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RESEARCH STUDY

THE CATALYSTS OF HEALTH CARE FRAUD:

AN INVESTIGATIVE STUDY INTO THE MOTIVATIONS THAT CONTRIBUTE TO DEFRAUDING HEALTH SYSTEMS WORLDWIDE

It is commonly assumed that healthcare professionals who commit fraud are fundamentally motivated by economic imperatives and career goals. This research article will examine this assumption in greater depth. It shows that healthcare fraud is a staple form of white-collar crime committed by powerful and privileged actors against weak and vulnerable health systems.

ABSTRACT

Healthcare fraud constitutes a significant source of economic waste which affects healthcare systems across the world. Despite increased awareness of the problem and the application of sophisticated anti-fraud mechanisms, individual actors and agencies continue to defraud public health systems, leading to fewer health resources for patients and higher premiums for consumers. It is commonly assumed that healthcare professionals who commit fraud are fundamentally motivated by economic imperatives and career goals.

This research article will examine this assumption in greater depth. It shows that healthcare fraud is a staple form of white-collar crime committed by powerful and privileged actors against weak and vulnerable health systems. Nevertheless, ethical justifications for health fraud persistent. Greater emphasis must be placed upon understanding how organisational pressures shape the actions and decisions of practitioners.

Keywords: ‘Healthcare fraud’, ‘white collar crime’, ‘strain theory’, ‘healthcare ethics’ and ‘managed care’.

INTRODUCTION

In most advanced economies, the healthcare sector accounts for anything between 8 and 15% of GDP (Smith and Walshe, 2011).

In the United Kingdom, the government spends approximately £109 billion on healthcare provision while the European Union allocates up to 1 trillion Euros on healthcare (Gee, Buttons and Brooks, 2009).

With a rapidly ageing population and the increased costs of providing long-term care placing substantial pressure upon already overburdened health and social care sectors; it is anticipated that healthcare spending may soon account for a fifth of the national economy in developed world countries (Appleby, 2013).

Furthermore, falling mortality rates and rising life expectancies across, coupled with the proliferation of communicable diseases such as HIV/AIDS, telegraphs an impending healthcare financing crisis for many developing world governments (Mirzoev and Morgan, 2015).

Then, across the world, states are confronted with a myriad of problems that undermine the fiscal viability of their healthcare systems in an unforgiving macroeconomic climate of deficit and debt (Smith and Walshe, 2011). In such a context, healthcare systems can ill afford to haemorrhage additional costs through corruption, fraud and other criminal acts (Brooks, Button and Gee, 2012).

Nevertheless, quantitative data indicates that healthcare fraud has risen starkly. Cross-country research undertaken by the **World Health Organisation (WHO) estimates** that, where losses have been measured and the types of health expenditure have been covered, **the average annual cost of fraud totals 7.29 % of healthcare budgets** (Gee and Button, 2014). As a result, up to **£160 billion is likely lost every year through fraudulent activity** (Gee, Button and Brooks, 2011). This constitutes over two times the value of the annual budget allocated to the NHS and more than the entire GDP of all but 29 of the world's 190 countries (Gee et al., 2011).

UK SPENDS APPROXIMATELY £109 BILLION ON HEALTHCARE PROVISION

MAJOR PHARMA CONDUCTS DUE DILIGENCE INVESTIGATION: LESSONS LEARNED: UNETHICAL PRACTICES, CONFLICT OF INTEREST, BRIBERY, AND CORRUPTION DISCOVERED AMONG A RANGE OF EMPLOYEES AT MAJOR PHARMA COMPANY, EVEN THE CFO WAS ON THE TAKE

A major pharmaceutical company engaged CRI Group to conduct an integrity due diligence and conflict of interest investigation.

The focus of the action was to uncover unethical practices, including bribery and corruption, by senior employees. The client's corporate security department had received conflict of interest complaints that reportedly involved a range of employees, from sales personnel on up to the chief financial officer (CFO). This ebook examines the following:

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An empirical analysis of 33 healthcare organisations in six countries (the UK, the Netherlands, France, Belgium, New Zealand and the United States) between 1998 and 2009 finds that the range of percentage losses (PLR) to **fraud across is between 3.29 and 10% of total revenue costs with average fraud rates of between 3 and 8%** (Brooks et al., 2012). Consequently, conservative **estimates predict that healthcare organisations are likely to lose as much as 10% of their total costs to fraudulent activity** (Miller, 2013a). However, it is imperative to recognise the methodological limitations of quantitative research on health fraud. Two issues are apparent.

Firstly, in most advanced economies, healthcare fraud is assessed through a patchwork of independent public institutions and private sector security firms (Button, 2011).

In the UK, for instance, the National Fraud Authority (NFA) works with the NHS, and other public and private bodies to ascertain the extent of fraudulent activity through fraud loss risk measurement exercises (Brooks et al., 2012). However, as Button and Gee (2014) assert, public institutions can only factor in losses that have been detected or cases that have led to criminal prosecution.

Given that fraud is, by its nature, an act of concealment, it is estimated that institutions and organisations are only able to account for a small fraction (approximately 1/30th) of the actual level of fraudulent activity (Button and Gee, 2014).

According to Kesselheim, Studdert and Mello (2010), **90% of healthcare fraud cases are uncovered through whistleblowers' actions.** Moreover, as Brooks et al. (2012) remark, many organisations choose not to disclose fraud cases, preferring instead to deal with the issue in-house.

Thus, official estimates of the prevalence and pattern of healthcare fraud represent, at best, an educated estimate of the actual levels of victimisation (Piper, 2016).

The situation is even more complex in many developing world countries where a lack of robust and independent institutions, coupled with weak and/or ineffectual judiciaries, renders it extremely difficult to gauge the extent of fraudulent activity which takes place in the healthcare sector (Carrin, 2011).

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Secondly, while fraud is best defined as an intentional deception made by a person or entity for profit or personal gain, complexities concerning the definition of fraud have made it exceedingly difficult to measure losses accrued through fraudulent activity (Brooks et al., 2012).

It is particularly difficult to locate the boundaries segregating fraud from related offences such as unrecorded losses, corruption, negligence, and financial abuse (Benson and Simpson, 2009). Consequently, fraud control performance indicators are conceptually ambiguous and can often yield misleading results (Button and Gee, 2014). For this reason, this study will look beyond the economic costs of defrauding healthcare systems to undertake a qualitative analysis of the motivations for healthcare fraud.

The study will concentrate upon the actors and agencies involved in healthcare systems rather than fraud committed by health consumers. This study will analyse healthcare fraud from the perspective of general strain theory to ascertain the extent to which healthcare fraud can be understood as a staple form of white-collar crime.

90% OF HEALTHCARE FRAUD CASES ARE UNCOVERED THROUGH WHISTLEBLOWERS' ACTIONS.

GENERAL STRAIN THEORY & WHITE-COLLAR CRIME

Several Strain theories were developed during the first half of the twentieth century to explain higher crime rates amongst people in the lower socioeconomic classes (Agnew, Leeper Piquero and Cullen, 2009). Merton's seminal strain theory, for example, outlined the paradoxical relationship between, on the one hand, widely accepted cultural goals and, on the other hand, the institutional barriers which prevent people from attaining those goals (Merton, 1938; 1968).

In a capitalist system, the primary goal for any individual is economic gain. Consequently, Merton (1938; 1968) argued that some people who are denied the opportunity to acquire economic gain through legitimate means will be motivated to attain money, status and power through illegitimate measures. Understood in this way, the strain which is generated through 'goal blockage' increases the likelihood of negative emotions such as anger and frustration which, in turn, creates pressure for corrective action of which criminal and illicit activity is one possible option (Agnew, 2001; Agnew et al., 2009).

General strain theory is an immensely valuable prism through which to view the behaviour and motivations of people who commit what is traditionally known as white-collar crimes. These crimes are committed by actors placed in considerable power, influence, and trust in the legitimate political and economic order (Benson and Simpson, 2009).

Although it was not a key feature of his research, Merton acknowledged that, due to the hierarchical nature of capitalist social and economic structures, people of wealth, power and status would also be susceptible to the strain generated through goal blockages. As a result, be motivated to engage in criminal activity as a means of realising goals that would otherwise be beyond their reach (Agnew, 2001).

There has been a plethora of theoretical research in the contemporary era, which has argued that white-collar crime, of which fraud is commonly perceived to be a sub-category. Is fundamentally a question of rational choice with individual actors and organisations seeking to attain economic and cultural goals through illicit means (Braithwaite, 1991; McBarnet, 1991; Agnew, 1992; Wheeler, 1994; Croall, 2001; Doig, 2006; Smith et al., 2010; Nelken, 2012).

Consequently, examining the motivations for health fraud from the perspective of general strain theory will reveal the extent to which fraudulent activity is:

1. determined by goal blockages; and
2. reflective of the 'crimes of the powerful' (Smith, Button, Johnston and Frimpong, 2010).

PRACTITIONER FRAUD

Physicians' decisions concerning what services to offer healthcare consumers account for a sizeable majority (over 80%) of all healthcare expenditure (Wynia, Cummins, Van Geest and Wilson, 2000). As a result, practitioner fraud represents the front-line of the defrauding of healthcare systems (Jung, Lurie and Wolfe, 2006).

Data analysis of physicians who have been convicted of fraud in the United States estimates that the total amount of fraud for each convicted physician amounts to US$1.4 million (Pande and Maas, 2013).

The literature indicates that there are a variety of ways in which practitioners can defraud healthcare systems. Typically, practitioners will either deliberately misdiagnose patients' conditions or attempt to deceive healthcare providers by falsifying records and medical data (Wynia et al., 2000).

In both cases, though, it is almost always third-party insurers and healthcare providers who target physicians' fraudulent activity. For instance, of 730 fraud-related physician convictions examined by Jung et al. (2006), focused upon exploiting weaknesses within the health system rather than the consumer.

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The primary aim of this study was to conduct investigative research into two recent case studies in order to demonstrate effective and adequate applications of Anti-Corruption procedures based upon specific case-level outcomes. Over the course of this exploratory research, the following core objectives have been accomplished:

- To compare and analyse the spectrum of regulatory instruments and corporate compliance standards in order to establish the comparative basis for Anti-Corruption policies and practices;
- To assess the specific cases of Airbus and Rolls-Royce to outline rules-based violations and identify compliance instruments for mitigating future replication; and
- To propose a combination institutional solution for managing and monitoring corporate compliance to prevent bribery and corruption in modern enterprise.

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MISDIAGNOSING THE HEALTHCARE CONSUMER: LINE JUMPING, PHYSICIAN-INDUCED DEMAND & UPCODING

The deliberate misdiagnosis of patients' conditions represents a high proportion of fraudulent activity (Wynia et al., 2000; Werner, Alexander, Fagerlin and Ubel, 2002; Jung et al., 2006). For instance, Mattei (2016) examines high-profile instances of fraud in organ transplant procedures in the United States.

The organ transplant market is a highly lucrative business. Not only are organ transplant surgeries extremely expensive, the costs of care before and after surgery are also very high (Folland, Goodman and Stano, 2016).

As Mattei (2016) asserts, over the past three decades, there has been a large spike in the offence of 'line jumping' where patients are fraudulently moved up waiting lists to receive organ transplants sooner than they would otherwise expect.

In 1999, for example, surgeons working in three hospitals in Chicago were accused of falsifying the diagnosis of dozens of patients to push them higher up the waiting list (Mattei, 2016).

The whistleblower who brought the fraudulent activity to light, Doctor Raymond Pollack, underlined the extent to which physicians' behaviour was motivated by the prospect of economic profit.

COMMON FRAUD IN THE PHARMACEUTICAL INDUSTRY REPORTED BY WHISTLEBLOWERS

Pharmaceutical fraud involves activities that result in false claims to insurers or programs such as Medicare in the US or equivalent state programs for financial gain to a pharmaceutical company. There are several different schemes used to defraud the health care system which are particular to the pharmaceutical industry. Explore the most common types of pharmaceutical industry fraud reported by whistleblowers...

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Doctor Pollack noted that: ***"Transplant programmes are extraordinarily expensive to run but can be extraordinarily profitable if they're run efficiently ... so the more patients you transplant, the more referrals you get, the more revenues you get. Volume drives the business"*** **(Mattei, 2016, p.159).**

As a result, there can be little doubt that the deliberate misdiagnosis of patients' conditions is motivated primarily by the desire to accrue capital wealth and attain career goals by bringing in a high volume of complex medical procedures (Harris and Slater, 2015).

The systematic manipulation of organ donor waiting lists has also been uncovered in Germany. A nationwide criminal investigation has revealed over one hundred cases of doctors falsifying the severity of patients' illness to move them higher up organ transplant waiting lists (Connolly, 2013).

Moreover, in India and Nepal, physicians have been involved in kidney transplant rackets, falsifying patients' diagnosis to benefit from line jumping and deceive poor patients into selling their kidneys for sale on the illicit international organ market (Ghosh, 2016). In this sense, doctors and physicians' fraudulent activity within a market where the demand for human organs far outstrips donors' supply, thus raising the costs of surgery and the price allocated to organs (Mendoza, 2010)—further reinforcing the economic imperatives which underpin healthcare fraud (Zweifel, 2013).
It is not only in the context of organ transplants, where physicians have been found to have deliberately misled patients.

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As Leap (2011) details, in 2009, a Florida dermatologist was sentenced to 22 years in prison and ordered to pay US$3.7 million after performing 3, 086 unnecessary surgical procedures.

Between 1998 and 2004, the dermatologist used fake biopsy results to generate fake diagnoses of skin cancer. The physician used various methods to falsify cancer claims, including placing chewing gum, pieces of Styrofoam or skin tissue from employees on slides, enabling the physician to perform five unnecessary surgeries per day at the cost of between US$1500 and US$2000 per procedure (Leap, 2011).

Furthermore, Noguchi, Shimizutani and Masuda (2008) examined quantitative data from the Tokai Acute Myocardial Study (TAMIS) study in Japan in a bid to account for regional variations in medical expenditure, and the duration of hospital

stays for patients who had experienced heart attacks.

Noguchi et al. (2008) found that the probability of receiving percutaneous transluminal coronary angioplasty (PTCA) for the treatment of acute myocardial infarction (AMI) - a highly expensive procedure for patients recovering from cardiac arrest - is primarily affected by the density of medical resources. Rather than rates of cardiovascular disease and diagnoses of illness. Furthermore, Noguchi et al. (2008) found that while healthcare expenditure is higher for treated patients, there were no substantial differences in the number of hospitalisation days for patients, thus indicating that the frequent use of PTCA is primarily motivated by economic interests.

A panel-study of French physicians' diagnostic behaviour has uncovered a similar trend of physician-induced demand in the sale of medical goods in the French healthcare market (Delattre and Dormont, 2003). Understood in this way, there can be little doubt that a desire to increase personal wealth acts as a powerful force motivating physicians' deliberate misdiagnosis of patients' conditions (Leap, 2011).

Similar motives for fraud have been found in mental healthcare. Mental health creates fertile grounds for fraudulent activity through deliberate misdiagnosis. Unlike physical health conditions where external symptoms limit physicians' capacity for creative diagnosis, mental health problems are inherently subjective (Singh and Rajput, 2006; Webber, 2011; Glasby and Tew, 2015). In many cases of anxiety, social phobias, mood disorders and depression, the diagnosis of a mental health disorder is entirely dependent upon

1. the patient's articulation of their condition; and
2. the counsellor's ability to interpret symptoms (Wood and Townsend, 2012).

In most western countries, the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) is the most viable means of ascertaining a patient's mental health condition (Rappo, 2002).

Health insurers use DSM classifications to determine health coverage criteria, the extent and the duration of treatment, and treatment outcomes (Rappo, 2002). Patients whose conditions are not covered by their health plans must pay through out-of-pocket expenses: an option was infrequently available to patients with severe and destabilising mental health conditions (Braun and Cox, 2005).

In response to the constraints imposed by managed mental health markets, psychologists and physicians may be motivated to 'upcode' the mental health diagnosis so that the patient can receive treatment via their existing health plan (Danzinger and Welfel, 2001; Braun and Cox, 2005). This not only enables the patient to acquire professional help for their condition, but it also enables the practitioner to bill the healthcare provider for a more expensive service that would otherwise not have been performed (Mead, Hohenshil and Singh, 1997).

For this reason, the upcoding of patients' mental health conditions has been described in terms of "diagnosing for dollars" (Wylie, 1995, p.22), yielding a culture where cost is privileged over the care and the patient-therapist relationship triumphs over ethical and professional codes of conduct.

A CULTURE WHERE COST IS PRIVILEGED OVER THE CARE & THE PATIENT-THERAPIST RELATIONSHIP TRIUMPHS OVER ETHICAL & PROFESSIONAL CODES OF CONDUCT.

FALSIFYING COSTS: PHANTOM BILLING, FEE-SPLITTING & KICKBACKS

In addition to deliberately misdiagnosing patients, practitioners may attempt to defraud health systems through falsifying costs. As Pande and Maas (2013) reveal, this is a problem which is particularly acute in the public sector. Most private insurers employ sophisticated databases and algorithms to detect fraudulent activity cases. However, public sector organisations have much weaker fraudulent activity detection capacity. Increasing the incentive for fraud and other illicit activities, particularly for opportunists (Friedrichs, 2002).

Besides, unlike private sector organisations, public sector healthcare organisations tend to pay out on all claims first and only attempt to recover fraudulent claims after an alleged fraud has been uncovered (Pande and Mass, 2013). Furthermore, as Hall and Schneider (2008) detail, the perverse 'sliding rule' scales introduced through managed care markets increase the financial incentives for physicians to make fraudulent claims against public healthcare providers.

The introduction of performance pay (or 'payment by results') contracts has also significantly increased the incentives for falsifying records and data to increase remuneration (Eijkenaar, 2013). Manifested most commonly in the form of 'phantom billing'. As Rashidian, Joudaki and Vian (2012) assert, phantom billing can occur in a variety of ways, including:

- invoicing insurance providers for service never provided
- fabricating claims to third party payers
- issuing fake prescriptions
- falsifying medical certificates and plans of treatment
- performing uncovered services but billing medical insurance companies for other services covered under the patient's health policy

'Exploding' charges (where physicians charge separately for procedures that should be billed as part of a single healthcare package)

Phantom billing can vary from relatively mundane acts of fraud committed by physicians in their family practices to systemic fraudulent activities committed by medical teams at the organisational level. For instance, Pande and Maas (2013) note that a common fraud involves illegal payments to physicians in return for them providing fraudulent letters of medical necessity (such as wheelchairs).

At the other end of the spectrum, Miller (2013b) reveals that, in October 2012, 91 healthcare professionals in seven cities across America were charged for a fraud scheme.

The fraud scheme involved US$432 million in phantom billing, including more than US$230 million in-home healthcare fraud, US$100 million in community mental healthcare fraud and $49 million in ambulance transportation fraud. Similarly, Pyrek (2011) reveals that, in 2009, the Medicaid Inspector General's Office (OMIG) and the Centres for Medicaid and Medicaid Services (CMS) uncovered 290 physician claims for patients who had already registered as deceased (Pyrek, 2011).

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CRI Group (parent brand of ABAC) has conducted an empirical review of international laws and conventions; professional association codes; and individual company Anti-Bribery and Anti-Corruption policies, as well as conducting in-depth interviews with ABAC and Life Sciences legal professionals, in order to validate the efficacy of existing measures, and to identify gaps in good practice and enforcement.
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In one case, a major teaching hospital received the body of a dead patient to harvest organs for transplant and billed Medicaid “as though they were treating the live patient” (Pyrek, 2011, p.91).

Research into healthcare fraud also outlines the detrimental impact of ‘fee-splitting’ practices. Fee-splitting occurs when “a physician receives compensation for professional services and then divides or shares it with a person or party who did not render the service” (Miller, 2009, p.387).

Fee-splitting thus represents a form of financial ‘kickback’ in which medical professionals accrue financial gains from moving patients to other institutions within the healthcare system (Rashidian et al., 2012).

Fee-splitting is also synonymous with self-referral: the practice of physicians referring patients to clinics with which the doctor has a pre-existing financial relationship (Anyanwu, Harrison and Onohwakpor, 2015). As is the case with phantom billing, in cases of fee-splitting and self-referrals, physicians’ decisions are motivated primarily by economic imperatives with little emphasis upon the healthcare needs of the patient or their family (Rashidian et al., 2012).

In a quantitative analysis of the offenders characteristics (offenders who have been convicted of defrauding the public healthcare system) in the United States, Pande and Maas (2013) reveal that the majority of practitioners who commit fraud against public health authorities are male (87%), older (aged 58 on average) and are international medical graduates (59%). Pande and Maas (2013) also reveal that family practitioners and psychiatrists are over-represented in samples of convicted medical professionals. These findings are corroborated by Harris and Slater (2015).

In an empirical analysis of cases where doctors have been removed or suspended from the General Medical Council (GMC) in Britain, Harris and

Slater (2015) find that males represent a disproportionate number (82%) of doctors erased or suspended from the GMC and that cases are more likely to involve doctors who have qualified overseas (69%) than doctors who have qualified in the UK (31%).

These findings raise several potential explanations for practitioner fraud. For instance, Pande and Maas (2013) hypothesise that the reasons why older physicians are more likely to commit fraud are because doctors who have worked in the healthcare sector for many years may become more cynical and jaded as a result of their interactions with medical bureaucracies.

It can also be assumed that the high proportion of male family practitioners indicates that physicians manipulate their position of trust within the community as a means of committing healthcare fraud (Harris and Slater, 2015). This also suggests that stereotypical gender norms continue to perform a crucial role in shaping public and practitioner perceptions of general practitioners (Adams, 2010).

Where male doctors face pressure to behave in typical masculine ways, female practitioners are conditioned to adopt orthodox feminine behaviour traits and uphold societal values of the caring healthcare professional (Fealy, 2004). It is also prudent to question whether the disproportionately high number of overseas doctors who have committed criminal offences against public healthcare systems results from their lack of knowledge about legal safeguards or a greater propensity for role confusion (Miller, 2013b).

ETHICAL JUSTIFICATIONS FOR HEALTHCARE FRAUD

Empirical research undertaken with healthcare practitioners has challenged the assumption that health systems' defrauding is always motivated by personal profit and the realisation of careerist goals.

For instance, Novack et al. (1989) sent 211 practising physicians four vignettes designed to ascertain the extent to which participants would be willing to engage in deception.

Novack et al. (1989) found that most participants were willing to misrepresent a screening test as a diagnostic test to secure an insurance payment for a sick patient. It should be noted, though, that in Novack et al.'s study, physician deception was motivated by the patient's health needs rather than financial gain. Likewise, Freeman, Rathore, Weinfurt, Schulman and Sulmasy (1999) undertook qualitative research with a sample of 169 physicians to determine participants' willingness to deceive third-party payers.

Freeman et al. (1999) sent a cross-sectional survey to each of the participants incorporating six vignettes of varying degrees of clinical severity. **The results indicated that physicians would be willing to mislead third party suppliers to secure coronary bypass surgery (57.7%), arterial revascularisation (56.2%), intravenous pain medication and nutrition (47. %), screening mammography (34.8%) and emergent psychiatric referrals (32.1%).**

Crucially, **only 2.5% of participants indicated a willingness to deceive third-party payers to secure cosmetic rhinoplasty surgery** (Freeman et al., 1999). This indicates that the patient's wellbeing, rather than financial gain, underpins practitioners' willingness to deceive third-party payers. The results from this study and Novack et al. (1989) therefore reflect an underlying tension between the traditional ethics of patient advocacy and the doctrine of cost control which restricts physicians' choices in tightly controlled healthcare markets (Freeman et al., 1999).

Novack et al.'s and Freeman et al.'s study findings have been replicated in subsequent research studies. Bogardus, Geist and Bradley (2004), for instance, also found that many physicians are willing to deliberately deceive third party suppliers to secure care for patients.

Bogardus et al. (2004) found that the likelihood of physicians fraudulently diagnosing their patients' conditions increases when illnesses are severe, and appeals procedures are cumbersome. In a random sample of 1617 physicians, Werner et al. (2002) also note that some medical professionals are willing to engage in

deception tactics to circumvent complex appeals processes which may deny patients access to vital care. According to Werner et al. (2002), the propensity for fraudulent diagnosis increases in tandem with the appeals process's complexity. The same pressures to engage in deceptive practices are prevalent in mental healthcare. For example, Rost, Smith, Mathews and Guise (1994) undertook a cross-sectional mail survey with 442 physicians to ascertain practitioners' willingness to deliberate substitute diagnostic codes so that patients could receive treatment through their health plans. Rost et al. (1994) found that **over half (50.3%) of practitioners had admitted to deliberately altering patients' codes as a means of circumventing inequitable health policies.** This is particularly prevalent in cases where patients presented symptoms of major depression (Rost et al., 1994).

Cohen, Marecek and Gillham (2006) uncover similar findings in semi-structured interviews with a sample group of psychotherapists. In particular, Cohen et al. (2006) found that working within managed care environments places pressure upon practitioners to violate standards of care and professional ethics to place the patient's needs at the centre of care. Braun and Cox (2005) report similar experiences of mental health professionals with **a large proportion (47%) of licensed counsellors reporting that managed care to undermine their capacity to meet their clients' needs.**

As in other research studies, Braun and Cox (2005) note that mental health professionals are willing to deceive third-party payers to improve outcomes for patients. In each of these studies, the fraudulent misrepresentors and counsellors were perceived to be the result of structural constraints within the healthcare system rather than a desire to increase capital wealth or attain career goals. Viewed from this perspective, it is apparent that "the motivation to defraud can be heterogeneous rather than a single phenomenon" (Levi, 2008a, p.394).

Physicians' attitudes towards costs and malpractice are not always motivated by the economic gain (Goold, Hofer, Zimmerman and Hayward, 1994).

It should also be noted that qualitative research with members of the public indicates substantial support for fraudulent practices so long as those practices are undertaken for the benefit of patients.

Alexander, Werner, Fagerlin and Ubel (2003), for instance, undertook a cross-sectional survey of over 700 prospective jurors in Philadelphia to assess public attitudes towards physicians' deception of insurance companies. Alexander et al. (2003) found that 26% of participants favoured deception, while 70% supported physicians who appealed cost management decisions. Meanwhile, only 4% of participants supported accepting insurance companies' decisions without any form of appeal (Alexander et al., 2003).

In a follow-up survey of over 700 prospective jurors and 1617 physicians, Werner, Alexander, Fagerlin and Ubel (2004) found that 26% of the public sanctioned deception (compared with 11% of practitioners) while 59% felt that the appeals process undermined practitioners' capacity to make informed decisions. As a result, it can be argued that physicians who deliberately deceive third-party payers are motivated by the needs and wishes of their patients over and above financial interests.

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HEALTHCARE FRAUD IN DEVELOPING COUNTRIES

Although it is impossible to accurately gauge the extent and the financial cost of fraudulent practices across the developing world, it is estimated that over 80% of the population of lesser developed countries (LDCs) have experienced some form of corruption and fraud in the public healthcare sector (Holmberg and Rothstein, 2011).

In many cases, health fraud in the developing world mirrors that in advanced economies. For instance, research was undertaken into healthcare fraud in the Kingdom of Saudi Arabia (KSA) demonstrates the extent to which fraud is inextricably linked with economic modernisation and the reform of the public healthcare system.

As Khaliq (2012) details, at the beginning of the twenty-first century, the Ministry of Health (2008) has overseen a period of far-reaching reform in a bid to reduce the economic burden of universal healthcare in the country.

Reform has involved the introduction of private sector organisations in the building and designing public hospitals, clinics, dispensaries, pharmacies, medical laboratories and other primary healthcare centres (Albejaidi, 2010). Furthermore, the public healthcare system's reform has witnessed the introduction of fee-based services for foreign nationals, thus necessitating the rollout of health insurance for private-sector employees (Almaki, Fitzgerald and Clark, 2011).

This has increased insurance fraud prospects in the private healthcare system (Malik and Niblock, 2005; Khaliq, 2012). It is estimated that private health insurance companies in **KSA are losing up to US$320 per year as a result of healthcare fraud (approximately 15% of the Saudi health budget)** (Willis, Towers and Watson, 2014).

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The primary causes of health insurance fraud in KSA are fraudulent claims by physicians, and hospitals misusing insurance holders' identities (Barakah and Alsaleh, 2011). Similar patterns of healthcare fraud have been reported across the Persian Gulf. **In the UAE, for example, it is estimated that up to 5% of all healthcare claims are fraudulent** (Willis, Towers and Watson, 2014).

The rapid deregulation of financial services, coupled with a lack of institutional oversight,

have been cited as factors which have facilitated large-scale health fraud across the Persian Gulf (Malik and Niblock, 2005). Economic imperatives thus shaper the motives for healthcare in the developing world, with unscrupulous actors and organisations seeking to profit from developing countries' transition to modern, quasi-private healthcare systems (May, 2016).

Research from China reveals the prevalence of serious academic fraud and intellectual property theft in the healthcare sector. Over the past two decades, there have been hundreds of reported cases of academics stealing other researchers' work and passing off the results as their own (Lin, 2013).

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As Qiu (2010) argues, the proliferation of serious academic fraud in China is associated with Chinese universities and medical institutions offering cash prizes, housing benefits and other financial incentives to publish medical journals. In this sense, fraud is clearly motivated by the desire to accrue economic wealth and attain career goals (Qiu, 2010).

However, it is crucial to recognise that fraudulent healthcare practices extend much deeper than insurance fraud, academic fraud, and price-fixing across most developed worlds. In many LDCs, healthcare fraud is inseparable from endemic political corruption, and the bribery of health officials, healthcare regulators and public officials (May 2016).

In Cambodia, for instance, it is estimated that 5% of the public health budget is lost every year to fraudulent practices committed by members of the central government (Dyer, 2006). Furthermore, Garuba, Kohler and Huisman (2009) note that poor registration for new drugs, a culture of corruption and a lack of inspection at ports renders Nigeria's domestic healthcare system vulnerable to mass fraud by international pharmaceutical companies through the production and sale of counterfeit drugs. Thus, the global supply chain of drugs and pharmaceuticals capitalises upon corrupt political practices and ineffective regulatory institutions in LDCs (Albin-Lackey, 2013; Yadav, 2015).

Healthcare fraud in developing countries can consequently be viewed as a macroeconomic symptom of globalisation (Cohen, Mrazek and Hawkins, 2007; Kesselheim et al., 2010; Holmberg and Rothstein, 2011; Mackay and Liang, 2012).

In many more LDCs, healthcare fraud is associated with the theft of medical supplies, informal payments to governmental organisations, embezzlement, public and private sector extortion, and the illegal procurement of public health contracts (Mackay and Liang, 2012).

In India, for instance, a far-reaching healthcare scandal revealed that domestic healthcare organisations had defrauded five World Bank healthcare projects, which sought to tackle domestic problems of malaria, HIV/AIDS and tuberculosis (Solberg, 2008).

Between 1997 and 2003, Indian healthcare organisations, in collusion with corrupt officials, rigged the bids for health contracts and engaged in systematic bid manipulation and bribery (Solberg, 2008). **87% of the contracts for the World Bank's Food and Drug Capacity Building Project (US$54 million), for instance, were procured through corruption and bribery** (Solberg, 2008). Moreover, in the Second National AIDS Control Project (US$194 million), it was found that Indian healthcare providers had purchased HIV/AIDS tests kits from bogus sources, thus yielding invalid and/or erroneous results for patients (Solberg, 2008).

Consequently, fraud was not limited to the procurement of contracts but was also extended to project implementation (Solberg, 2008). As is the case in advanced economies, healthcare fraud in LDCs is also motivated by economic interests. However, it should also be acknowledged that healthcare fraud in many parts of the developing world is a product of ingrained and taken-for-granted social, cultural and political norms (Ganahl, 2013).

Historical patterns of patrimonialism, patronage and clientelism, in addition to economic incentives, shape the contours of healthcare fraud in many LDCs (Kimanuka, 2009). As a result, health resources are distributed according to the way in which informal systems of governance operate rather than via a formal rational-legal/social/political apparatus (Bach, 2013).

DISCUSSION

It has been consistently demonstrated that healthcare systems' defrauding is primarily motivated by economic interests and the realisation of career goals.

Fraud enables practitioners and agencies involved in healthcare delivery to accrue capital wealth through corrupt and illicit systems of payments and reimbursements and to increase the volume of business through fraudulent medical referrals.

The deliberate misdiagnosis of patients' conditions represents one of the most obvious ways practitioners can attain payments for services they would otherwise not be eligible to receive. Line-jumping, upcoding and physician-induced demand are testimony to the economic and social gains that can be accrued through the abuse of the power and authority bestowed upon medical practitioners.

In addition, it has been shown that the structure of public healthcare systems in most advanced economies, where public health systems are underwritten by private-sector health insurance and cost management processes, significantly increases the scope for fraudulent practices by healthcare professionals.

The majority of practitioner-inducted healthcare fraud targets public sector healthcare systems with relatively weak systems of fraud detection and generous reimbursement policies.

Phantom billing, fee-splitting and kickbacks are indicative of

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systematic fraud committed by doctors against public healthcare systems. This clearly suggests that healthcare fraud is best understood as an orthodox white-collar crime which is committed by actors and agencies in a position of power, influence and trust in the legitimate political and economic order. Doctors, physicians, and other registered healthcare professionals take advantage of patients' weaknesses and the vulnerabilities of health systems to realise goals that would otherwise be blocked. Furthermore, this also suggests that healthcare fraud is a product of the strain which is exerted on practitioners through:

1. bureaucratised systems of managed care; and
2. the introduction of market-based ideologies which privilege profit over people.

The dynamics of the healthcare market, which are based upon supply and demand economics' fundamental principles, place pressure upon healthcare professionals to act in criminogenic ways. However, while it is important to recognise the structural factors that shape healthcare fraud patterns, it is essential to acknowledge two important issues.

Firstly, it is prudent to consider the conceptual ambiguities of fraud. For instance, Levi (2008b) outlines three typologies of fraud including:

1. pre-planned fraud (where businesses are established as a means of defrauding victims);
2. intermediate fraud (where legitimate businesses become fraudulent over time); and
3. 'slippery slope' frauds (where deception spirals out of control).

As has been discussed, in public healthcare systems, there is an intrinsic relationship between the strain, which is exerted by managed care environments and physicians' deliberate deception.

To meet the health needs of their patients, practitioners are frequently moved to engage in deceptive tactics with third-party payers. This represents the ethical justification for healthcare fraud. It can therefore be argued that while high-profile instances of healthcare fraud are pre-meditated white-collar crimes, the motivation to commit healthcare fraud can also be interpreted as a 'slippery slope' fraud where an initial inclination to deceive can lead to the wider-scale defrauding of healthcare systems. From this perspective, it may be prudent to conceive many aspects of healthcare fraud in terms of 'occupational deviance' rather than white-collar crime (Friedrichs, 2002).

Secondly, it is important to underline the distinction between healthcare fraud in advanced economies and health fraud in the developing world.

In advanced economies, healthcare fraud is influenced by the behaviour of actors located within healthcare organisations. In developing countries, healthcare fraud must be examined as part of a much broader system of corruption involving government officials and public authorities.

Consequently, in developing countries, historical patterns of patrimonialism and patronage shape the contours of healthcare fraud and economic motivations to accrue capital wealth and attain career goals. As a result, it must be noted that healthcare practitioners face additional strains to engage in fraudulent activity.

In the developing world, then, healthcare fraud is a multidimensional concept that is inseparable from wider political, social and cultural stressors that shape healthcare professionals' behaviour and the distribution of vital health resources.

CONCLUSION & RECOMMENDATIONS

Healthcare fraud is an orthodox white-collar crime.

Economic gain and the attainment of career goals are the most common motivations for healthcare fraud. Public health systems, rather than consumers, bear the brunt of practitioners' fraudulent activities. Nevertheless, research with practitioners emphasises the ethical justifications for healthcare fraud.

Most notably, the introduction of managed care markets places pressure upon physicians to deceive third-party payers to place the patient's needs at the epicentre of the healthcare process. In this sense, fraudulent activity is motivated not by economic gain but by the bureaucratic constraints of operating within public health systems. Therefore, healthcare fraud must be examined both as a pre-meditated crime and as an occupational offence; intrinsically related to the organisational context in which it is committed.

Physicians face multiple pressures to engage in fraudulent activity. It is recommended that future research concentrates upon ascertaining how and in what ways organisational pressures in the healthcare sector influence the actions and decisions taken by individual practitioners. In particular, it would be beneficial to consider why some practitioners are compelled to circumvent complex appeals processes. In contrast, others are motivated to act within the confines of unjust and restrictive healthcare systems.

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