



UWL REPOSITORY

repository.uwl.ac.uk

Fraud, error and corruption in healthcare: a contribution from criminology

Brooks, Graham ORCID: <https://orcid.org/0000-0002-1220-2932>, Tunley, Martin, Button, Mark and Gee, Jim (2017) Fraud, error and corruption in healthcare: a contribution from criminology. In: Healthcare Fraud, Corruption and Waste in Europe. Eleven Publishers, The Hague, Netherlands, pp. 25-44. ISBN 9789462366855

This is the Accepted Version of the final output.

UWL repository link: <https://repository.uwl.ac.uk/id/eprint/4256/>

Alternative formats: If you require this document in an alternative format, please contact: open.research@uwl.ac.uk

Copyright:

Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

Take down policy: If you believe that this document breaches copyright, please contact us at open.research@uwl.ac.uk providing details, and we will remove access to the work immediately and investigate your claim.

Chapter 2: Fraud, Error and Corruption in Healthcare: A Contribution from Criminology

Graham Brooks, Martin Tunley, Mark Button and Jim Gee

2.1 Introduction

This chapter will focus primarily on fraud, error, and corruption in the National Health Service (NHS) in England and Wales but, where useful, will make reference to international literature as well. It will offer a definition of fraud, but also highlight the fact that fraud and corruption are often used interchangeably to define the same act, which adds confusion to the complex matter of providing a clear definition of fraud. Once the definition has been clarified, there will be a review of the structure of the NHS and how it tackles fraud. This is followed by how we can measure fraud, and the estimated extent of fraud in the NHS. Finally, we review the contribution of criminology in developing theoretical frameworks to help us understand why people commit fraud and how to prevent it.

2.1.1 What Is fraud?

In this book we have defined fraud as “illegally obtaining a benefit of any nature by intentionally *breaking*¹ a rule”.² 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 victimized. However, the *Fraud Act* 2006 (for England and Wales and Northern Ireland) has defined three types of fraud, namely fraud by false representation under Section 2, fraud by failing to disclose information under Section 3, and fraud by abuse of position under Section 4 of the act.³ England, Wales and Northern Ireland are thus unique in codifying the offence of fraud with the passage of the *Fraud Act* 2006. Under this definition, a failure to disclose is also considered fraud, indicating that both active and passive behaviour is unacceptable.

Clear standards are useful to combat fraud, but even if this were the case within the European Union, the law would be applied differently, 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? The clearest definition is that of *stretching* rather than breaking the rule(s) or guideline(s), or taking advantage of an absence of rules or guidelines in an unjust fashion. Errors, by contrast, are qualitatively different as these are where there is an unintentional breaking of a rule or guideline. For example, 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.

¹ Emphasis added.

² EHFCN, Waste Typology, <https://ehfcn-powerhouse.org/groups/4-ehfcn-waste-typology-matrix/welcome> (accessed 24 March, 2015).

³ Home Office, *Fraud Act 2006*, Chapter 35, HMSO, London, 2006.

All of this is complicated by corruption; those that work under the disciplines of political science and economics tend to focus on corruption.⁴ Innumerable definitions of corruption are available⁵ with most emphasizing the public sector as a cause of or conduit for corruption. This view, however, would be to underestimate the private sector and its penchant for corruption. Fraud is often defined as, stated by the anti-fraud organization Transparency International,⁶ the abuse of entrusted power for private gain. This definition is not a simple definition of public sector corruption, even though it is often used as one. Corruption is also a term of appraisal and one that is negative. It has a range of meanings; specialized, technical and professional meanings but also a public social meaning and understanding of what is corrupt. This has produced a consistent feature in the corruption literature, but there is no conclusive definition of the term. A working definition is, however, useful and we will use “illegally obtaining a benefit [...] by abuse of power with third party involvement”.⁷ It is always possible to abuse power in a manner that is not necessarily illegal, however.

Any definition can have two elements;⁸ 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; it is therefore useful, perhaps, to place corruption, and all the illegal and legal but immoral acts that it can include, onto a continuum to highlight how different theoretical approaches emphasize different aspects of corruption and ways of preventing them.⁹

This chapter will, however, primarily focus on how to measure fraud and the contribution of criminology to understanding and preventing healthcare fraud. However, because fraud covers some aspects of corruption, when a reference is made to fraud in this chapter, it will also cover some aspects of corruption. It is important to note, nevertheless, that measuring corruption necessitates different methodological approaches and poses challenges that are beyond the scope of this paper.

2.2

2.2.1 NHS Counter Fraud Structure

The NHS is an organization that is in a state of change; recently the *Health and Social Care Act 2012* expanded the role of the private sector in health services. We now have a competitive market which the state pays for (only in England) via Clinical Commissioning

4 P.M. Heywood (ed.), *Routledge Handbook of Political Corruption*, Routledge, Abingdon, 2015, pp. 1-13.

5 *Ibid.*, pp. 137-154.

6 Transparency International, *Corruption Perception Index 2012*, London, Transparency International, Berlin, 2012.

7 EHFCN 2015, see n. 2.

8 M. Philp, ‘The Definition of Political Corruption’, in Heywood 2015, see n. 4, pp. 17-29.

9 G. Brooks, D. Walsh, C. Lewis & H. Kim, *The Prevention of Corruption: Investigation, Enforcement and Governance*, Palgrave Macmillan, Basingstoke, 2013, pp. 119-121.

Groups (CCGs). These are subject to competition law and buy in services from the public and private sector but still work under NHS logo.

Those working in counter fraud in the NHS are charged with preventing and detecting fraud, bribery and corruption. However, the NHS in the United Kingdom is a complex structure, and as such this chapter will confine itself to counter-fraud provisions within England. As of October, 2015, there are counter fraud specialists within the Department of Health, NHS Protect and Local Counter Fraud Specialists. These specialists are either employed directly by the NHS or under contract, working in local NHS Trusts¹⁰ and/or other health-orientated providers that deliver services on behalf of the NHS and that require some form of counter-fraud specialism.

2.2.2 Anti-Fraud Unit: NHS Protect

The Department of Health delivers a range of critical services to NHS organizations. However, it is the NHS Business Services Authority that oversees the work of NHS Protect – the role of which is to prevent crime(s) and protect NHS resources. The Department of Health also has its own tactical fraud unit, known as the Department of Health Anti-Fraud Unit (DH AFU) and aims to offer support to and empower employees to expose fraud in the NHS. This could perhaps best be described as a campaign to tackle the way concerned employees in the NHS have been treated by their employers^{11, 12} when they have tried to expose poor standards of care and fraud.

However, it is a step in the right direction, providing support to employees and encouraging people to report suspicions of potential and/or known cases of fraud. A dedicated anti-fraud unit therefore has been created within the Department of Health. The terms of reference for the unit include “raising awareness of types of fraud, and encouraging employees to expose fraud and financial impropriety”. The DHAFU is also responsible for preventing fraud and coordinating counter-fraud activities throughout the “entire health family”¹³ with the remit of conducting investigations into “national, large or complex cases”¹⁴ that NHS Protect cannot realistically be expected to take on.

NHS Protect was established in April 2011, and replaced the NHS Security Management Service (NHSMS), the previous body that was charged with preventing and reducing fraud. The remit of NHS Protect is to take national responsibility for protecting NHS employees and its resources from crime. Little appears to have changed so far, but NHS Protect should focus on protecting NHS resources from crime by protecting “health and care employees and resources from actions that otherwise undermine their effectiveness and ability to meet the needs of patients and professionals”.¹⁵ As such, this body is tasked with preventing fraud, but also other types of corruption. It claims to have adopted an intelligence-

¹⁰ A Trust is an organization that provides services in a geographical area in England.

¹¹ M. Barrow, ‘2000 Nurses Warned to Keep Quiet about risks to Patient’s Lives’, *The Times*, Tuesday, April 23, 2013, p. 18.

¹² C. Smyth, ‘NHS Boss Tells Gagged Staff They Can Speak Out’, *The Times*, Tuesday, March 19, 2013, p. 11.

¹³ NHS Protect, *Annual Report 2014-15*, NHS, London, 2015, pp. 11-14.

¹⁴ *Ibid.*

¹⁵ NHS Protect, *NHS Protect Business Plan 2015-16*, NHS, London, 2015, p. 7.

led approach that underpins “prevention, disruption and enforcement”¹⁶ and works in collaboration with the Department of Health Anti-Fraud Unit and Local Counter Fraud Specialists (LCFS) employed by NHS Trusts, and where possible with other organizations contracted to perform NHS functions.

At the local level there is a legal requirement for each health body to appoint a person or person(s) to carry out a range of counter-fraud work – prevention, deterrence and investigation. This requirement is determined by the terms of service within the NHS Standard Contract which applies to all healthcare providers. This service condition requires providers to implement satisfactory measures to address all counter-fraud issues. Initially, providers are required to produce “an organization crime profile using a toolkit provided by NHS Protect”, and once this is completed, to “take the necessary action to meet the standards set by NHS Protect at the level indicated by the organizational crime profile.”¹⁷

Depending upon the responses provided, an organizational category of one to three is allocated. Category one for example is where an organization is deemed to have “high value NHS contracts, a high number of employees, high value NHS assets and large numbers of patient interactions”. Furthermore, Strategic Governance Standard 1.3 requires an organization to employ or contract in:

an accredited person (or persons) to undertake full range of anti-fraud, bribery and corruption work, including proactive work to prevent and deter fraud, bribery and corruption and reactive work to hold those who commit fraud bribery and corruption to account.¹⁸

Those providing counter-fraud expertise are required to perform to a satisfactory professional standard and, accordingly, should “attend specialist training that has been accredited by the Counter Fraud Professional Accreditation Board”¹⁹ where necessary.

The number of LCFS required by each organization is determined by the level of risk which is calculated from the crime profile. Health services have some flexibility in how they deal with this risk, but must adhere to expected standards sets by NHS Protect. Some health services employ LCFS directly, whilst some share the same LCFS, and others buy time from organizations that offer fraud and security solutions. However, with the changing structure of the NHS, it is still unclear which powers of investigation LCFS and NHS Protect will have in the future.

2.3

2.3.1 Measurement of Fraud in Healthcare

As a discipline, criminology has a history of debating the usefulness and limitations of crime data and the problematic nature of recording and measuring crime. The literature²⁰ explains

¹⁶ *Ibid.*

¹⁷ NHS England, *NHS Standard Contract 2015/16 Service Conditions*, NHS, London, 2015.

¹⁸ NHS Protect, *Standards for Providers 2015-16: Fraud, Bribery and Corruption*, NHS, London, 2015, p. 13.

¹⁹ *Ibid.*, p. 26.

²⁰ C. Coleman & J. Moynihan, *Understanding Crime Data*, Open University Press, Buckingham, 1996.

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; lack of confidence in the police, no insurance, crime committed whilst victimized, items stolen of little personal value, and so on. However, if we consider these 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 crime²¹ and reveals how the police work (i.e. different rates of cautions, in relation to whom, in different locations) and offers an insight into how those from poor backgrounds are arrested and convicted, perhaps indicating a bias in policing and criminal justice bodies. Furthermore, there are problems with recording “hidden crimes” such as domestic violence and child abuse. Fraud, although different in that it is predominantly, but not always a non-violent crime, is similar in that it is “hidden”. It is therefore difficult to assess the amount of fraud that exists and the number of victims.

However, there have been and continue to be many attempts to measure fraud and error²² and corruption,²³ and criticism of them. As with all crime data, it is useful to reflect on whether the measurement of fraud and acts of criminal corruption – those that contravene criminal law rather than civil law – is worthwhile. We would 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. As the points above indicate, 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 the development of more sophisticated approaches can increase our knowledge of the problem and, in turn, the level of victimization. This is particularly important for all crime but as we attempt to continue to deliver high-quality healthcare to expanding populations, funds lost to fraud adversely affect our ability to safeguard the most vulnerable in need of healthcare.

2.3.2 Detection of Fraud – the Fraud Loss Measurement Method

One method of detecting fraud which has made some headway is the process of Fraud Loss Measurement (FLM).²⁴ As an exercise, it involves the assessment of a statistically valid sample of transactions within a specific population such as procurement or payroll. The sample is used to determine whether these transactions are correct, have been made in error, or acts of fraud. Clear standards are set to define fraud and error that draw on the civil definition of fraud, so there are different FLM exercises in different settings – i.e. health, welfare, international aid – are held to the same standard and in different contexts – i.e. purchasing of products, services and/or buildings.

²¹ S. Jones, *Criminology*, Oxford University Press, Oxford, 2006, pp. 31-52.

²² M. Levi & J. Burrows, ‘Measuring the Impact of Fraud in the UK: A Conceptual and Empirical Journey’, *British Journal of Criminology*, Vol. 48, No. 3, 2008, pp. 293-319.

²³ Brooks *et al.*, 2013, see n. 9, pp. 27-42.

²⁴ J. Gee, M. Button & G. Brooks *The Financial Cost of Healthcare Fraud. What the Data From around the World Shows*, London, PKF/CCFS, 2011. M. Button, C. Lewis, D. Shepard & G. Brooks, ‘Fraud in Overseas Aid and the Problem of Measurement’, *Journal of Financial Crime*, Vol. 22, No. 2, 2015, pp. 184-198.

FLM is based on the principle that in a given number of transactions, a few cases of fraud will be detected, there will also be some cases of undetected fraud and a high number of correct transactions. It is perhaps the undetected cases of fraud that cause most trouble; providing evidence of undetected fraud is difficult, and if in fact it is fraud, the scale of fraud and the potential offenders increase the complexity of this problem, depending on the position they hold in the organization, and/or whether they are still part of the organization, have moved abroad, and/or died if the fraud was committed years ago. Such questions, and the capacity of the organization to seek financial redress, make the measurement of fraud a difficult task. If we are unable or unwilling to enforce civil or criminal laws, reclaim lost funds and punish offenders, the question arises: “why would we measure fraud?”

FLM has largely been used in sizeable public sector organizations that deal with social security payments, taxation, and payment to contractors for services and also insurance fraud in the private sector. FLM exercises are used in different jurisdictions. These investigations go beyond a normal assessment and there is also an expectation of recovering losses from the payments made in fraud and error (in the USA, this is known as Payment Recapture Audits or Recovery Audits). In the United Kingdom, FLM exercises are used regularly by the Department for Work and Pensions (DWP) (responsible for social security payments), Her Majesty’s Revenue and Customs (responsible for collecting taxes) and the NHS. The DWP invests a significant amount of time in the investigation and prevention²⁵ of fraud but also in measuring losses to fraud. The NHS has also made use of FLM in the past for a number of areas of expenditure; these have included patient prescription payments, patient optical fraud, and procurement fraud. A number of research exercises have examined losses across healthcare where fraud loss measurement has been applied. In the latest overview of such exercises,²⁶ the average loss between 1997 and 2013 in health care was 6.19%, ranging from 0.60% to 15.40%. Of these reviews, 57.7% showed losses between 3% and 8%, 30.8% over 8% and 11.5% below 3%.

They are, therefore, more than an academic exercise to gauge the size of the problem. From these assessments, it is possible to estimate the extent of fraud and error to a statistical level of confidence and tolerance range. This is usually presented as a fraud frequency rate (FFR), which is the number of transactions which are fraudulent and/or made in error and the fraud loss rate (FLR), which is the monetary value of losses.

2.3.2.1 Criticisms of the FLM

There are, however, some issues which need to be considered. First of all, substantial sample sizes are needed for an accurate assessment. For many organizations, regardless of the sector, the better the assessment and levels of accuracy, the better they can plan, initiate policy and design and implement a strategy to reduce fraud and errors. However, this means that the sample size has to be at least around 1000 to obtain an accurate representation of the actual level of fraud and error. This involves detailed investigation, and is a labour-intensive process, particularly if all the information required is not readily available. This means it can

²⁵ Department of Work and Pensions, ‘Fraud and Error in the Benefit System: Preliminary 2013/14 Estimates’, London, DWP, 2011, pp. 8-35.

²⁶ Gee & Button, 2011, see n. 24, pp. 1-15.

be an expensive exercise costing anything from GBP 30,000 to GBP 100,000 per FLM, depending on the sample size and the ease with which it can be conducted.²⁷ For many organizations – particularly those who sense (perhaps rightly so) that they have low levels of fraud, spending such amounts, only to be informed that the fraud level is low, has little appeal. Linked to the cost is the potentially disruptive impact on the organizations, including on the morale of the ethical majority of employees, especially as each sample transaction is investigated as if it were a fraud.

An added issue to consider is that of automation and efficiency: to make the FLM process less disruptive and secure the best results, it is suited to organizations where records are orderly, coherent, perhaps online, and accessible (i.e. can someone from outside an organization make sense of the system and recording of data?). FLM exercises that involve paper trails are not impossible, but add to the cost, as will an unnecessary complex system of recording data; complex systems also add to the potential for both fraud and error to occur.

2.3.3 Fraud Loss Measurement Limitations

FLM exercises, as stated, are suited to substantial numbers of similar transactions within a specified population; they are not suited to assessing the total fraud in an organization or sector unless they are broken down into small chunks of similar transactions. An FLM exercise is of use, then, if there are sufficient numbers that focus on a type of payment in a specific sector. Furthermore, when fraud and error are combined into a single “improper payments” category, it is impossible to establish the level of fraud, rendering the whole process less useful if it is being done in order to measure fraud. Whilst fraud and error can both be counted as a “loss” to an organization, the solutions to these problems are very different.

It is clear, however, that fraud remains a significant problem in healthcare systems around the world and one which implies a higher cost than previously estimated. Where organizations have undertaken repeated exercises to measure their losses in the same areas of expenditure, evidence suggests that this has helped to reduce fraud.²⁸ In the United Kingdom, however, the NHS has moved away from FLM exercises and a programme of measuring the cost of fraud (and error); between 1998 and 2006 there were fifteen loss measurement exercises, with six exercises in 2007–2008, but there were only two such exercises between 2009 and 2014.

Fraud within the healthcare system can be committed by patients, pharmacists, healthcare practitioners (such as dentists, opticians, doctors and hospital consultants), NHS employees, external contractors, and overseas visitors, known as “health tourists” who exploit the free healthcare offered by the NHS. This, however, is a problem for all healthcare systems, not only the NHS. Some of these cases of fraud can be broken down into specific typologies, including procurement fraud, payroll expenditure fraud and expenses fraud. These frauds also range from high-volume, low-value fraud such as prescription fraud to what is

²⁷ Button *et al.*, 2015, see n. 24, pp. 184-198.

²⁸ Button *et al.*, 2015, see n. 24, pp. 184-198.

considered high-value, low-volume such as the procurement of medicines or the falsification of patient records by doctors.

Furthermore, whilst definitions of corruption are available, with most emphasizing the public sector as a cause or conduit of crime, social sciences have for many years been trying to identify and explain a range of behaviours at the individual, organizational and state level that are considered corrupt. This is exacerbated by trying to explain acts which are motivated social actions – whether they are rational, calculated and/or temporary deviations from “normal behaviour”. Fraud and corruption are therefore placed into a context in which people interact. The majority of the academic literature is still marked by a Western assumption about the need for free markets and liberal constitutional orders. However, there are significant differences within states – democratic, autocratic, and across sectors – health, finance – because of transnational and cross-border fraud and corruption. In addition, fraud as an aspect of corruption is still seen, even by major organizations such as the IMF and World Bank, as a public sector issue.²⁹

This is incorrect. With the increase in the privatization of public services, the distinction between the public and private spheres of influence and power is becoming more blurred. The private sector can commit fraud without any contact with the public sector and is hidden until egregious acts are exposed and civil and criminal law is invoked. This emphasis on the public sector means that we miss real instances of fraud and corruption and focus predominantly on the public sector.

2.3.4 Fraud as a Multi-Faceted and Global Phenomenon

The problems encountered when trying to construct a consistent and unambiguous definition of fraud and corruption exhibit that many factors undermine attempts to arrive at a definitive version, particularly when studying the issue from an EU perspective, let alone a global perspective. As a result an unequivocal definition of fraud and corruption remains elusive and also provides challenges in terms of strategies for prevention and enforcement. Fraudulent acts should therefore be viewed as a complex and multifaceted phenomena with a multiplicity of causes and effects, as they exhibit many different forms and functions in very diverse contexts, ranging from either a single act that transgresses the law to a way of life for an individual, group of people, and/or societal order, which is may be deemed morally acceptable.

Exactly what counts as fraud and corruption is relative, but our understanding of this is rooted in a social, political and cultural context. Corruption is a product of its environment, history and social development. We therefore fall into a trap whereby we try to define corruption as a technical problem that can be dealt with by changing processes – this view of people is a predominantly economic one, where incentives to act corruptly must be removed, and popular understandings of corruption which are often wide-ranging and diverse. This, however, tells us little about the reality of living with fraud and corruption and the damage that it can and does do people that have services withdrawn due to lack of funds, lack of

²⁹ D. Hough, *Corruption, Anti-Corruption and Governance*, Palgrave Macmillan, Basingstoke, 2015, pp. 25-27.

access to medicines, unwanted and unnecessary operation(s), and the effect this has on those close to the victims.

Fraud is also viewed, depending on the factors mentioned above, as an illustration of moral decay. However, focusing on morality alone is also flawed since it does little to assist those in the social sciences to explain such acts with a focus instead on behavioural indicators and their potential manifestations. What is needed is a clearer understanding of what motivates people to commit fraud and act in a purely self-interested way, particularly if we expect people to change the way they behave. It is here that sociology and criminology have much to offer beyond the discourses of political science and economic theory.

However, whilst it is necessary to consider the measurement of fraud particularly for politicians and civil and policy administrators to fund counter fraud specialists and law enforcement to tackle and reduce the level of “known” fraud in healthcare systems, understanding *why* rather than simply *how* or *how much* fraud is committed is also important if we wish to prevent substantial losses to healthcare services in the European Union. In the next section, we will consider *why* fraud is committed.

2.4

2.4.1 *Fraud and Corruption in Healthcare: A Contribution from Criminology*

Sociology and criminology focus on the broad range of human relationships and institutions. These are briefly reviewed here in the clearest chronological order possible but as with all theoretical approaches they are criticized, revised and built upon. Often dismissed as “empty ruminations”, theoretical thoughts have future consequences for how we treat, punish and deter offenders.³⁰ 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 preventing crime. This is where the usefulness of sociology and criminology comes into play. They both have a history of explaining deviance, the breaking of rules and moral codes and also criminal acts.

It was originally 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 criminology as to why people in such positions would commit such crime(s). Sutherland was convinced that the criminal law did not cover all forms of white-collar crime because most of the harmful activities by white-collar criminals are settled outside the criminal court by civil law procedures or disciplinary rules, as many still are. Given that the crimes of powerful businessmen and women often go undetected, and if detected may not be prosecuted, and if prosecuted they may not be convicted, the amount of criminally convictions for white-collar crime is far below the real population of white collar criminals.³¹

Sutherland suggests 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

30 R.J. Lilly, F.T. Cullen & R.A. Ball, *Criminological Theory: Context and Consequences* (5th edition), Sage Publications, Newbury Park, CA, 2015, p. 12.

31 G. Slapper & S. Tombs, *Corporate Crime*, Pearson, Essex, 1999, p. 9.

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 observing what are referred to as definitions favourable to violation of law(s). This process includes the techniques, motives, drives, rationalizations 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 rationalize such acts as an acceptable way to behave. This approach departs radically from the notion that criminals are pathological, and driven to crime by a range of internal struggles that can fall under the umbrella of “cognitively defective constitutions”. It was assumed that when crimes were committed, and this was by mostly “poor people”, this was due to psychopathic or sociopathic conditions. The problem with this approach, however, was 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 institutionalization, rationalization and socialization. In one proposed model³², the combination of these elements are that institutionalization is where an initial act becomes embedded in structures and processes and thereby rationalized through a self-serving justification for committing a criminal act; socialization is the process whereby new employees are induced or seduced into the view that corruption is permissible. In this sense, young doctors may potentially be corrupted by older ones 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?

2.4.2. Fraud and How It Relates to (a Lack of) Opportunities for Success

The notion of strain describes a lack of legitimate opportunities for “success” and the pursuit of wealth, meaning that for those unable to attain this “expected” aim an illegitimate route to success potentially is tempting.³³ This explanation, however, focuses primarily on street crime and is based on the views of Durkheim that people experience anomic thoughts in times of social and economic turmoil. While human needs such as food and shelter remain a static part of the human condition, sudden changes in the social structure lead to a decline in social regulation and hence social unrest. For Merton, however, a lack of legitimate opportunity for “success” in America, remains a permanent part of society rather than any sudden change to the social and economic context. A common criticism of “strain” is that there is an assumption that there is a consensus in America, or indeed in any capitalist society, regarding the pursuit of the increasing wealth and how people interact with one another to establish meaning and understand the context of life. It fails to recognize pluralism, ethnic and otherwise, and is therefore too broad a description of cultural attitudes in a society. Limited in its original form in explaining white-collar crimes, this theoretical approach helps explain how affluent people might engage in criminal acts.³⁴ These approaches may contribute to the

³² B.E. Ashforth & V. Anand, ‘The Normalization of Corruption in Organisations’, *Research in Organizational Behaviour*, Vol. 25, 2003, pp. 1-52.

³³ R.K. Merton, ‘Social Structure and Anomie’, *American Sociological Review*, Vol. 3, 1938, pp. 672-682.

³⁴ R. Agnew, ‘Foundation for a General Strain Theory of Crime and Delinquency’, *Criminology*, Vol. 30, 1992, pp. 47-87.

debate on healthcare fraud; some level of strain is experienced by most, if not all of us at some time in life, regardless of our social position and status. Highly trained and educated doctors and pharmacists, for example, might engage in fraud as they assess their success, or lack of it, in terms of the position they hold in an organization. If they are turned down for a promotion that they think they should have received, this could become a justification for fraud – abusing the system in which they work.

2.5

2.5.1 *Techniques of Neutralization*

However, how can those working in healthcare commit crimes and still deliver the service(s) expected of them? Sykes and Matza explain that part of the process of learning social norms consists of learning excuses, or what are called “techniques of neutralization”.³⁵ They focused on those that were accessible – young people and street crimes – rather than acts of fraud. This approach, however, has some resonance and value as it can explain that individuals and crowds of people can temporarily suspend or neutralize their commitment to expected behaviour and laws. There are five “techniques” but a few should suffice here. There is the denial of *injury*, which is where offenders insist their actions did not cause any harm or damage i.e. nobody was put in physical danger. For example, a doctor might claim for allowances which they are not entitled to such as putting in a claim for home visit to patients, particular out-of-hours activities that did not occur, refuse patients appointments at their place of work (doctors’ surgery) to claim expenses for home visits that were unnecessary, add non-existent “ghost patients” to the doctor’s 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 a company, or co-accused is caught committing an illegal act – be it breaking the internal rules of a company or breaking the law but claiming that the company was well aware of the acts, and either actively encouraged such behaviour or failing to stop it. These techniques should not be seen in isolation; they can and do combine to create a “wall of justification”, particularly if perpetrators are caught, in order to diminish the impact and seriousness of the offence committed. Supporting these techniques of neutralization is the work of Dittenhofer³⁶ and Zeiltn, and the syndrome of *injustice and dissatisfaction*. Behaviour in this category is justified as a sense of injustice felt vis-à-vis an employer. As Coleman³⁷ pointed out, neutralization techniques are not only post hoc rationalizations of white-collar crime, but can

R. Agnew & H. White, ‘An Empirical Test of general Strain Theory’, *Criminology*, Vol. 30, 1992, pp. 475-499.

35 G.M. Sykes & D. Matza, ‘Techniques of Neutralization: A Theory of Delinquency’, *American Sociological Review*, Vol. 22, 1957, pp. 664-670.

36 M.A. Dittenhofer, ‘The Behavioural Aspects of Fraud and Embezzlement’, *Public Money and Management*, January – March 1995. L.R. Zeiltn, ‘A Little Larceny Can Do a Lot for Employee Morale’, *Psychology Today*, Vol. 5, No. 1, 2001, pp. 22-24.

37 J.W. Coleman, ‘Toward an Integrated Theory of White-Collar Crime’, *American Journal of Sociology*, Vol. 93, No. 2, 1987, pp. 406-439. J.W. Coleman, ‘Motivation and Opportunity: Understanding the Causes of White Collar Crime’, in G. Geis, R Meier & L. Salinger (eds.), *White Collar Crime* (3rd edition), Free Press, New York, 1995, pp. 360-381.

also precede the rule breaking and thereby morally facilitate non-compliance. A rationalization is not an after-the-fact excuse that a perpetrator uses to justify his or her behaviour, but an integral part of the actor's motivation for the act. However, then as now, these techniques fail to offer a proper explanation for violent behaviour and those individuals and/or organizations that commit serious offences, and the role that resistance plays in committing fraud and exercising choice is limited.

2.5.2 Social Control

This leads us on to the notion of control, and why is it that people conform rather than commit crime. The theoretical approaches that fall under the umbrella of control theory suggest that crime and delinquency is to be expected unless sociocultural controls – family, teachers, and police – operate effectively to prevent crime.³⁸ The theoretical approaches that follow emphasize weak social control or bonds between people, ideals, and society. Most focus on the family and youth delinquency and view the family as the primary source of socialization. Delinquency and crime is explained as the lack of internalized control or a “moral compass”. The problem here is that rationality is assumed; there is no scope for enquiring how people make sense of the world which they inhabit. There is also the possibility that delinquency leads to a weakening of social bonds rather than weak bonds leads to delinquency. Furthermore, these approaches assume that “decent parents” should be trying to teach middle class values (however, these are defined) to children. However, even for Hirschi, morals are variable rather than fixed and immutable, and as such keeping “poor company” can have an influence – i.e. a corrupt doctor may affect the moral compass of trainees.

2.6

2.6.1 Rational Choice

In the 1980s in the USA and Great Britain, in particular, this view of people as rational secured much political support. With rising crime rates and recessions, social/bio-psychological approaches and those that fall under the umbrella of “right realism” focused on the causes of crime as lying within individual rather than the social structure. The notion of individual responsibility was therefore embedded as a central tenant of a range of political and policy approaches associated with a conservative view of personal responsibility, behaviour and accountability with the criminal law defined by the state as non-problematic, focusing predominantly on street crime.³⁹ For these authors, human behaviour, particularly acts of violence by young men, included three elements: constitutional factors, the presence and/or absence of reinforcement, and the nature of conscience. The majority of crime was committed

³⁸ A.J. Reiss, ‘Delinquency as a Failure of Personal and Social Controls’, *American Sociological Review*, Vol. 16, 1952, pp. 196-207. Lilly *et al.*, 2015, see n. 30, pp. 82-115.

³⁹ J.Q. Wilson & R. Herrnstein, *Crime and Human Nature*, Simon and Shuster, New York, 1985; R. Clarke, ‘Situational Crime Prevention’, *British Journal of Criminology*, Vol. 20, No. 2, 1980, pp. 136-147. D. Cornish & R. Clarke, *The Reasoning Criminal: Rational Choice Perspective on Offending*, Transaction Publishers, New Brunswick, 2014, pp. 1-13.

by young urban males and it was the constitutional and social origins of maleness and youthfulness, and the biological status of young people and factors such as sex, age, intelligence, body type, and personality that explained criminal behaviour, together with permissiveness and dependency on welfare benefits. This approach is not solely rooted in explaining crime from a biological point of view, it simply accepts that such above factors are “facts” rather than the direct causes of acts, particularly of criminal acts. They suggest, however, that these “facts” can account for a predisposition towards crime. This approach proposes that the individual learns 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 internalized set of attitudes, mainly formed in childhood, which prevent us from being tempted to commit crimes. This approach, however, focuses on specific type of crimes such as visible street crime and associates criminal disposition with the poorest sections of society, and therefore frames crime as embedded in human nature (or that of the poorest) rather than the social fabric. As such, it sees offenders as “beyond reform” and in need of punitive control. It thus portrays crime as a very simple phenomenon which can be dealt with using simple solutions.

As part of this view of people as rational actors, Cohen and Felson⁴⁰ suggest that crime is routine (for some people) and that crime is the product of three factors that combine in time and place: a motivated offender, a potential victim, and the absence of a capable guardian. It is important to note that this approach offers suggestions about the probability of criminal behaviour rather than making definite claims about when crime will occur. The presence of a motivated offender, a suitable target – a victim or item owned by a victim – and the lack of a guardian does not mean that a crime is inevitable. Instead, this theoretical approach suggests that the likelihood of crime increases or decreases based on the existence of these three elements. Much of this is about “lifestyle”; what we do, where we live, who we interact with. This is particularly true for the element of victimization. The hallmark of this approach is its lack of emphasis on the offender and focus on what are referred to as the target and guardian. Routine activity 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 guardians are more capable than others. Neither does it endeavour to really explain why some individual behaviour renders them more susceptible to victimization.⁴¹

All of these theoretical approaches may assist us in understanding why people commit acts of fraud and corruption, but seem to include at least three elements. These are: pressure on the individual; the opportunity to commit a crime; and the ability rationalize crime. These are all part of what is known as the Fraud Triangle.⁴² All theoretical approaches in this chapter, however, are limited and indeed at times contradictory, dependent on a particular view of “human nature”. They are, however, useful: as mentioned earlier, a brief scan of criminal justice policy illustrates that theoretical approaches affect which laws and techniques

⁴⁰ L.E. Cohen & M. Felson, ‘Social Chance and Crime Rates Trends: A Routine Activity Approach’, *American Sociological Review*, Vol. 44, No. 4, 1979, pp. 588-608.

⁴¹ S. Walklate, *Understanding Criminology*, Buckingham, Open University Press, 1998, pp. 34-47.

⁴² R. Kassem & A. Higson, ‘The New Fraud Triangle Model’, *Journal of Emerging Trends in Economics and Management Sciences*, Vol. 3, No. 3, 2012, pp. 191-195.

are implemented and therefore theoretical approaches are a core element of crime prevention. The measurement of fraud, which was once of little interest to sociology and criminology, particularly compared to explaining street crimes, is of some use. They both have a history of explaining deviance, the breaking of 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 the EU has an ageing population, the rising cost of healthcare, immigration, the refugee crisis – contributes to this rise in interest in fraud in healthcare. All crimes and interest in them are dependent on structural and changing circumstances.

2.7 Conclusion

This chapter has highlighted the complex problem of how to define acts of fraud and corruption, but it has also emphasized the need for a working definition even if this is limited. It has also stressed the need to challenge the view that fraud is a public sector matter when acts of fraud and corruption are also committed in the private sector. Furthermore, we have provided an account of the contribution that criminology can make regarding the measurement of crime and fraud, and also its limitations, and put forward a “new” approach to developing a framework for measuring fraud. This FLM, as with all attempts to measure crimes, is limited, but offers an approach that is useful in combination with other types of assessment. Finally, we 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 chapter has hopefully demonstrated, there is much in the literature that could be used to enrich the much needed debate on fraud in healthcare system around the world.

References

- Agnew, R., “Foundation for a General Strain Theory of Crime and Delinquency”, *Criminology* Vol. 30, 1992, pp. 47-87.
- Agnew, R. & White, H., “An Empirical Test of General Strain Theory”, *Criminology*, Vol. 30, 1992, pp. 475-499.
- Ashforth, B.E. & Anand, V., “The Normalization of Corruption in Organisations”, *Research in Organizational Behaviour*, Vol. 25, 2003, pp. 1-52.
- Barrow, M., “2000 Nurses Warned to Keep Quiet about Risks to Patient’s Lives”, *The Times*, Tuesday, April 23, 2013, p. 18.
- Brooks, G., Button, M. & Gee, J., “The Scale of Healthcare Fraud: A Global Evaluation”, *Security Journal*, Vol. 25, No. 2, 2012, pp. 76-87.
- Brooks, G., Walsh, D., Lewis, C. & Kim, H., *The Prevention of Corruption: Investigation, Enforcement and Governance*, Palgrave Macmillan, Basingstoke, 2013.
- Button, M., Gee, J., & Brooks, G., “Measuring the Cost of Fraud: An Opportunity for the New Competitive Advantage”, *Journal of Financial Crime*, Vol. 19, No. 1, 2012, pp. 65-75.
- Button, M., Lewis, C., Shepherd, D. & Brooks, G., “Fraud in Overseas Aid and the Problem of Measurement”, *Journal of Financial Crime*, Vol. 22, No. 2, 2015, pp. 184-198.

- Clarke, R., "Situational Crime Prevention", *British Journal of Criminology*, Vol. 20, No. 2, 1980, pp. 136-147.
- Cohen, L.E. & Felson, M., "Social Chance and Crime Rates Trends: A Routine Activity Approach", *American Sociological Review*, Vol. 44, No. 4, 1979, pp. 588-608.
- Coleman, C. & Moynihan, J., *Understanding Crime Data*, Open University Press, Buckingham, 1996.
- Coleman, J.W., "Toward an Integrated Theory of White-Collar Crime", *American Journal of Sociology*, Vol. 93, No. 2, 1987, pp. 406-439.
- Coleman, J.W., "Motivation and Opportunity: Understanding the Causes of White Collar Crime", Geis, G., Meier, R. & Salinger, L. (eds.), *White Collar Crime*, Free Press, New York, 3rd ed., 1995, pp. 360-381.
- Cornish, D. & Clarke, R., *The Reasoning Criminal: Rational Choice Perspective on Offending*, Springer, New York, 1986.
- Dittenhofer, M.A., "The Behavioural Aspects of Fraud and Embezzlement", *Public Money and Management*, Vol. 15, No. 1, 1995, pp. 9-14.
- Department of Work and Pensions, "Fraud and Error in the Benefit System: Preliminary 2010/11 Estimates", London, DWP, 2011.
- European Healthcare Fraud and Corruption Network, Waste Typology, <https://ehfcn-powerhouse.org/groups/4-ehfcn-waste-typology-matrix/welcome> (accessed 24 March, 2015).
- Gee, J. & Button, M., *The Financial Cost of Healthcare Fraud; What Data From around the World Shows*, University of Portsmouth Centre for Counter Fraud Studies, Portsmouth, 2015.
- Gee, J., Button, M. & Brooks, G., "The Financial Cost of Healthcare Fraud. What the Data From Around the World Shows", PKF/CCFS, London, 2011.
- Heywood, P.M., *Routledge Handbook of Political Corruption*, Routledge, Abingdon, 2015.
- Home Office, Fraud Act 2006, Chapter 35, HMSO, London.
- Hough, D., *Corruption, Anti-Corruption and Governance*, Palgrave Macmillan, Basingstoke, 2015.
- Jones, S., *Criminology*, Oxford University Press, Oxford, 2006.
- Levi, M. & Burrows, J., "Measuring the Impact of Fraud in the UK: A Conceptual and Empirical Journey", *British Journal of Criminology*, Vol. 48, No. 3, 2008, pp. 293-319.
- Lilly, R.J., Cullen, F.T., & Ball, R.A., *Criminological Theory: Context and Consequences*, Sage Publications, Newbury Park California, 5th ed., 2015.
- Merton, R.K., "Social Structure and Anomie", *American Sociological Review*, Vol. 3, 1938, pp. 672-682.
- NHS Counter Fraud and Security Management Service, *Countering Fraud in the NHS*, NHS, London, 2001.
- NHS England, *NHS Standard Contract 2015/16 Service Conditions*, NHS, London, 2015.
- NHS Protect, *Annual Report 2014-15*, NHS, London, 2015a.
- NHS Protect, *NHS Protect Business Plan 2015-16*, NHS, London, 2015b.
- NHS Protect, *Standards for Providers 2015-16: Fraud, Bribery, and Corruption*, NHS, London, 2015c.

- Philp, M., "The Definition of Political Corruption", in Heywood, P., (ed.), *Routledge Handbook of Political Corruption*, Routledge, Abingdon, 2015, pp. 17-29.
- Reiss, A.J., "Delinquency as a Failure of Personal and Social Controls", *American Sociological Review*, Vol. 16, 1951, pp. 196-207.
- Slapper, G. & Tombs, S., *Corporate Crime*, Pearson, Essex, 1999.
- Smyth, C., "NHS Chief on Ropes after "Memory Error" about Whistleblower," *The Times*, Wednesday, March 20, 2013, p. 16.
- Smyth, C. "NHS Boss Tells Gagged Staff They Can Speak Out", *The Times*, Tuesday, March 19, 2013a, p. 11.
- Sykes, G.M. & Matza, D., "Techniques of Neutralization: A Theory of Delinquency", *American Sociological Review*, Vol. 22, 1957, pp. 664-670.
- Transparency International, *Corruption Perception Index 2012*, London, Transparency International, Berlin, 2012.
- Walklate, S., *Understanding Criminology*, Open University Press, Buckingham, 1998.
- Wilson, J.Q. & Herrnstein, R., *Crime and Human Nature*, Simon and Shuster, New York, 1985.
- Zeiltin, L.R., "A Little Larceny Can Do A Lot for Employee Morale", *Psychology Today*, Vol. 5, No. 1, 2001, pp. 22-24.