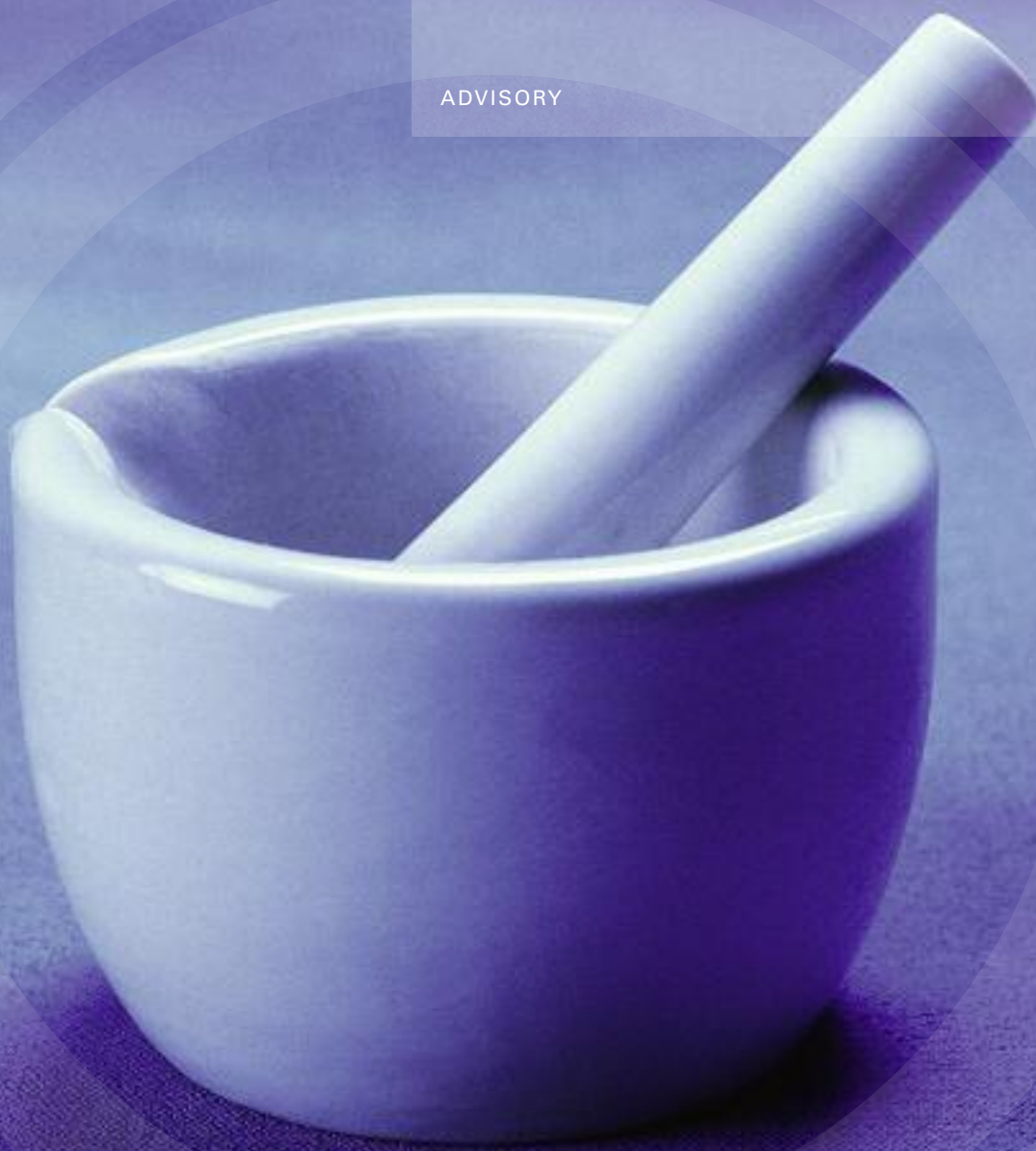


FORENSIC

Medical Schemes' Anti-Fraud survey

ADVISORY





“The purpose of this survey is to measure the response to fraud and to consider trends in terms of prevalence and frequency.”

Introduction



Welcome to the second South African Medical Schemes' Anti-Fraud Survey. KPMG is proud to offer this survey as part of our service to our clients with the aim of reducing the costs and losses experienced due to fraud.

As fraud increases, the medical industry is exposed to its impact and astute manoeuvring is needed to reduce its effect. The purpose of this survey is to measure the response to fraud and to consider trends in terms of prevalence and frequency. It is anticipated that the survey will serve as a tool in the fight against fraud.

This survey has been undertaken with the cooperation of the Medical Scheme Administrators and the Board of Healthcare Funders and for this we thank them.

We hope that the insights provided by this survey will be of value. For more information, to access KPMG fraud surveys in other parts of the world, or for advice on dealing with fraud issues, please do not hesitate to contact us.

A handwritten signature in black ink, appearing to read 'P. Marais'.

Petrus Marais

Chairman – KPMG Forensic Africa

www.kpmg.co.za

About this survey

Introduction

KPMG Forensic is pleased to present the results of the second South African Medical Schemes' Anti-Fraud survey covering the three years to 2006.

In 2007, KPMG circulated an anti-fraud survey questionnaire to medical scheme administrators in South Africa. The survey was performed on a confidential basis with the guarantee that no information would be released regarding any specific survey respondent.

For the purpose of this survey, 'fraud' is defined as a deliberate deceit, planned and executed, with the intent to deprive another of property or rights.

Respondents

Responses were received from seven administrators but only six of the responses could be included in these results.

These six administrators represented 2 074 211 principal members out of a total of 2 985 350 principal members, as published in the 2006/2007 annual report of the Council of Medical Schemes. This is a 70% representation. These included:

- Discovery Health
- Medihelp
- Medscheme
- Metropolitan Health
- Old Mutual Healthcare
- Providence Healthcare Risk Managers.

The analysis of the survey responses is based on the average number of principal members of each respondent during 2006. The respondents represented open and restricted medical schemes.

Contributions and claims

During 2006, respondents collected contributions to the value of R38.2 billion and paid claims to the value of R35.8 billion. These contributions represent 66% of the total collected by all medical aid schemes during 2006 as reported in the Council for Medical Schemes' annual report for 2006/2007.

Electronic Data Interchange

The survey indicates that 73% of claims were submitted through Electronic Data Interchange.



Fraud

All respondents acknowledged incidents of fraud during the period. Schemes representing 99% of principal members indicated that fraud would increase, with the remaining 1% being unsure.

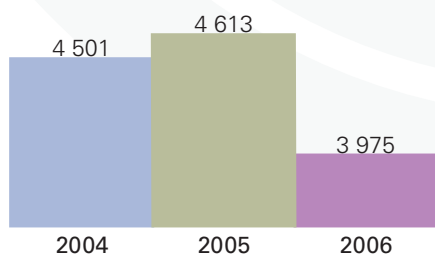
Number and value of fraudulent cases

The number of fraudulent cases investigated over the three-year period amounted to 13 089. The monetary value of these cases for the three years is in excess of R254 million.

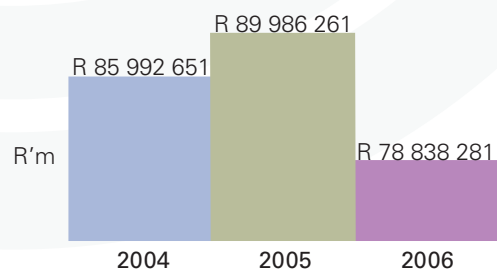
This contrasts with the previous three years, which indicated in excess of 28 000 cases amounting to R213 million.

Respondents indicated that the number and value of fraudulent cases investigated increased from 2004 to 2005 and then decreased in 2006. This resulted in an overall 12% decrease in the number of cases and an 8% decrease in monetary value.

Number of fraud matters



Value of fraud matters



Percentage of investigated fraud

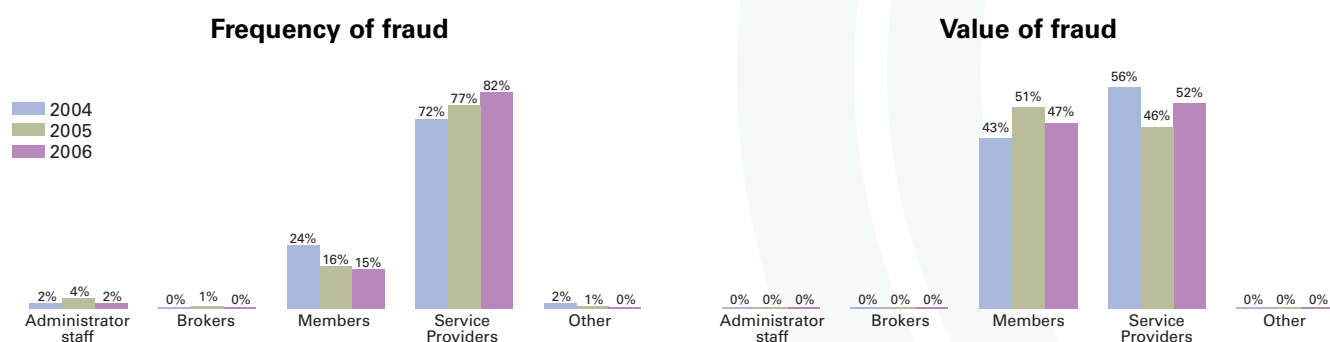
The value of investigated fraud, as a percentage of claims for the three years ended 2006, was 0.26%. This percentage has dropped significantly from the previous three years, when investigated fraud as a percentage of claims was 0.70%.



Perpetrators of fraud

Of the number of investigated fraud cases during the three-year period under consideration, the respondents indicated that service providers accounted for 77% and members for 18% of the cases, a total of 95%.

The same two groups accounted for 99% of the value of fraud cases – service providers for 52% and members for 47%.

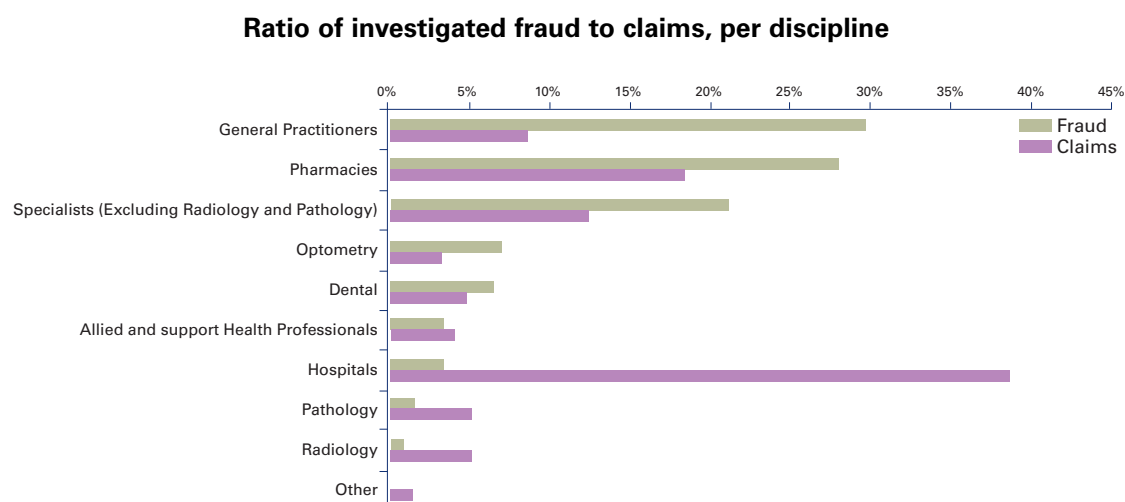


Service provider perpetrators

Respondents indicated that the highest value of investigated fraud had been perpetrated by General Practitioners. The value of claims paid in respect of General Practitioners amounted to 8% of the total claims paid out by respondents for the period. The value of investigated fraud in respect of General Practitioners represented 29% of the total value investigated.

Pharmacies were paid 18% of the total claims paid, whereas the value of investigated fraud in respect of pharmacies represented 28% of the total value investigated. The next largest value of fraud investigated was Specialists (excluding radiology and pathology) at 21%, with claims of 12%.

Although the highest value of claims paid out was for hospitals, at 38%, the value of fraud investigated in this discipline was only 3%.



Categories of service provider fraud

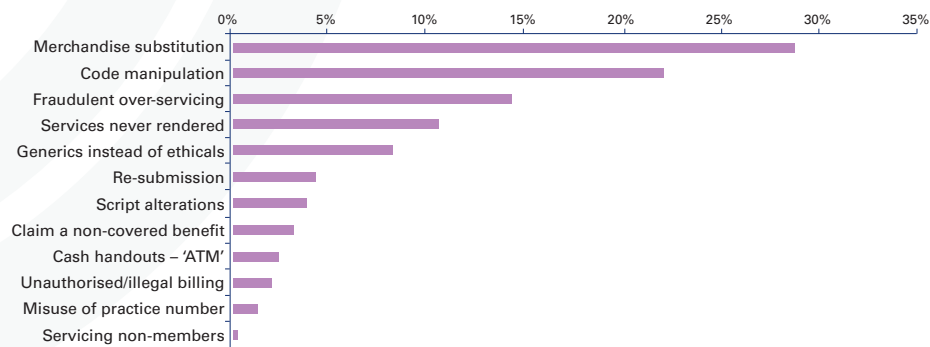
In respect of our analysis of service provider fraud, respondents were asked to report on the category of investigated fraud. Two of the respondents were not able to supply this data, so the percentages in the table are based on investigated fraud for service providers totalling R80,6 million, as opposed to the reported total of R133,7 million.

Respondents indicated that the greatest value of service provider fraud was through merchandise substitution, at 29%, followed by code manipulation, at 22% and fraudulent over-servicing, at 14%.

There is an increasing trend over the three-year period in respect of code manipulation as well as the provision of generics instead of ethicals.

Despite merchandise substitution accounting for the greatest value of service provider fraud, a decrease has been indicated for the trend over the last three years.

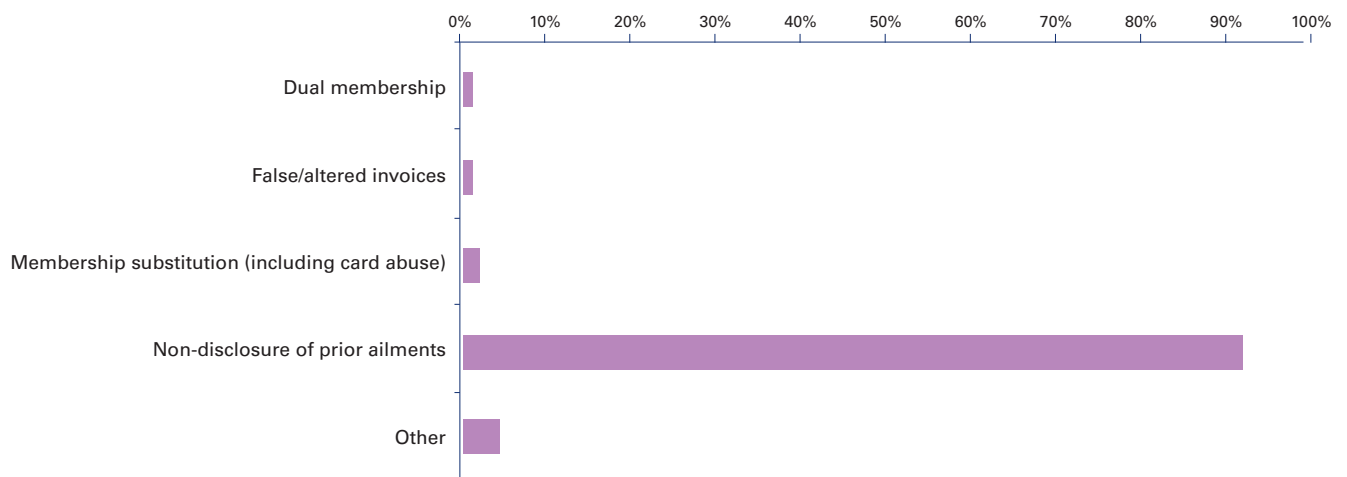
Service provider fraud per category



Member fraud

Respondents indicated that by far the greatest value of member fraud had been the non-disclosure of prior ailments at 95%.

Member fraud per category



Administrator fraud

Administrator fraud appeared to be very small in comparison to member and service provider fraud, as it was a mere 0.27% of average fraud value over the three-year period.



Response to fraud

All respondents have a policy regarding the treatment of fraud perpetrators.

The following is an indication of the reaction to fraud:

Reaction to fraud	Current			Previous		
	% principal members			% principal members		
	Always	Sometimes	Never	Always	Sometimes	Never
Kept it quiet	0%	7%	93%	0%	51%	49%
Reported to the applicable Governing Body	23%	76%	1%	16%	84%	0%
Reported to SAPS	0%	99%	1%	12%	86%	2%
Instituted civil action for recovery	0%	63%	37%	12%	79%	9%
Blacklisted the service provider	45%	23%	32%	8%	46%	46%
Shared information through the Board of Healthcare Funders' Forensic Management Unit	69%	31%	0%	48%	52%	0%
Negotiated a settlement/Recovered losses	63%	32%	5%	0%	93%	7%
Stopped direct payment to provider	28%	72%	0%			

Significant differences noted between the current responses and those of the previous survey are:

- 93% never 'kept it quiet' as opposed to only 49% previously
- Previously, 12% 'always' reported to SAPS, but the current survey indicates zero
- Previously, 12% 'always' instituted civil action, but the current survey indicates zero
- 45% 'always' blacklist service providers, as opposed to 8% previously
- There is a positive trend in 'always' sharing information, from 48% to 69%
- 63% 'always' negotiate a settlement compared with zero previously.



Not reporting to SAPS

The major reasons provided for not reporting fraud were a lack of confidence in the ability of SAPS and a lack of confidence in the Justice system. This is a significant difference from the results indicated in the previous survey.

Another noteworthy difference is the move from 8% to 63% regarding 'no chance of financial recovery'. With regard to cost implications of investigations, respondents indicated less concern than previously; however, respondents are now more concerned with the 'inconvenience' factor.

	Current	Previous
Main Reason for not reporting	% principal members	% principal members
Lack of confidence in the ability of SAPS	77%	56%
Lack of confidence in the Justice System	70%	47%
No chance of financial recovery	63%	8%
Cost implications of investigations	54%	97%
Inconvenience	41%	0%
Other	9%	19%
Fear of negativity	0%	0%

The lack of confidence in SAPS and the Justice system is borne out by the statistics that only 130 of the 13089 investigated fraud cases were reported to and investigated by SAPS over the three-year period.

Of the 130 cases reported to SAPS, only 28 resulted in trials. Of these, four had a 'not guilty' verdict and the other 24 resulted in suspended sentences. There were no custodial sentences and 73 cases are still subject to ongoing investigation.

Respondents indicated that over the past three years, 131 cases had been reported to the relevant governing bodies. In 58 instances, the offenders had been found guilty, resulting in four strike-offs and 12 suspensions.



Internal control

Uncovering fraud

Respondents indicated that fraud had been uncovered most frequently through:

- Internal controls
- Informants or whistle-blowers
- Notification by member or by other external sources
- Board of Healthcare Funders' Forensic Management Unit.

Category	Rating weighted to % principal members
Internal controls	10
Informant/'Whistle Blower' process	9
Notification by member/Other external sources	9
Board of Healthcare Funders Forensic Management Unit	8
Testing allegations (undercover probing)	7
Internal auditor review	7
'Medical rules based' detection software	4
Accident	4
Member and Provider profiling	4
External auditor review	3
Specialised software	3
Specific investigation by third party	1



Fraud climate

Respondents were asked to rate the circumstances believed to facilitate fraud.

The results showed that 'collusion between member and service provider' and 'member apathy/ignorance' were the primary causes.

Contrary to the previous survey, member apathy is now believed to be a major contributor to the fraud climate. Similarly, where Electronic Data Interchange was considered low on the list of contributory factors in the last survey, it now rates fifth.

Category	Rating weighted to % principal members
Collusion between member and service provider	13
Member apathy/ignorance	12
Benefit structure	9
Collusion between service providers	8
Electronic Data Interchange (EDI)	7
Reliance on Board of Healthcare Funders screening before issue of practice numbers	7
Lack of sophisticated interrogation/detection software	6
Poorly trained claims-processing staff	4
Poor internal controls	4
Collusion between service provider and administrator staff	4
Collusion between member and administrator staff	3
Other	3
Collusion amongst administrator staff	2



Fraud reduction

Respondents indicated that establishing a Code of Conduct and a Fraud Policy were the most effective methods of reducing fraud. This strategy is currently in operation with all six administrators represented.

Introduction or improvement of data interrogation and detection software was rated the next most effective.

Category	Rating weighted to % principal members
Establish a code of conduct	14
Establish a fraud policy	14
Introduce/Improve data interrogation/detection software	13
Forensic Investigative Review	11
Fraud Awareness Programmes	11
Review and improve controls	9
Implement a comprehensive ethics programme	9
Quality control or claims-vetting of paper claims	9
Introduce screening of service providers	8
Electronic alert to members of claims	7
Training courses on fraud prevention and detection	7
Increase Budget of Investigative function	6
Screen staff members	6
Incentives for whistle-blowing	5
Improve screening of new members	4
Other	1

Code of ethics

Regarding the impact of ethical standards on fraud prevention and detection, all respondents claim to communicate ethical standards to employees, members and service providers.

Ethical standards are predominately promoted through the display of ethical standards in the workplace. Brochures and training workshops are also considered to be effective.

Screening

Five of the administrators, representing 99% of principal members, have screening procedures in place. Of these administrators, all screen administrative staff, but none screen service providers.

Fraud risk management

All respondents indicated that Fraud Risk Management processes are in place.

These were as follows:

Category	Percentage principal members
Forensic Investigative Unit or outsourced specialist assistance	100%
Hotline for whistle-blowers	100%
Systematic claims review	95%
Fraud response plan	77%
Data interrogation or detection software	35%
Other	7%

Claims audit

All respondents indicated that claims paid out run the possibility of being audited before being paid.



Forensic Unit

All respondents indicated the existence of dedicated Forensic Units. Five have been in existence for more than three years and the others for one year.

Established Forensic Units consisted of three to 25 dedicated staff members.

All respondents indicated that their respective Forensic Units are represented at management meetings.

Budgets

Of Forensic Units that have been in existence for more than three years, only one does not have its own budget. Of those with their own budgets, one has a budget exceeding R10 million, one has a budget between R2 million to R5 million and the other three respondents indicated budgets of less than R2 million.

Recoveries

All respondents indicated that the Forensic Investigative Units had achieved recoveries. Two respondents, representing 48% of principal members, indicated recoveries in excess of R10 million. One respondent, representing 22% of principal members, indicated recoveries of between R2 million and R5 million. The remainder of respondents recovered amounts below R500 000.

Only one respondent indicated recoveries amounting to less than its Forensic Unit budget.



General

Increase in fraud

Respondents representing 99% of principal members think that fraud will increase. The reasons provided are as follows:

Reason	Percentage of principal members
Economic pressures	100%
Weakening of society's values	100%
Emphasis on electronic claims and payments	72%
Lack of emphasis on prevention and detection	71%
Lack of adequate penalties and enforcement	54%
More sophisticated criminals	54%
Other	54%

Motives

Respondents indicated that the strongest motives for perpetrating fraud are:

- Misplaced community spirit
- Greed
- Economic need
- Culture of entitlement.

Motivation	Percentage of principal members
Misplaced community spirit, such as providing a medical scheme card to help a sick neighbour or extended family member	100%
Greed	98%
Economic need	94%
Culture of entitlement	93%
Member pressure on service providers	77%
Practitioners believe they are being underpaid in terms of medical scheme rates/national price list	76%
Getting away with it	69%
Syndicate involvement	69%
Everyone else is doing it	46%
Familial pressures	7%

Summary

Fraud

Following the survey, the findings can be summarised by the following key points:

- The perception is that fraud will increase in the medical environment in future.
- The percentage of investigated fraud has dropped from 0,7% to 0,26%.
- The frequency of fraud by service providers is increasing and fraud by members is decreasing.
- The highest value of service provider fraud was perpetrated by General Practitioners, followed by Pharmacies and then Specialists.
- The greatest value of service provider fraud was Merchandise Substitution, followed by Code Manipulation and then Fraudulent Over-servicing.
- Despite Merchandise Substitution accounting for the greatest value of service provider fraud, the last three years have shown a decreasing trend, in this regard.
- Code manipulation and substitution of generics for ethicals reflected a steadily increasing trend over the three-year period.
- The greatest value of member fraud was the non-disclosure of prior ailments.
- Administrator fraud was minor in comparison to member and service provider fraud.

Response to fraud

There is a significant change from the previous survey regarding the reporting of fraud to SAPS and instituting civil action for recovery. Respondents indicated a greater reluctance to report fraud to SAPS and institute civil action.

In addition, more respondents indicated a preference to blacklist service providers.



Internal control

Fraud was uncovered most frequently by:

- Internal controls
- Informants or whistle-blowers
- Notification by members or other external sources
- Board of Healthcare Funders' Forensic Management Unit.

The primary facilitators of fraud appear to be 'collusion between member and service provider' and 'member apathy or ignorance'.

Electronic Data Interchange was considered low on the list of contributory factors in the last survey, but now it rates fifth.

The most effective methods of reducing fraud are the establishment of a Code of Conduct and the development of a fraud policy.

None of the respondents screen their service providers.

Forensic Unit

All respondents have dedicated Forensic Units and all, except one, have effected recoveries in excess of operating budgets.





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