Mobilizing the honest majority to fight health-sector fraud

Courtesy of Jim Gee

Jim Gee

Jim Gee has more than 25 years of operational, policy and strategic experience as a counter fraud specialist. From 1990 to 1998, he worked in counter fraud for local government in the United Kingdom (UK). In 1998, he headed the country's National Health Service (NHS) Counter Fraud Service and, in 2003, became chief executive of the NHS Counter Fraud and Security Management Service. In 2005, he became director-general of the new European Healthcare Fraud and Corruption Network and helped to develop the United Kingdom's first cross-economy counter-fraud strategy. He is currently director of Fraud Economics Ltd.

At a time when the global financial crisis is squeezing government budgets, Jim Gee says that the argument for fighting fraud in health systems has never been stronger.

Q: Why is it important to define 'fraud'?

A: Sometimes 'fraud' is used as a catch-all for all kinds of undesirable behaviour. However, fraud is only one problem among several. And different problems need different solutions. It's very important to be clear what fraud is and what it isn't. Fraud is something that people find very difficult to talk about; they imagine it's perpetrated by a much wider group than it is. When you explain to people what it is, many more people feel that they can support you. In civil law in the United Kingdom and other European countries, fraud is when someone knowingly obtains resources to which they are not entitled. Using a common definition makes it easier to work together and compare statistics on losses.

Q: How can you measure success in reducing losses due to fraud?

A: We undertook eleven fraud-loss measurement exercises across the NHS budget and then re-measured the reduced losses in each. Our work reduced losses by up to 60% and delivered £811 million worth of financial benefits between 1998 and 2006. And now that's been followed up in nine other countries, where there have been 57 fraud-loss measurement exercises in 43 organizations. These are statistically valid, highly accurate exercises that show the total cost of fraud. Two showed losses of less than 3% of expenditure, five of over 8% and 50 of 3–8%.

Q: Is the financial crisis and the prospect of tighter government budgets driving the trend towards fraud prevention in the health sector?

A: Yes, but not as widely as I would like. Health-care systems are losing, on the basis of available evidence to date, between 3% and 8% of their expenditure to fraud. That's an enormous amount across Europe and beyond, but we have shown that these losses can be massively reduced. The benefits to patients of professional work to measure and reduce fraud losses are manifest.

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Q: What are the main forms of health sector fraud?

A: In all the countries where I have worked, I have found that there are four main areas of fraud that are usually found: fraud by patients; by clinical professionals (often claiming for work they haven't done); by managers and staff misusing their position or authority; and fraud by companies and contractors supplying goods and services (a major area there is around the pricing of drugs).

Q: What personal experiences led to your campaigning approach?

A: It always seemed to me that fraud involved the irrational allocation of resources on the basis of greed, rather than the rational allocation of resources on the basis of need. When the NHS celebrated its 50th anniversary in 1998, nothing had been done to stop fraud and corruption since it was founded. I was the first person appointed to deal with this issue. I was given three staff and a budget of £210 000 a year (US$ 290 000 at exchange rates on 10 March 2009) to stop fraud across an organization of 1.2 million employees with a budget of £40 billion (US$ 55.2 billion). We built the NHS Counter Fraud Service into one of 250 staff and a budget of £20 million by delivering a financial return of 12 to 1 on the cost of our work. Health care is probably the area where fraud has the most direct negative impact on human life, because people have to wait longer for treatment or they don't get the quality of care they would otherwise have had. Sometimes they wait so long that they don't get treatment in time. I enjoy my work because I can see the benefits that it brings.

Q: Why did it take so long to take action against health sector fraud in United Kingdom?

A: If you think of fraud as mostly about investigations, policemen, auditors and people being sent to jail, it doesn't align itself very easily with the ethical professional approach of people delivering health care; one is seen as rather hard and uncaring, the other as caring and human. We got over that by establishing a new profession of counter-fraud specialist that emphasized the prevention of fraud by mobilizing the honest majority and deterring the dishonest minority. People working in the health-care sector realized that we were different, that we had a professional ethos just like them. Our common goal was

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to ensure that patient care was properly funded. I also got a commitment before I took the job that every pound [sterling] we saved wouldn't go back to the Treasury [finance ministry] but would be spent on better patient care – people saw the benefits that could flow from that commitment.

Q: How important are whistle-blowers in fighting fraud in the health sector?

A: It's important to have channels of communication so that people who have information can provide it without risk to their careers and families. But whistle-blowing is only one route to uncover fraud and is sometimes overemphasized. There are many ways of detecting fraud, from advanced data analytics, which detects anomalies and potential fraud, to proactively looking for fraud where administrative weaknesses exist. It's also vital to mobilize people to protect the health-care system so that less fraud happens in the first place.

Q: How is your approach to uncovering fraud different to traditional approaches?

A: For years, it was thought that to tackle fraud, it was enough to react to individual problems as they arose. That's because fraud was seen in terms of individuals, rather than economics. Some individuals will need to be taken to court, but the most important thing is to prevent fraud happening and to reduce its economic cost so that patients get the quality of care that they deserve. Measurement of fraud losses is crucial to reducing them – if you don't know the nature and scale of the problem how can you apply the right solution?

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Q: Have you worked with any developing countries?

A: Not yet – but I would like to. There is a real need to avoid the loss of scarce health-care resources to fraud and the potential for successfully reducing fraud losses is often greater. Sometimes the sophisticated technology in developed countries makes it harder to find the nature and scale of fraud. The transition from paper documents, which are full of rich detail, to electronic data means that you can lose an awful lot. My view is contrary to the prevailing view that it's harder to do this work in developing countries.

Q: Can you tell us about your work with other developed countries?

A: By 2003, we were coming across cases where mobility of labour and the growth of international provision of services put us in touch with other European countries that were facing similar problems. We were awarded funding from the European Union to set up the European Healthcare Fraud and Corruption Network but it is now self-funding. Representatives from health-care systems in 29 European countries and from Australia, Canada, New Zealand and the United States of America came to our founding conference in 2004 and unanimously agreed the Network's Charter.

The international dimension of this work is very important and I have been involved in several countries: France recently set up a new health-care counter-fraud unit; the Netherlands has a well developed network of health insurance counter-fraud organizations; Belgium has had a successful unit in place for several years; New Zealand has just completed its first measurement of fraud losses in this sector; Canada has been working on the problem for several years; Australia too; and counter-fraud specialists that I speak to in South Africa want to set up a network similar to the one that we created in Europe. So a lot is being done, but there is still an awful lot more to do! ■

Recent news from WHO

- WHO called for more research into childhood diarrhoea, on 10 March. Despite the persistently high burden of disease, research into **childhood diarrhoea** has been steadily decreasing since the 1980s. Nearly two million children die from diarrhoea every year. If childhood diarrhoea is not addressed urgently, the countries that are worst affected will fail to achieve the fourth Millennium Development Goal target of reducing child deaths by two-thirds by 2015.
- The emergence of **parasites resistant to artemisinin** at the border between Cambodia and Thailand could undermine global malaria control efforts. WHO said, on 25 February, that a recent shift from treating patients with failing drugs to the highly effective artemisinin-based combination therapies (ACTs) had provided a breakthrough. Appropriate treatment with ACTs succeeds in more than 90% of cases, but parasitical resistance to these drugs along the Thai–Cambodia border threatens these gains. WHO said that it would assist efforts to contain the spread of artemisinin-resistant malaria parasites with a US$ 22.5 million grant from the Bill & Melinda Gates Foundation.

For more about these and other WHO news items please see: http://www.who.int/mediacentre

Corrigendum

In volume 87, Number 2, February 2009, page 89, the caption for the second photo should read "Dr Amphon Jindawatthana, secretary-general of the National Health Commission Office, Thailand".