patient care of the quality which it wishes to;
- These losses can be reduced substantially. This is not just shown globally but from the NHS's own history between 1998 and 2006, where, losses were substantially reduced and fell significantly below the healthcare global average loss rate.

So what is to be done?

5.43 So what is to be done? It is the view of the authors of this Report that there are three first steps for the NHS to take to reduce the cost of fraud:

- 1) The NHS needs to re-adopt an approach which is focussed on reducing the cost of fraud not just investigating and prosecuting individual examples (although this is important too);
- 2) It therefore needs to re-commence loss measurement exercises across key expenditure streams. It is only with accurate knowledge about the nature and extent of fraud that proportionate, effective action can be taken to reduce its extent;
- 3) It needs to re-create a powerful, well-resourced organisation to lead this work with a remit and authority across all parts of the NHS.

¹⁰ The Daily Mail – 30 December 2014

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Conclusion

- 6.1 This Report renews research into accurate information concerning the extent of losses to healthcare fraud (and error). Without such information it is impossible for healthcare organisations to properly prioritise the problem or to invest proportionate sums in solving it.
- 6.2 The research demonstrates that it is possible to measure the nature and extent of healthcare losses – and to reduce them. It may be embarrassing for some organisations to find out just how much they are losing but it is possible to do this.
- 6.3 The report is based on global research and highlights a global healthcare average loss rate both for fraud (and error) and for fraud alone. However, it also focusses on the UK's National Health Service and shows what the issues and problems are there, making some recommendations for improvements, including recommencing work to measure and reduce losses.
- 6.4 Because of the direct, negative impact on human life caused by 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?
- 6.5 Where losses have been measured, and the organisations concerned have accurate information about their nature and extent, there are many examples where losses have been substantially reduced. Indeed, these examples include historic success in 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 period.
- 6.6 Four 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 over 10%;
 - with the benefit of accurate information about their nature and extent, they can be reduced significantly; and
 - countering fraud effectively could free up considerable resources for better patient care, whether in the UK or globally.
- 6.7 The authors of this Report hope that it focuses attention on the problem of healthcare fraud (both in the UK and globally) and on the potential benefits to be derived from starting to solve it.

About the authors



Jim Gee is Director of Counter Fraud Services at PKF Littlejohn LLP, a leading accountancy and business services firm and Visiting Professor and Chair of the Centre for Counter Fraud Studies at University of Portsmouth. During more than 25 years as a counter fraud specialist, he led the team

which cleaned up one of the most corrupt local authorities in the UK – London Borough of Lambeth – in the late 1990s; he advised the House of Commons Social Security Select Committee on fraud and the Rt. Hon. Frank Field MP during his time as Minister of State for Welfare Reform; between 1998 and 2006 he was Director of Counter Fraud Services for the Department of Health and CEO of the NHS Counter Fraud Service, achieving reductions in losses of up to 60% and financial benefits equivalent to a 12:1 return on the costs of the work.

Between 2004 and 2006 he was the founding Director-General of the European Healthcare Fraud and Corruption Network; and he has since worked as a senior advisor to the UK Attorney-General on the UK Government's Fraud Review. He has also worked with a range of healthcare organisations, companies and charities as well as delivering counter fraud and regulatory services to companies both in this country and internationally. His work has taken him to more than 35 countries to counter fraud and he has advised the Chinese and New Zealand Governments about how to measure, pre-empt and reduce the financial cost of fraud. 2013 also saw him jointly author a book – 'Countering Fraud for Competitive Advantage' – with Professor Mark Button, which was published by Wiley.



Professor Mark Button is Director of the Centre for Counter Fraud Studies. He has written extensively on counter fraud and private policing issues, publishing many articles, chapters and completing six 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);
- Fraud, Corruption and Sport (Published by Palgrave with Graham Brooks and Azeem Aleem)
- Studying Fraud as White Collar Crime.

With Jim Gee he wrote a book (published globally by Wiley) called 'Countering Fraud for Competitive Advantage' and the 'Accredited Counter Fraud Specialists Handbook'. The former highlights the financial benefits to be obtained from countering fraud effectively. He is also a former Director of the Security Institute. 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 has also worked on a research project funded by the National Fraud Authority and ACPO looking at victims of fraud.

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The Centre for Counter Fraud Studies (CCFS) is one of the specialist research centres of the Institute of Criminal Justice Studies, formed in 2009 to accommodate the growing interest in counter fraud that has occurred within the Institute over the last ten years. The Centre aims to collate and present the widest possible range of information regarding fraud and the solutions applied to it, and to undertake and publish further research where needed. Additionally, the Centre's Fraud and Corruption Hub gathers the latest thinking, publications, news and research in one central resource for counter fraud professionals.

www.port.ac.uk/centre-for-counter-fraud-studies



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