

# Ethics in health care: healthcare fraud

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## Abstract

Healthcare fraud is a type of white-collar crime involving the filing of dishonest healthcare claims in order to achieve a profit. Healthcare fraud is a worldwide problem and is on the increase in South Africa. In this article, healthcare fraud is explored, healthcare fraud identified as a white-collar crime and the South African legal term, "fraud", defined. Common types of medical aid fraud, a rising concern within South African healthcare practice, are detailed. Finally, the role of ethical and moral reasoning is deliberated and the psychological factors that are believed to contribute to fraud discussed. Healthcare fraud is not a victimless crime. Therefore, healthcare professionals must inform on colleagues who practice it.

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## Introduction

Vintage images are easily found depicting a virtuous doctor with a look of honesty and compassion on his or her face bending over a patient, stethoscope in hand, ready to perform a clinical examination. With a cynical imagination, a present-day replacement of this image can be conjured. Imagine the look on the doctor's face as he or she discovers that the patient is "wired" and the doctor suspected of medical scheme fraud. According to a report in the *Medical Chronicle*, "doctors are being probed by medical schemes that send investigators (wired) as undercover patients for consultations to practices".<sup>1</sup>

## Discussion

Healthcare fraud is a worldwide problem, which is on the increase in South Africa and explored in this article. In the first section, healthcare fraud is identified as a white-collar crime, and the South African legal term, "fraud", defined. Common types of medical aid fraud, a rising concern within South African healthcare practice, are identified. Finally, the role of ethical or moral reasoning is deliberated, and psychological factors that are believed to contribute to fraud discussed.

Healthcare fraud is white-collar crime involving the filing of dishonest healthcare claims in order to achieve a profit. The term "white-collar crime" was created at an American Sociological Association lecture in 1939 by guest lecturer, Dr E Sutherland. He defined the term as a "crime committed by a person of respectability and high social status in the

course of his occupation".<sup>2</sup> The characteristics of white-collar crimes remain similar to other criminal acts in that deceit, concealment or a violation of trust takes place. However, no threats of force or violence transpire in classic white-collar crimes. "Fraud" is defined in South African law as "the unlawful and intentional making of a misrepresentation which causes actual and/or potential prejudice to another".<sup>3</sup> In practice, the use of the term is broad and is interpreted to include all acts of dishonesty, misconduct and unethical behaviour in economic crimes.

Healthcare fraud can be viewed as a variant of a white-collar crime. The perpetrators may be doctors, nurses, pharmacists or other healthcare practitioners. However, it also involves other parties, i.e. patients, consumers, and companies that provide medical services or equipment, as well as employees who work in healthcare industries, arguably marking it a greyer shade of white-collar crime.<sup>4</sup> In addition, it is noted from international trends that there is the increased participation of multinational syndicates in healthcare fraud.<sup>5</sup> In South Africa, the costs of medical fraud to industry are estimated to be R3 billion-R15 billion.<sup>6</sup>

Jonathan Broomberg, chief executive officer, Discovery Health, identifies common types of healthcare fraud perpetrated against medical aid schemes in South Africa, and which are classified as follows:<sup>7</sup>

"Fraud by scheme members:

- Members found forging and submitting claims for services ostensibly rendered by healthcare professionals, but which were never rendered.

- Members ordering high-cost equipment from a supplier, e.g. a wheelchair or other high-cost medical item, submitting the claim and obtaining reimbursement, but then failing to pay the supplier and not collecting the equipment.
- Members, in collusion with doctors and hospitals, submitting claims for false hospital admissions, in order to benefit from claims payments.
- Members sharing their medical scheme cards with non-scheme members who require hospital admission or treatment by a doctor, resulting in the scheme paying for claims for non-members.

Fraud by healthcare professionals and service providers:

- Pharmacies dispensing generic medication and claiming for expensive brand-name medication.
- Pharmacies selling cosmetics and other front-shop items to scheme members, and submitting claims for medicines to the scheme.
- Pharmacies selling members high-cost devices, often several times per year, in surplus to their needs, and submitting the claims to the medical scheme.
- Healthcare professionals and service providers submitting claims for services that have not been rendered to patients, e.g. claiming for consultations when the member did not attend the practice or claiming for counselling services for unconscious patients in the intensive care unit.
- Healthcare professionals colluding with members in card sharing, e.g. healthcare professionals agreeing to see a non-scheme member and submitting a claim using another person's membership.
- Dispensing doctors providing members with low-cost generic medicines and claiming for higher cost non-generic medication.
- Healthcare professionals providing fraudulent sick notes to members, and then claiming for consultation from the scheme.
- Healthcare providers performing cosmetic surgery on scheme members (generally not covered by the scheme) and then claiming for some other procedure which is covered.
- Healthcare professionals fraudulently changing the diagnosis of a patient in order to access a specific benefit.
- Healthcare professionals claiming excessive or additional material and consumables, not then used during the consultation or procedure.
- Dentists claiming for additional fillings or extractions that are not carried out, or providing members with cosmetic gold inlays and claiming for normal crowns.
- Biokineticists acting as personal trainers to healthy members in gyms, and then submitting claims to the scheme as if rehabilitation services had been rendered to those members.

Fraud by other individuals and syndicates:

- A syndicate identified attempting to submit false membership applications, then submitting fraudulent claims on those memberships.
- A syndicate identified trying to change member or service provider bank details in order to divert claims payments to their own account.
- A syndicate identified admitting healthy members to hospital, in order to benefit from "hospital cash-back insurance".
- Syndicates colluding with unscrupulous employees of healthcare funders.
- Brokers providing the scheme with false details for medical scheme membership applicants in order to avoid waiting periods and late joiner penalties being imposed".

It is obvious that healthcare fraud presents a major problem for medical aid schemes. Importantly, scheme members are the eventual victims. It is estimated that approximately R 2 500-R 2 800 a year of each member's contributions covers the cost of fraudulent activities.<sup>8</sup> For example, the following are two of a number of cases from an Health Profession Council of South Africa (HPCSA) report. A physiotherapist was caught billing one medical aid scheme for 93 appointments and another medical aid scheme for 100 appointments, both on the same day. Doctors often complain of being overworked day in and day out, but one doctor appeared not to mind. He billed for 107 two-hour appointments in a day, so that one working day equalled 214 hours.<sup>9</sup>

The HPCSA's professional misconduct report states that of approximately 1 830 reviewed cases in the 2013 financial year, 734 were completed. Of these, 200 doctors were referred to the HPCSA's Professional Conduct Committee and found guilty of professional misconduct.<sup>10</sup> A breakdown of the offences ranged from theft and fraud, providing insufficient care or treatment and mismanaging patients, overcharging patients or charging for services not rendered, negligence, and bringing the profession into disrepute. Most of those who were found guilty of an offence were in the category of theft and fraud.<sup>11</sup>

Bateman reports on the HPCSA's spokesperson registering distress about the increase in the number of doctors making fraudulent money, many from claims submitted to medical aid schemes:<sup>12</sup> "Not only is committing fraud strictly against the council's good practice guidelines, but it is a criminal offence. The council supports the authorities in imposing the appropriate sanctions on practitioners found guilty of this unethical and disgraceful conduct".<sup>9</sup>

Medical practice is now being shaped by commercial considerations. As Cassell correctly reports, the financing of health care dominates all facets of medicine, including education, research, doctor-employer and doctor-doctor

interactions, as well as doctor-patient relationships.<sup>13</sup> This is a fact. And yet, although the organisational structure of medical practice is changing, at least in some areas, it does not follow that the fundamental principles of ethics and ethical reasoning no longer apply.

The demarcation between what is right and what is wrong may appear to be blurred in some cases of medical ethics. In others, such as fraud, an ethical discussion on the reasons why fraud in health care is wrong might appear to be absurd. After all, healthcare professional guidelines, oaths, codes and declarations oblige healthcare professionals to be honest and trustworthy. For some, an affective reaction is inherent and intuition automatic and effortless in respect of fraud being wrong. For others, the affective response is not so rapid or decisive. Their intuition may be conflicting or unsteady. According to Haidt, no matter how rapid the intuitive process, when that stage is passed, a moral judgement is made, followed by moral reasoning which serves to justify their action.<sup>14</sup>

It is not as important, when studying ethics, to become proficient in reciting ethics tracts or principles. Learning how to ethically or morally reason is one of the objectives.<sup>15</sup>

A general framework for moral reasoning in the case of a medical practitioner who is faced with debt and who has the opportunity to commit medical aid scheme fraud follows:

- The problem is identified, e.g. "I have debt and the opportunity to commit fraud. Committing fraud makes me uncomfortable, but so does my debt".
- The facts are checked and may need to be revised in the light of new information. (Some problems disappear upon closer examination of the situation. Others may drastically change).
- Relevant factors are identified. (Who is affected by my decision? An individual, several individuals? An organisation? What are the consequences for the affected parties? Do any laws, professional guidelines or codes exist that should be considered? Are there any practical considerations?)
- Responses are formed to the following questions. Does this option do less harm than any alternative? Would I want my choice of this option published in a newspaper or on the Internet? Could I defend my choice of this option before a committee of my peers, my parents or my community? Would I still consider the choice of this option to be good if I was one of those adversely affected by it? Would taking this first step make it easier to choose this option often? Is that a good situation or a bad one? What do my profession's ethics say about this option? What might my colleagues say if I described my problem and suggested this option as my solution?
- A decision is made based on the previous steps.
- Action is taken on the decision and responsibility taken for it.

According to Ainsworth, the commission of a crime involves a combination of three elements; a motivated offender, a suitable (and vulnerable) victim and the absence of a capable guardian.<sup>16</sup> This applies to all criminal acts. Most research concludes that opportunistic fraud is more prevalent than planned criminal fraud, and that when tackling fraud, ethics, attitudes and psychology are important aspects to research.<sup>17</sup> The "fraud triangle" consists of three factors, which when present together, are considered to be predictors of the likelihood of fraud. They are opportunity, incentive or pressure, and attitude or rationalisation.<sup>18</sup> In the case of fraud, three additional risk factors have been identified; collusion, justice avoidance and organisational orientation.<sup>19</sup>

Financial strain is a given reason for fraudulent activities pertaining to almost every type of fraud.<sup>20</sup> However, to use the excuse of "I did it because I desperately needed the money" is not feasible because the term "financial strain" is subjective. Financial strain (grappling with financial difficulties) that arises from "living a particular lifestyle", for example, is quite different from financial deprivation in which impoverishment is a feature.<sup>20</sup>

An element of ego is also inherent in those who commit fraud. This is demonstrated through comparisons being made with others who are more wealthy, a desire to match their lifestyle or possess material wealth, as well as a "perception of power, status and pride".<sup>20</sup>

According to many psychologists, the intensity of a potential fraudster's desire and his or her perception of opportunity are personality variables.<sup>20</sup> Motivation is a combination of an individual's personality and the situation in which he or she finds him- or herself. Psychologically, the way in which a person interprets the situation influences the decision that is taken. To prevent having a bad conscience, the process of rationalisation or neutralisation is carried out and tends to diminish the fraudster's inhibitions. Common examples of rationalisation used by healthcare fraudsters are convincing themselves that healthcare fraud is a victimless crime, the organisation "can afford it", or they'll "do it just this one time". The problem with rationalisation or neutralisation of the act is that it may compound psychological problems. Sometimes an individual's initial motivation to commit crime is relative deprivation and greed, as well as combating threats to continued goal attainment. However, with success, they began to gain secondary delight in the knowledge that they are deceiving the world and believe that they are superior to others.<sup>21</sup>

## Conclusion

The majority of doctors in South Africa continue to practice their profession with integrity and professionalism, but the number of fraudsters is increasing.<sup>22</sup> Ethics and moral

reasoning, can only help to a point. There will always be a small percentage of individuals who while being fully aware of the difference between ethical conduct and misconduct, will opt for the latter. Healthcare fraud is not a victimless crime. Therefore, healthcare professionals must inform on colleagues who practice it.

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