

EHFCN



EUROPEAN HEALTHCARE
FRAUD & CORRUPTION NETWORK

Cross Border Fraud in European Healthcare systems

An EHFCN Risk Analysis

EHFCN Working Group on Cross Border Fraud



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Annex 1 Complete overview analysis (Matrix that already has been identified by the CBF Working Group)

1. Introduction - About EHFCN

The EHFCN was formally established in 2005 to coordinate and advance efforts to counter healthcare fraud and corruption in Europe.

Its foundations lie in the European Healthcare Fraud and Corruption Declaration, agreed by the delegates of the first pan European conference held in London in October 2004.

The Network is a not-for-profit organisation, based in Brussels, financed through subscription fees and is the only European organisation dedicated to combating healthcare fraud and corruption across Europe. In aggregate, the member organisations of EHFCN provide healthcare services to millions of people in Europe.

The EHFCN's primary objective is to reduce fraud and corruption in healthcare throughout Europe.

By working together, its members aim to fraud proof European healthcare systems and release billions of Euros from fraud, bringing it back to healthcare services.

Healthcare and counter fraud organisations throughout Europe are members of the EHFCN.

In addition to providing information, tools, training and assistance in fighting fraud and corruption, the EHFCN provides a forum to its members for exchanging information and ideas.

The EHFCN is also a partner in raising awareness and building an anti-fraud and anti-corruption culture.

The Network's Executive Committee is tasked with taking forward the aims and objectives agreed in the Declaration.

2. The Cross Border Fraud Working Group

Following the EHFCN's 2008 conference in Malta, a Cross Border Fraud (CBF) working group was established and tasked with analysing the issues and contributory factors underlying cross-border healthcare fraud. Although the Group has focussed its efforts on healthcare fraud within Europe, the Group is of the opinion that the same issues and contributory factors will be found to underlie healthcare fraud wherever it happens.

Membership:

- Jef de Gruyter, Chief Inspector of Healthcare (LCM Belgium)
- Sandra Lowe, Head of Counter Fraud Policy Unit, (DHSSPS Northern Ireland)
- Eadaoin Flynn, Intelligence and International Liaison Manager (General Medical Council, UK)
- Loubna Boufrach, Policy and Legal Advisor, Counter Fraud Department (Association of Healthcare Insurers, the Netherlands)
- Paul Vincke, President of the EHFCN (EHFCN, Belgium)

The **General Medical Council** is the regulatory body for doctors working in the UK health service. The organisation's mandate is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. The GMC works closely with other regulators and with the various anti-fraud agencies to share information and to reduce the opportunities for fraudulent practitioners to obtain registration.

Zorgverzekeraars Nederland was formed in 1995 and is an organisation representing the providers of healthcare insurance in the Netherlands. The primary task of ZN is to promote the interests of its members. ZN plays an active role in the national debate on the structuring of the healthcare insurance system, the supply of healthcare facilities and the quality of these facilities. ZN has a Counter Fraud Department. This department co-ordinates the development of counter fraud policy and brings together all counter fraud officers at the health insurance companies. Together they form the Counter Fraud Platform, where they exchange their experiences and share cases of fraud. In this way, instruments and policies to prevent, detect and repress fraud are developed.

The Counter Fraud Policy Unit of the **Department of Health, Social Services and Public Safety** was established in the Department in 2000 to support the strategic management of the DHSSPS by minimising the level and impact of fraud in the delivery of Health Care, Personal Social Services and Public Safety through the provision of a focal point for counter fraud activity and initiatives throughout the DHSSPS.

The **National Institute for Health and Disability Insurance (INAMI)** organises and financially manages healthcare insurance in Belgium.

From within INAMI the Service for Medical Evaluation and Control (SECM) is developing highly efficient systems and tools of evaluation, prevention, detection and investigation of improper use of the federal healthcare resources (€20 billion) by healthcare providers and suppliers.

With its 4.5 million members **Christelijke Mutualiteiten** is the largest health insurance provider in Belgium. Its operation is based on values such as solidarity, respect for the person and focus on others, especially the most vulnerable.

Many know CM mainly as a back payer of medical expenses. However, it is more than a pure insurance company. CM also offers its members a comprehensive package of services and benefits and is also a dynamic social movement.

Common goal

The common goal of these organisations is to counter fraud in healthcare, to operate transparently and with integrity, to ensure patient safety and to maximise the resources available for frontline patient care.

Aim and scope of risk analysis

The CBF working group was tasked with defining the problem of cross border fraud in healthcare, including determining the scale and nature of the problem, listing the possible risks and actual cases, and with proposing actions that could be taken to counter the problem of cross border fraud and corruption.

The aim in compiling this information is to produce a matrix outlining all of the issues and contributing factors affecting fraud, along with examples of case studies and preventative measures. This could then be used as a tool to assess risk, to share best practice in combating fraud and to identify loopholes in the various systems that could be exploited by persons seeking to commit fraud.

Methodology

In this Risk Analysis we used, and were inspired by, the Enterprise Risk Management—Integrated Framework (COSO ERM Framework).

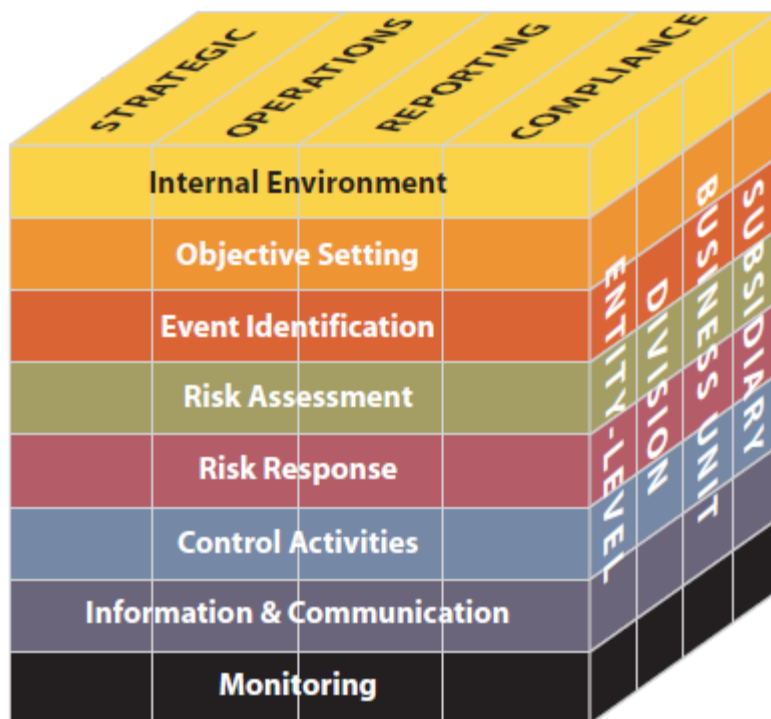
The COSO ERM Framework can provide a solid foundation which can be used by companies to enhance corporate governance and deliver greater stakeholder value.

The components of the COSO Model which we took into account in an operational context were:

- internal environment
- objective setting
- event identification
- risk assessment
- risk response

One component of this risk management is event identification, which involves developing a list of events that could affect the ability of the enterprise to achieve its strategic and operating objectives. The guidelines establish objectives for risk identification and suggest general procedures for identifying events that represent risks.

The CBF working group agreed the following approach (risk components) inspired by the COSO ERM Model, see below:



COSO's ERM Framework, 2004

Enterprise Risk Management: tool to enhance Corporate Governance



Environmental analysis

Global process analysis

Identifying the weaknesses

Detailed process analysis

Concrete recommendations

Environmental analysis (Internal environment):

The EU draft directive 2005/36/EC gives patients and practitioners the right to free movement throughout the Member States (MS). This means that patients are more mobile than ever before. Providers in various Member States are also keen to attract patients across borders and may emphasise the higher quality of treatment outside a patient Member's State. As a result it is now common place for patients to shop around for the best quality most affordable and most readily available treatment. This increases the opportunities to commit fraud.

Global process analysis (Objective setting)

This concerns the operational relationships between organisations and the way they counter fraud in healthcare systems across Europe and in line with the requirements of the diverse legislations.

Identifying the weaknesses (event identification)

What can go wrong? What are the potential internal and external factors that might affect the involved organisations concerning fraud in a cross border context? Both risks and opportunities are identified in the matrix (Annex 1)

Detailed process analysis (risk assessment)

This involved analysing the risks by looking at the likelihood and impact. (see Annex 1 and next chapter for detailed explanation).

Concrete recommendations (risk response)

The CBF working group has identified some general prevention/detection/investigation managing tools (as set out in 6.1, including examples).

In this last risk component the CBF working group will determine what to do to manage, avoid, reduce, share or perhaps accept various risks in a cross border fraud context based on input from EHFCN member organisations.

3. Background

We have identified the following groups as primarily being affected by Cross Border Healthcare Fraud:

Patients	Practitioners
Regulators	Government
Healthcare Providers	Insurance Companies
European Parliament	EHFCN members

And the following groups as being involved in, and sometimes contributing to the problems:

Patients	Practitioners
Organised Crime	Media & Internet
Organ Traffickers	Pharmaceutical and Medical Products Industry
Medical tourism brokers	

For information on how these groups are involved and affected, see the Matrix.

Legal differences and national sovereignty

The CBF working group acknowledges the existence of national sovereignty and is of the opinion that the legal differences this creates between member states is an important and complex fraud risk.

The CBF working group therefore decided to identify the most important obstacles that the member states will encounter once they start to cooperate and share information to prevent, detect and sanction fraud in a cross border context. The most important obstacles are as follows:

- ***Different rules governing healthcare systems.*** Different regulatory systems and inability or reluctance to share information provides opportunities for patients and healthcare providers to commit fraud.
- ***Inconsistent legislation.*** Loopholes in legislation and differences in legislation between member states can result in patients or healthcare providers committing fraud
- ***Variation in privacy regulations and data protection rules.*** Variations in privacy regulations and data protection regimes mean that patient records and other information cannot be shared between healthcare providers, regulatory

bodies, etc. This means that unscrupulous practitioners can cross-borders following disciplinary action in order to escape their past and to continue to practise unsafely. Patients who commit fraud can likewise cross borders knowing that information about the fraud they have committed cannot be shared and therefore they can carry out the same activities in another member state.

- ***Lack of good governance.*** Failure to establish and implement rigorous and robust controls over healthcare provision facilitates fraudulent activity.
- ***Lack of transparency.*** Lack of transparency and the inability or reluctance to share information makes it easier for people to commit fraud. If they can do so without risk of exposure, they will continue to do so, and may commit fraud in more than one member state.
- ***Absence of European penal code or sanctions and redress policy.*** Lack of a European penal code or sanctions ***and redress*** policy enables fraudsters to commit fraud in the member states with the lowest sanctions for certain types of fraud.
- The EU directive on patient mobility concerning cross border health care, could potentially increase the opportunity to commit fraud. This directive was due to be discussed by the European Council on the 12th of October.

4. Development of the “Risk Matrix” (Annex 1)

The CBF working group undertook an exercise in line with the Coso Enterprise Model as set out in section 2 to identify the main issues involved when considering cross border fraud in relation to healthcare.

Step 1

The main types of fraud, the parties involved and the associated risks were identified.

Step 2

Each issue was broken down to consider the main contributing factors and to see which factors would contribute to more than one of the main issues. A total of 26 contributing issues were identified.

Step 3

The identified information formed the basis of the Matrix:

The *Matrix* indicates the occurrence of fraud in a cross border context as a combination between the risk factors and the types of fraud for every party involved and also indicates who bears the responsibility for the occurrence.

Step 4

Behind every cross reference a link was put in place to provide an explanation to facilitate understanding between the type of risk and the type of fraud for the given party.

5. Identifying the weaknesses

In the different countries of EHFCN-members there are mutual risk areas, where per risk area different weaknesses can be pointed out.

We have identified the weaknesses as follows

Bottlenecks/ contributing factors	Description Bottlenecks/ contributing factors
Access to and lack of information	Access to the internet and other sources of information provides patients with options about their healthcare that were previously unavailable. With this information come opportunities to commit fraud. The free movement of patients and practitioners across European borders means that fraud can be committed in more than one member state, possibly simultaneously. Information can also be shared to allow others to also commit fraud, or to do so on an organised basis.
Lack of transparency	Lack of transparency and the inability or reluctance to share information makes it easier for people to commit fraud. If they can do so without risk of exposure, they will continue to do so, and may commit fraud in more than one member state.
Availability or transfer of patient records	When patients cross borders in search of treatment, their records may not be available to the treatment provider. This means that the patient has the opportunity to commit fraud, and may also put themselves in a position to commit prescription or medication abuse, as their information cannot be used by the practitioner to determine the best options for treatment and they are reliant on information provided by the patient, which may not be accurate or complete.
Availability of treatment (too much or too little)	If sufficient treatment options are unavailable in a patient's member state, they may seek treatment in another state, where it is more readily available.
Availability of experimental or unapproved treatment or medication	Differences in approval and regulation regimes result in differential access to certain medications and treatments between states. Patients will cross borders in search of treatment, while practitioners committed to providing experimental or unapproved treatments will seek out the locations where regulation is least rigorous.
Availability of technology	New medical treatments and products are always being developed. Different regulation and governance regimes can

	mean that the availability differs between states and again, both patients and practitioners can cross borders for opportunistic reasons.
Different rules governing healthcare systems	Different regulatory systems and inability or reluctance to share information provides opportunities for patients and healthcare providers to commit fraud.
Different standards (what's acceptable)	See comments on experimental and unapproved treatments above
Diversity of services	See comments on availability of treatment above
Patient compliance	Patient compliance can be a problem if a patient is seeking multiple treatments for the same problem, or is not complying with the requirements of their healthcare provider.
Medical Shopping	Freedom of movement means that patients are more flexible than before in where they can seek treatment. They may do so in more than one member state, and exploit opportunities to commit fraud in doing so. This can include committing identity fraud, or lying about residency in order to obtain treatment to which they would otherwise not be entitled.
Hospitals emphasising economic principles rather than patient care	Emphasising economic issues and targets rather than patient care can alienate patients and result in them seeking treatment elsewhere. They may resort to committing fraud in order to obtain this.
Inconsistent legislation (loopholes)	Loopholes in legislation and differences in legislation between member states can result in patients or healthcare providers committing fraud
Inconsistent accessibility (deprivation)	See comments on availability of treatment above
Inconsistent analysis and identification of anomalies	Lack of analysis, or inconsistent analysis and failure to identify and analyse anomalies can mean that regulators and healthcare providers fail to identify loopholes and opportunities to commit fraud, thereby providing further opportunities for fraudulent activity.
Lack of organ donors	Lack of organ donors in a member state can result in patients seeking treatment elsewhere, to which they may not be entitled. The involvement of organised crime in illegal organ trafficking is also a factor. Practitioners may be tempted to obtain organs illicitly in order to assist patients.
Lack of control over residency	Freedom of movement has enabled patients to cross borders between member states, and internationally, in search of treatment.

Lack of good governance	Failure to establish rigorous and robust controls over healthcare provision facilitates fraudulent activity.
Tolerance of practices unacceptable elsewhere	See comments above
Media interpretation and manipulation of information	The media can influence patient's choices in highlighting the availability, or non-availability of healthcare in various member states. Their manipulation of information and advertising of various procedures and healthcare providers, as well as their highlighting of procedural loopholes can also influence potential fraudsters.
Free movement of patients and practitioners	See comments above.
Exploitation of different systems by multinational companies	Multinational companies including pharmaceutical companies, producers of medical products, and healthcare providers, take advantage of different regimes to provide different services. They then advertise these services in other countries to encourage patients to cross borders to receive these goods and services.
Ignorance	Ignorance of legislation and regulatory requirements can often be used as a reason for commission of fraud.
Over/under prescribing	See comments above
Prescription / medication abuse	See comments above
Variation in privacy regulations	Variations in Data Protection regimes mean that patient records and other information cannot be shared between healthcare providers, regulatory bodies, etc. This means that unscrupulous practitioners can cross-borders following disciplinary action in order to escape their past and to continue to practise unsafely. Patients who commit fraud can likewise cross borders knowing that information about the fraud they have committed cannot be shared and therefore they can carry out the same activities in another member state.

Scope of weaknesses

What is the interest of the involved fraudster(s)?

The various parties involved want to obtain financial gain and an advantage over others (shorter waiting lines, better quality treatment, unlicensed practice...)

The CBF Working Group did its best to formulate a complete list of potential risks. However the list is not definitive and will need to be updated regularly to reflect the latest trends and developments in cross border activity.

6. Risk Response/Possible managing tools

In this section we have looked at the tools available for the prevention, detection and investigation of fraud and the tools available for sanctions and redress.

6.1 General Prevention/Detection/Investigation tools

Proactive information sharing between organisations.

Sharing information and best practice allows organisations to learn from each other, to identify methods of committing and combating fraud, and to obtain and record information about individuals and organisations who have been convicted or who are suspected of committing fraud.

Example: The GMC maintains a database of doctors who have been the subject of disciplinary action by regulators in other countries, as there is a possibility that these individuals may seek to obtain registration in the UK.

Identification checking and credentialing

Identity fraud is a growing problem everywhere, and can be facilitated by poor or non-existent identity checking. By insisting on the use and careful checking of identification documents, organisations can reduce the instance of identity fraud.

In employment or regulatory situations, credential checking is also important. Checking of qualifications and employment history should be supported by rigorous verification procedures, rather than relying on documentation alone.

It should be noted however that rigorous identity and credential checking should take account of the requirements of European legislation, so that an individual's right to freedom of movement is not impeded.

Example: The BIG Register in the Netherlands holding details of all the healthcare professionals practicing in the country. Before being registered thorough identity checks are being performed.

Awareness campaigns

The EHFCN and a number of member organisations run a variety of events during the annual fraud awareness month. These aim to highlight awareness of fraud, by bringing examples of fraud into the public arena, by publicising the effects of fraud and corruption on the services available, and by encouraging members of the public to report fraud and corruption when they become aware of it, so that the opportunities to commit fraud and corruption can be minimised and eliminated where possible.

Publicizing high profile fraud cases (“naming and shaming”)

In cases where the Data Protection legislation allows, organisations can publish and publicize the cases they deal with. This will highlight awareness of these cases among the public, and act as a warning to potential fraudsters that their actions may lead to unwelcome publicity.

Example: the General Medical Council publicizes all of its disciplinary decisions, including those related to fraud, by circulating details of the decisions to other regulatory bodies both within Europe and overseas. By sharing information in this way the GMC seeks to reduce the opportunities for these individuals to commit fraud elsewhere.

Data mining/matching

Where information can be shared, it can be used for analysis, to assess the incidence of fraud, to identify trends and patterns.

Example: Zorg en Zekerheid (the Netherlands) has successfully implemented a data mining solution in order to detect *possible* fraud. They use a variety of ‘undirected data mining’ techniques. Undirected means that there is no preset target. By modelling the data in different shapes outliers or striking behaviour becomes visible. Some examples of the techniques they’re using are anomaly detection, regression models, Kohonen models and heat-mapping. Recently they detected a dentist with a suspicious behaviour; he claimed several sealing treatments for his patients. Since you can have one sealing for each molar, the maximum number of sealings is sixteen for a person. The specific dentist claimed on different occasions more than fifty sealings for each patient.

Bilateral agreements

Member organisations are involved in setting up bilateral agreements to share information. This enables them to analyse trends and patterns, to identify cross-border offenders and to share best practice in countering fraud.

Example: A new bilateral agreement has been established between CNAMTS (France) and INAMI (Belgium) giving the organisations the rights to proactively share information and to pursue fraudsters across their national borders.

Comparison of anomalies

This allows organisations to compare information, to identify outliers and incompatibilities and to direct their investigative efforts accordingly.

Example: The UK National Fraud Initiative includes a data matching exercise to identify incompatible data which can be used in an investigation against fraudsters.

Monitoring and auditing cross border expenses

Monitoring cross-border expenses will yield information about who is crossing borders in search of healthcare or providing healthcare services, where they are going, what procedures or treatments they are having or providing. This can be used to assess the incidence of fraud, to identify loopholes in legislation or policy that enable fraud to be committed, and to put counter fraud initiatives in place which specifically tackle cross-border fraud.

Auditing these expenses will yield comparative information which can be used to assess where and when fraud is being committed, and will facilitate the development of counter fraud initiatives.

Example: The Belgian sick funds perform checks and audits on cross border expenses in order to detect or avoid fraudulent billings.

Influencing processes and control mechanisms

Organisations dealing with fraud need to be active, not just within their own sector, but also on a higher level relating to legislation and policy in relation to issues such as cross border travel, freedom of movement, and the right to obtain healthcare outside a patient's home state. This can also affect measures to counter fraud.

Example: The GMC has recently been liaising with the UK Department of Health in relation to a European Directive (2005/36/EC) code of conduct which appeared to suggest that it could no longer carry out identity checks on EU applicants.

6.2. Methods of sanction and redress

Individual sanctioning in relation to cross border fraud needs to be considered. Opportunities may exist for investigating the possibilities of mutual sanctioning on a European level. This could involve an international register or index of known fraudsters. However there are many variations in data protection legislation in different member states, and this could influence the ability of some organisations to participate in initiatives of this nature.

Possible sanctions could include:

- Oral/Written Warnings;
- Termination of contracts;
- Repayment of amounts defrauded;
- Financial penalties;
- Publication of the cases including the names of individuals/companies involved;
- Civil and/or criminal proceedings;
- Referral to regulatory bodies; and,
- Maintaining a database of known and high risk offenders (for example, EVR in the Netherlands)

7. Conclusions

It is clear that cross border healthcare fraud involves a large number of complex contributing factors. These are often difficult to define and hard to detect.

Where some factors relate to cultural and economical differences between member states (i.e. informal payments or involvement of organized crime in real estate projects) others can be the result of legal ambiguity and uncertainty or the lack of information and transparency (tariff-setting), opportunistically “exploited” by both patients and providers.

When financial incentives are the “primum movens” for purchaser as well as provider, medical tourism will be established for share lucrative purposes, eventually leading to fraud and corruption.

Where patients crossing borders can be the victim of fraudulent healthcare providers in a foreign member state, these problems may also be exported by those providers when they start up a practice in another member state. Lack of effective communication between involved parties and relevant authorities will contribute to the continuation of these problems.

This Risk Analysis is a first attempt to list contributing factors and to suggest appropriate measures.

What are the first conclusions?

First conclusions on the matrix

All conclusions for now are by definition premature because of the fact the matrix has had at this stage input only from Belgium, The Netherlands, and the UK. As the matrix will get enriched with the feedback from the other member countries, the conclusions that can be drawn from it will be more relevant in a European context, will show differences between member countries, and will most definitely clearly show the most important fields for the network to work on.

Looking at occurrence

Working on this section it immediately struck us that, although we all know the risk of fraud is high, it is hard to fill in actual examples. To complete this section we absolutely need the collaboration of all members. The sharing of information on actual cases is necessary. If we want to tackle the problem, prevent it from happening again, we first need to understand what is going on, and examine how this was possible. Studying the cases we must look for the weaknesses in our systems, the loopholes in regulations, in order to come up with appropriate counter actions.

Looking at responsibility

Logically we cannot put responsibility with practitioners or industry for patients who try to get reimbursed for more than they are entitled, just as patients generally do not bare responsibility for practitioners overbilling.

There is however one situation in which both can be present, which is when over claiming and overbilling coincide: when practitioner and patient work together in an effort to illegally drain money from the social security system. This is possible when organised crime is involved (setting up carrousels), and for practitioners/industry with weaker morals, thinking the system can easily deal with a little 'deviation' from time to time. It's all these little 'exceptions' put together that we have to bare in mind; they constitute a huge amount of money, posing a real threat to the weak within society in desperate need of good and affordable healthcare.

Looking at cross border fraud on a time line, everyone will agree the occurrence is rising as the line on a Gauss curve. The media and the internet, the youngest players in the healthcare field, most certainly play a large role in this. More than ever before information on healthcare abroad is available to the public and has become a big market. This publicity added to the increased mobility of the public in general, is being discovered in the healthcare sector. The proportion, to which this market has grown, has increased the risk of fraud and corruption accordingly.

Looking at the matrix it quickly becomes obvious all parties involved in healthcare bare responsibility in a lot of cases, which could be read backwards as the risk for fraud in healthcare is ever present and must be considered high.

Recommendations

Reading the explanations of the links between the contributing factor and the types of fraud shows that in most cases fraud in a cross border context is happening as a result of people abusing the lack of transparency and information exchange between MS. As a network this is where we can have a big added value, this is where we can help each other. We must offer a maximum of transparency to each other. How can we do this? We have an internet site, and we have all modern communication facilities, but we still need to develop a communication strategy that we must invest large amounts of money in.

8. The way forward

The CBF working group is encouraged by some recent developments including:

- The contribution of the EHFCN to the Council of Europe to their “Draft Recommendations on Good Governance in health systems” has been accepted, regarding explicit mentioning of the words “fraud” and “integrity”.
- The European Commission announced on the 9th of July its support of the Dutch initiative to create a European black list for fraudsters.

However there is much work still to be done to determine the appropriate response required to the risks set out in the Matrix.

Further detailed analysis is required to identify all significant factors. This will require the active involvement of all EHFCN members.

To achieve this we plan the following:

- organising workshops to get input from other EHFCN members (Jan-Lisbon)
- consolidation of the output of the workshops (identify priorities, etc) (Feb/March)
- publication and presentation of the findings in a report (June)
- identify priorities for action (implement recommendations in short, medium and long term)
- coordinate action

Organisations involved in CBF Working Group Risk-analysis:

Zorgverzekeraars Nederland



General
Medical
Council

