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A SICKNESS IN THE SYSTEM

Understanding fraud and corruption in healthcare: A contribution from criminology

In England and Wales we have an aging population and the cost of providing healthcare is increasing. Whilst demand for health services has swollen, and will continue to do so, funds made available for the NHS since 2010 have been low by historical standards. Due to perhaps negative coverage and criticism from the health care sector the Department of Health spent £124.7bn in 2017/18), £126.4bn in 2018/19, and will spend £127.2bn in 2019/20 on providing health care. Of the current level of spending in 2017/2018 £110 billion was spent on the NHS with the rest spent on public health (healthy eating habits), education, and infrastructure such as building new hospitals (Johnson et al. 2018). Out of these funds it is estimated that £1.25 billion per annum is lost to fraud (data from 2016/17, National Health Service Counter Fraud Authority, 2017).

Extra funds, approximately £20 billion have been promised by the current Prime Minister for 2023/24, but it is as yet still unclear how such an increase will occur. The increase has been welcomed by the NHS but will fail to address the fundamental challenges that it currently encounters or help fund developments in services that are essential. One of these challenges is that elderly people are lying in hospital beds instead of at home due to a lack of people to care for them. This is a social care issue, though and dealt with mainly by local councils, but with cuts to services councils are unable to deliver much needed services to elderly people. Therefore, issues beyond NHS can affect its operational capacity and thus service to all citizens.

There are ongoing debates as to how to fund the NHS in the future, which has yet to be decided. Proposed suggestions are increase in personal taxation, streamlining services, if possible, use of technology; restructure (yet again) the NHS, and a health insurance model expanding the role of the private sector. There is little or no mention on how these will reduce fraud and corruption, though.

Regardless of how we fund the NHS in the future a loss of £1.25 billion per annum is unacceptable. This loss, however, is with all crime data only an estimate and the £1.25 billion is below that of the actual level of fraud and corruption in the NHS. This article will address this issue with particular reference to the NHS in England and Wales but, where useful, make reference to international literature as well. It will offer a definition of fraud and corruption, but also highlight that fraud and corruption are often used interchangeably to define the same act. Once a definition is provided, I will review the contribution of sociology and criminology in developing theoretical frameworks to help us understand why people commit fraud and acts of corruption.

Trying to define a flexible beast: The problem with fraud and corruption

Any definition can have two elements (Philip, 2015); it can articulate the import and usage of a word and also act as a tool to help construct an explanation; the social sciences are primarily concerned with the latter. Understood as a tool, a definition aims to identify a set of criteria that suggest necessary and sufficient conditions for a phenomenon to occur. These criteria, however, differ depending on the focus of the discipline. Much of the literature on corruption is dominated by political science. This discipline along with law primarily sees people as rational and as such often proposes changing laws, policy and/or procedures to tackle fraud and corruption. Economics also primarily see people as rational economic units. As such all three approaches place fraud and corruption into a personal and political cost benefit analysis. This is a rather crude distinction but how we view people and what we think motivates them to commit crime affects how we prevent and punish offenders.

Often dismissed as 'empty ruminations' our underpinning view on why a crime is committed has consequences on how we treat, punish and deter offenders. A brief scan of criminal justice policy will highlight how theoretical approaches affect what laws and techniques are implemented and therefore constitute a core element of preventing crime and how we 'punish' what is often referred to as white collar crime. I suggest, however that the term white collar crime is sometimes misleading. It is popular in the USA and has expanded its reach into Europe but white collar crime denotes the position – white collar – of the person that has committed the crime. If a doctor working in the NHS committed prescription fraud it is a fraud but also seen as a white collar crime, but if a patient that is unemployed

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committed prescription fraud, it is a fraud. The same act has been committed but the position, the status of the person has defined the crime rather than the crime itself (Brooks, 2016).

However, whilst it is difficult to clearly define fraud in this article, it will be defined as illegally obtaining a benefit of by intentionally breaking a rule. Based on deception, fraud is an intentional act to secure a mainly financial advantage – in the present or future – with, but usually without, the knowledge of those victimised. The Home Office Fraud Act 2006 (for England and Wales and Northern Ireland) has defined three types of fraud in an attempt to clarify the matter, namely:

- fraud by false representation (section 2),
- fraud by failing to disclose information (section 3),
- fraud by abuse of position (section 4)

Under this definition, a failure to disclose is also considered fraud. Fraud is thus seen as both active and passive behaviour and is considered as unacceptable. Clear national standards are useful to combat fraud, and yet laws are often only rigorously applied depending on the resources available and political will. This, however, is only the start of the problem. What is the difference between an act of fraud and one of abuse? Abuse might be seen as manipulation of rules rather than breaking them, or even taking advantage of an absence of rules or regulations in an unjust fashion. Errors, by contrast, are where there is an unintentional breaking of a rule or regulation i.e. errors could be where a patient is made a payment by mistake or extra treatment is provided beyond what is covered or allowed under insurance. The problem here is 'did the patient know and keep quiet about the payment?' and 'once discovered where the costs recoverable?'

All of this is further complicated by corruption. Countless definitions of corruption are available with most emphasising the public sector as a cause of or conduit for corruption. This view, however, underestimates the private sector and its penchant for corruption. Corruption has a range of meanings: specialised, technical and professional and also a public social meaning and understanding of what is corrupt. This has produced a consistent feature in the corruption literature, and resulted in that there is no conclusive definition of the term. Acts of corruption can be perceived as unethical but legal (i.e. nepotism) or criminal (i.e. fraud): instead it is useful to place corruption onto a continuum of corruption (Brooks, 2016), and all the legal and illegal acts that it can include to highlight how different theoretical approaches emphasise different aspects of corruption and ways of preventing them.

Moving beyond the political science, economic and legal views on why people commit fraud and acts of corruption, this article draws on sociology and criminology to help our understanding of why people commit fraud in the healthcare sector. Whilst it is unable to highlight all theoretical approaches it will emphasise a few key approaches that help our understanding of fraud and corruption. The 'original' texts are also utilised here as a reference point so

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that those unfamiliar with sociology and criminology can access these texts and make a personal assessment of the usefulness of each approach rather than rely on the interpretation of others.

Fraud and corruption in healthcare: a contribution from criminology

As a discipline, criminology has a history of pondering the usefulness and limitations of crime data and the problematic nature of recording and measuring crime. The literature explains how crime is recorded and also why crime statistics substantially under-record crime. Regardless of the nature of the criminal justice system – adversarial or prosecutorial – similar issues arise such as lack of confidence in the police to report a crime or items stolen of little personal value, and so on. However, if we consider these crime data for what they are and are aware of their limitations, they serve a purpose and are of use. For all its limitations, recorded crime is an antidote to wildly inaccurate views of crime (Jones, 2006) and are thus of use. Fraud and corruption though are at the difficult end of the spectrum to measure as they are primarily 'hidden crimes' and it is therefore difficult to assess the volume fraud and corruption and the number of victims.

As with all crime data, it is useful to reflect on whether the measurement of fraud and acts of criminal corruption – those that violate criminal law rather than civil law – is worthwhile. I suggest that it is more than worthwhile; it is necessary. Whilst all crime data can be flawed, this is no reason to abandon the exercise. Crime data are still useful even if they are incomplete. Any policy or strategy will need to be based on some indication of the size of the problem to put in place a system of prevention, and as such the measurement of fraud and corruption and the development of more sophisticated approaches can increase our knowledge of the problem and, in turn, reduce the level of victimisation (Brooks, 2016). This is particularly important with our aging population and the pressure on delivering health care, whose costs will increase. Understanding fraud and corruption then are highly significant issues that affect us all – healthcare employees or current and future patients. What is needed is the clearest understanding of what motivates people to commit fraud and acts of criminal corruption in the health care sector. It is here that sociology and criminology have much to offer beyond political, legal and economic discourse.

Whilst criminology is a discipline that has crime as its primary object of study, and there are many acts of criminal corruption, it has rarely been the focus of the voluminous literature in criminological research unless part of a broad analysis of health and safety crime and/or organised crime. Criminology often, but not always, uses the criminal law as its basis on which to define crime. In the case of corruption the criminal law definition covers a substantial corpus of work but fails to encapsulate the range of crimes that are part of the continuum of corruption. Drawing briefly on a range of theoretical approaches on the aetiology of crime most are based on the assumption that corruption is mostly committed by people operating in the context of organisations either as individuals or in collusion with others. This is where the usefulness of sociology and criminology comes into play. They both have a history of explaining deviance, moral codes and also criminal acts.

Learning crime by association?

It was the notion of white-collar crime, committed by the 'powerful' and members of the upper socio-economic class that stimulated an interest in sociology and later criminology as to why people in 'power' committed such crime(s). Sutherland (1939) suggested that there are nine key tenets that explain why people in white-collar position commit crimes; whilst it is not possible to review all of them here, the key elements of this approach are that criminality is learned through interaction with others in a process of communication – known as differential association. This process of communication is learned by witnessing what are referred to as definitions favourable to violation of law(s). This process includes the techniques, motives, drives, rationalisations and attitudes towards set criminal actions. For a person to commit criminal acts there needs to be a culture of dominant attitudes that justify and rationalise such acts as an acceptable way to behave. The problem with this approach, however, is how to explain that people in white-collar positions could commit criminal acts and yet continue to function. This is explained by developing a positive self-concept that was a combination of institutionalisation, rationalisation and socialisation (Ashforth and Anand, 2003). The combination of these elements are that institutionalisation is where an initial act is embedded in structures and processes and thereby rationalised through a justification for committing a criminal act; socialisation is the process whereby new employees are induced or seduced into the view that corruption is permissible. In this sense, young doctors are corrupted by old established doctors in the healthcare sector. This approach, however, fails to explain the origins of criminal behaviour; if the behaviour/acts did not previously exist, how could they be learned?

A lack of legitimate avenues for success

The notion of strain (Merton, 1938) considers a lack of legitimate avenues for 'success' and the pursuit of wealth: i.e. those unable to attain 'success' seek an illegitimate route to achieve personal aims. This explanation, however, was developed to explain street crime and a common criticism of strain is that it is assumed that there is a consensus on what is success. It fails to recognise pluralism, ethnic and otherwise, and is therefore too broad a description but still has some value here. Highly trained and educated doctors/dentists/pharmacists might engage in fraud as they assess their success, or lack of it, in terms of the position they hold in an organisation. For example if rejected for a promotion, which they thought they should have, this might become a justification for fraud. Often anti-corruption and fraud initiatives overlook established healthcare sector employees, and yet these powerful individuals are seduced by the temptation to commit fraud and corruption.

An individual might enter the health care profession with corruption in mind or become corrupt at some point in time in a long career as a health care professional. This is why we have to be constantly watchful, and consider that healthcare employees have the potential to commit fraud and/or a corrupt act throughout a career.

Techniques of neutralization: justification for crime

However, how can those working in healthcare commit crimes and still deliver the service(s) expected of them? Sykes and Matza (1957) explain that part of the process of learning consists of learning excuses, or what are called techniques of neutralisation. These techniques were to explain, yet again, street crime rather than fraud and corruption. This approach, however, has some resonance and value as it can explain that individuals and healthcare units can temporarily suspend or neutralise their commitment to expected behaviour and laws. Rather than recall all techniques a few should suffice for the purposes of this article.

There is the denial of injury, which is where offenders insist their actions caused no harm or damage i.e. nobody was put in physical danger. For example, a doctor might put in a false or exaggerated claim for home visit(s) to a patient(s), particularly out-of-hours, or refuse patients appointments at their place of work (doctors' surgery) to claim expenses for home visits, add non-existent ghost patients to the doctors' register to obtain additional reimbursement from the NHS, keep deceased patients names on the register and continue to claim reimbursement for ongoing healthcare. This leads on to passing the blame or disbursement of blame, whereby an individual/co-accused or even a company is caught committing an illegal act but claim that the management/company was well aware of the acts, and in some cases actively encouraged fraud/corruption. We often see this 'excuse' in the financial sector but it is also relevant in the healthcare sector. For example, a private doctor might prescribe the most expensive medicine for a medical problem rather than another less costly medicine because his employer has a 'close relationship' with a pharmaceutical company that funds the company in indirect ways.

These techniques should not be seen in isolation though; they can and do combine to create a 'wall of justification', particularly if the offender(s) are caught, in order to diminish the impact and seriousness of the offence committed. Supporting these techniques of neutralisation is the work of Dittenhofer (1995) and Zeiltin (2001), and the syndrome of injustice and dissatisfaction. Neutralisation techniques should precede acts of fraud/corruption rather than some kind of post hoc rationalisation (Brooks, 2016). A rationalisation is not an after-the-fact excuse but an integral part of motivation for the act. Furthermore, a doctor or dentist might commit fraud once or twice,

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such as inflating payment for some service to help pay a personal tax bill or purchase a car or private school fees rather than always commit an act of fraud; as such they drift in and out of corruption. As we can see an act of fraud and/or corruption might be 'rational' in that it is calculated but the context is all important. Policy, procedures and laws can change in an attempt to prevent and reduce fraud and corruption but the motivation is often context specific.

Relying on a moral compass: notions of social control

This leads us on to the notion of control, and why is it that people refuse to commit fraud and corruption, even if possible. Here crime is expected unless sociocultural control such as family members and teachers etc. help prevent crime. This might have some resonance in a small, local community or unit in a hospital but is limited in a huge organisation such as the NHS. Fraud and corruption though are explained as the lack of internalised control or 'moral compass'. The problem here is that rationality is assumed; there is no scope for enquiring how people make sense of the world – and justify fraud as above – which they inhabit and morals are variable rather than fixed and immutable, and as such keeping 'poor company' can have an influence – i.e. a corrupt dentist can affect the moral compass of trainees.

Crime as a rational choice?

This moral compass or lack of it is part of what is referred to as rational choice and is close to the political, legal and economic view of corruption. Here the causes of crime are lying within individual rather than the social structure. The notion of individual responsibility is therefore embedded as a central tenant of a range of political and policy approaches associated with a conservative view of personal rational responsibility (Wilson and Herrnstein, 1985). This approach proposes that the individuals learn how to behave in the social world based on what type of behaviour is rewarded and under what circumstances, and that our conscience is an internalised set of attitudes, mainly formed in childhood, which prevent us from committing crime. This approach, however, focuses on specific type of crimes such as visible street crime, and therefore frames crime as embedded in human nature) rather than the social fabric. As such, it sees offenders as beyond reform and in need of punitive control. The problem is that white collar crime offenders are often treated in a lenient way, if caught, by criminal justice systems (Brooks, 2016). Due to its focus on street crime this approach fails to address the egregious acts of fraud and corruption that cause unbearable pain and disability i.e. an unwanted and unnecessary surgery or poorly tested medicine 'pushed' onto the health market in search of a profit for a pharmaceutical company.

Crime as routine

People are thus seen as rational actors (Cohen and Felson, 1979) where crime is routine (for some people) and that crime is the product of a motivated offender(s), a potential victim, and the absence of a capable custodian (i.e. the presence of someone keeping people under control). It is important to note that this approach offers suggestions about the probability of criminal behaviour rather than definite claims about when crime will occur. Much of this is about "lifestyle"; what we do, where we live, who we interact with. Crime as a routine does not seek to explain the motivation for crime (even though it states that a motivated offender is also needed), nor does it offer an explanation of the social context, which might highlight the combination of these variables or why some individuals are more capable than others in committing fraud and/or corruption.

All of these theoretical approaches may assist us to understand why people commit acts of fraud and corruption, but seem to include at least three elements. These are: (a) pressure on the individual, (b) the opportunity to commit a crime and (c) the ability rationalise crime. These are all part of what is known as the Fraud Triangle, but how and who is seduced by fraud and corruption, and when and where acts will occur are still issues we wrestle with in trying to prevent fraud and corruption and loss of much needed funds to the NHS.

All theoretical approaches in this article are limited and indeed at times contradictory, dependent on a particular view of 'human nature'. They are, however, useful because as mentioned earlier, a brief scan of criminal justice policy illustrates that theoretical approaches affect which laws and techniques are implemented and therefore theoretical approaches are a core element of all types of crime prevention no matter what the crime. Both sociology and criminology have a history of explaining deviance, breaking rules and moral codes and also criminal acts. As such, a theoretical framework is a useful template on which to place debates on fraud in healthcare, but the current context – in which we have an ageing population, and consequently a rising cost in healthcare, should become of more interest to those in the social sciences that have much to offer.

Conclusion

This article has highlighted the complex problem of how to define acts of fraud and corruption, but it has also emphasised the need for a working definition of fraud and corruption even if this is limited. Furthermore, I have illustrated that theoretical frameworks can be useful because they have consequences on how we treat, punish and deter offenders. Further research into fraud in healthcare is needed, however and particularly in the field of the social sciences. As this article has hopefully demonstrated, there is much in the literature that could be used to enrich the much needed debate on fraud and corruption in healthcare systems around the world.

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