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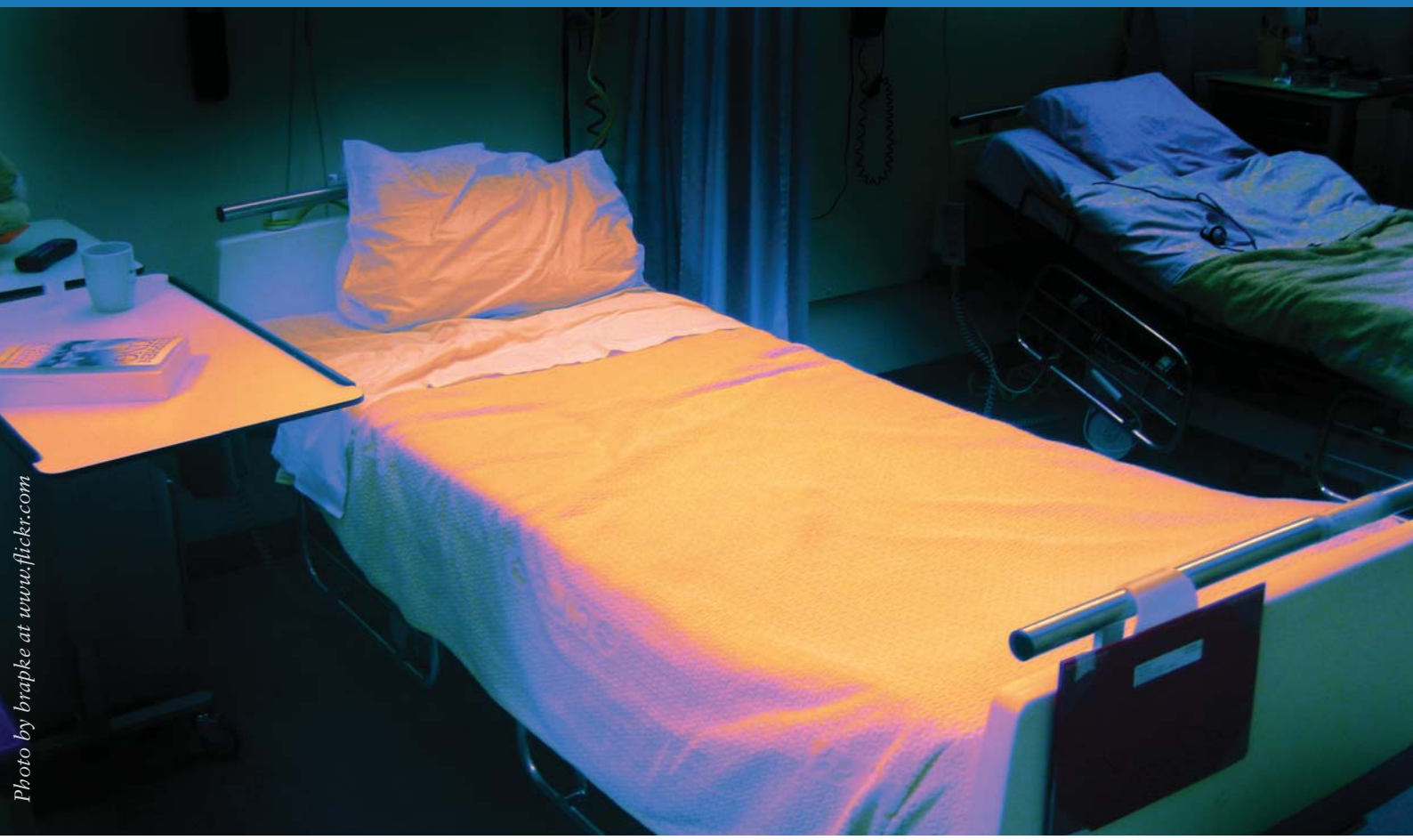

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# Fraud in hospitals

Hospitals are vulnerable to corruption. In the U.S., health care fraud has been estimated to cost $60 billion per year, or 3% of total health care expenditures – much of it in the hospital sector. Hospitals account for 50% or more of health care spending in many countries. Fraud and corruption in hospitals negatively affect access and quality, as public servants make off with resources which could have been used to reduce out-of-pocket expenditures for patients, or improve needed services. This U4 Brief discusses common types of fraud which occur in hospitals in low-income countries, and suggests ways to prevent and control it.

## Introduction

According to the National Health Care Anti-Fraud Association in the United States (www.nhcaa.org), health care fraud is an intentional deception or misrepresentation that could result in unauthorized benefit. In insurance-based health care systems, fraud often involves fraudulent reimbursement and billing practices. Within private, for-profit providers and health care suppliers, fraud may include falsification of financial statements to deceive regulators, shareholders, or industry analysts. Embezzlement, or the misappropriation of property or funds legally entrusted to someone in their formal position as agent or guardian, is another type of health care fraud.

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Hospitals in low income countries are particularly vulnerable to fraud in part because administrative systems are not well developed or transparent, making it hard to distinguish between intentional fraud and abuse due to incompetence or ignorance. In addition, hierarchical structures and personnel management systems may discourage people from voicing concerns or pointing out poor performance for fear of retaliation.

According to auditors who have worked in resource-constrained hospitals, three types of fraud are particularly common. These include: 1) diversion of patient fee revenue at point of service; 2) diversion of accounts receivable, or checks submitted by patients or companies to pay debts owed on their accounts; and 3) collusion between hospital purchasing agents and suppliers. Each of these is discussed below.

## Diversion of fee revenue

Many hospitals in developing countries charge fees for services. While on average the fee revenue in public hospitals does not often amount to much – generally less than 10% of hospital revenue – it can still be an important source of local funding for under-funded expense items like medicines, supplies, or small repairs. In private hospitals, fee revenue is the most significant source of funding. Generally, a patient will pay the user fee at a cash collection office, where a clerk records the amount paid and issues a receipt. There could be several cash collection offices spread across the campus of the hospital, usually close to where services are rendered. At the end of the day, the cashier will prepare a summary of cash collections and turn this, together with the cash collected, over to the accountant (or chief cashier in a large hospital). The accountant or chief cashier will then "post" or record the transaction into the cash book, and into a patient revenue account in the general ledger. The daily cash collections are banked on the next business day by the accountant or chief cashier. In many cases, the accounting function is kept separate from the cash collection function.

One way in which fraud occurs in the process of collecting and recording of fee revenue is through the use of a "refund" account. A refund account is a legitimate accounting category, meant to include revenue to pay legitimate refunds for services which were erroneously charged or where a refund is due for some other valid reason. However, refund accounts can also be abused. Instead of posting patient user fee revenue to a patient revenue account, accountants may post the revenue into a "refund" account. Later, a fictitious "refund" to a non-existent client can be made, which is actually sent to an accountant's own personal bank account. This type of fraud can be controlled through the introduction of better internal control procedures, such as requiring a higher level of authorization for the release of refunds.

Another way to divert fee revenue is by altering receipts. Many government accounting offices and NGOs with low levels of computer automation use manual business supplies such as registers, forms, and receipt books. To avoid the possibility of fraud, it is advisable to fill out receipts with the amount noted in numbers and in words (i.e. "$10.00" and "Ten dollars and no cents").However, some common types of manual receipt books do not have enough space to write the amount of cash received in words. Unfortunately, where this information is omitted it is much easier for a fraudster to change a number on the receipt. In one hospital, an audit detected that cashiers were in fact doing just that: altering the carbon copy of receipts after the patient had been given a receipt with the correct amount recorded. The cashiers slipped a card between the original and the copy so that they filled in a different amount on the copy after issuing the original to the patient. The use of electronic cash registers is helping to solve this problem. Another strategy for prevention is to alert patients to watch how the receipt is prepared, and to report any suspicions or concerns.

## Diversion of accounts receivable

A second type of fraud involves accounts receivable. Accounts receivable is an accounting term which refers to money owed to the company by customers for services provided on credit. Patients may come in to settle their debt with a check, or a company may send a check to pay for services provided on credit to company employees. Accounting clerks who open the mail or receive the checks from patients may deposit the check into a personal bank account. Since the debt still appears as owed by the client, the accountant may later write off the client's outstanding balance as "bad debt" or may wait for another check from a different patient/client and apply this to the account whose check was stolen. This is termed lapping, or "teeming and lading". This type of fraud can be avoided by separating duties, i.e. having one person open the mail or handle customer cash, while a different person is responsible for cash deposits and collection follow-up. Providing monthly statements to clients, and requiring employees to take regular leaves, can also help expose this fraud.

## Collusion with suppliers

The third major type of fraud in hospitals in developing countries involves collusion with suppliers. After personnel, purchases of goods and services is the next largest expense item. Accountants and purchasing clerks may collude with suppliers to make a deliberate overpayment for an order. The amount by which the order was overpaid is then refunded by the company to the accountant directly, as a kickback. Sometimes a supplier will legitimately offer a "discount" off of list price. In this case, the refund check may be made out to the hospital, and will be sent at a later date. In such a situation, the accountant can still commit fraud by depositing the check into his or her own personal account.

## Prevention and control

Improvements in administrative and financial systems can deter employees from attempting these types of fraud. These systems aimed at preventing and controlling fraud are generally part of an organization's internal control system. According to the Committee of Sponsoring Organizations (COSO) of the National Commission on Fraudulent Financial Reporting (also called the Treadway Commission), a system of internal controls "can help an entity achieve its performance and

profitability targets, and prevent loss of resources. It can help ensure reliable financial reporting. And it can help ensure that the enterprise complies with laws and regulations, avoiding damage to its reputation and other consequences. In sum, it can help an entity get to where it wants to go, and avoid pitfalls and surprises along the way".[1] The design of an internal control system depends on an organization's size and the nature of its transactions. Certain aspects of an internal control system may also require investment in staff and/or equipment and hence cost may be a factor to consider in deciding what kinds of controls an organization puts in place.

The problems described above can be controlled with fairly simple internal controls:

## Segregation of duties

The division of duties between cashiers and accountants can help to control against fraud. Where feasible, these two functions should be separate. The cashier is responsible for collecting cash and issuing receipts to patients. The cashier prepares a summary at the end of the day to show how much revenue was received in cash and how much was accounts receivable, payable either by patients personally, by employers, or by insurance companies. The cashier's summary should also indicate the sources of the revenue, i.e. what service the patient was paying for: laboratory, x-ray, inpatient, outpatient consultations, etc. This allows the hospital to perform a reconciliation report which compares patient volumes from the different service areas with the revenue received.[2]

The accountants' role is to record transactions, cash should not be handled at all. They receive details of cash collected from the cashier, and enter them into the accounting records. If an accountant has to handle cash for banking, it is important that the banking records are cross checked against the cashier's summary by someone more senior – for example, the administrator – to make sure that all cash collected has been banked. None of the cash should be used for "petty cash", or small, discretionary hospital expenditures where it is not feasible to pay by check.

## Comparing actual and expected revenue

Another control against fraud is to compute expected revenue and compare it to actual revenue. Health statistics such as patient volumes from each department can be multiplied by the average prices of services to estimate expected revenue per service. When actual cash and accounts receivable are compared to expected revenue, they should be approximately equal. Gaps should be investigated as they could be due to fraud. This control is not very difficult to implement but requires that, at the point of cash collection, the source of the revenue is noted (e.g. laboratory, x-ray, inpatient stay, etc). To enhance the effectiveness of the control, the staff in the department providing the service could also record in their treatment registers the amount of money that the patient paid or that treatment was on credit. Each department should be required to present a monthly report to the administrator showing the volume of services rendered and how they were paid for: cash, accounts receivable, etc. The administrator can then compare the departmental workload and revenue reports with the cashier's revenue report to make sure that they are similar. This was one of the most important controls over revenue in Kenya when user fees were re-introduced in the early 90's.

A possible drawback of this control is that staff in the departments providing services may resist being asked to perform "financial" duties. Careful explanation that they are protecting their service's revenue, and that losses of cash lead to non-availability of the supplies and tools they need to do their work, may help overcome resistance. The monthly reports they prepare would also show how much their department is contributing to the total revenue of the hospital; any loss of cash reflects badly on their department.

## Internal audit

In low income settings, most hospitals cannot afford internal auditors. Some large public hospitals will have an internal audit department that audits payments and other aspects of the financial management system. Where an internal audit function is affordable, this can be a very valuable component of the internal control system, but only if it is given the ability to function independently and without interference from other hospital staff. Internal auditors should report to the chief executive and should be given authority to obtain any documents they may need to examine. The hospital can determine what value of transaction must be internally audited so that internal auditors need not see each and every transaction. Internal auditors are not restricted to checking the accuracy or authenticity of transactions only, but are also involved in checking the functioning of all financial management systems, including internal controls.

> *"The use of competent external auditors, while important, should act as a last defense since it happens only after 12 months and much damage can be done during that time."*

Hospitals that cannot afford to hire an internal auditor may choose to have external auditors perform an interim audit (or audits) during the year so that irregularities can be detected before much damage is done. These interim audits form part of the annual audit, increasing the overall cost. NGO hospitals in a network may be able to make the cost of internal audit more affordable by hiring an internal auditor who is shared within the network. However, this may not

1 Internal Control – Integrated Framework, Executive Summary. COSO. http://www.coso.org/publications/executive_summary_integrated_framework.htm

2 See U4 Brief 1 (2006) "Using financial performance indicators to promote transparency and accountability in health systems", for further discussion of how comparing expected versus actual revenue and expenses can help detect anomalies and deter corruption. www.U4.no/themes/health

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catch some frauds until after they are committed since this individual would not be fully resident at the hospital. The auditor would, however, be able to do these audits more regularly and frequently than an external auditor and may also reduce the cost of the external audit.

### *External audit*

The use of competent external auditors, while important, should act as a last defense since it happens only after 12 months and much damage can be done during that time. In many countries, external audit is a legal requirement for private organizations whether they are for-profit or not. The external audit serves an important role. It allows an independent, technically qualified, registered person to examine the annual financial reports, the underlying accounting records and systems, and to issue a report as to whether the financial statements are free of material error. In the process of examining transactions, fraudulent activities can also be detected and reported to management. However, fraud detection is not the objective of an external audit.

When evidence of fraud is discovered during an external audit, the auditor is supposed to report it to management. It is up to management to decide whether to hire the external auditor or another financial investigator, to do a special investigation to determine those involved and the extent of the fraud. Management can use the investigator's recommendations for systems improvement and can also use the report to bring legal proceedings against the fraudulent staff.

### *Investing in fraud control: costs and sustainability*

The internal control systems to prevent fraud need to be tailored to the hospital's size and volume of transactions. Often, relatively small investments in technology can provide major benefits. For example, cash registers can easily reduce the ability of cashiers to tamper with patient fees. The major cost is the initial purchase of the machines.[3] Use of more sophisticated receipts which allow more information to be captured may increase supplies cost only marginally. However, hiring of new staff in order to allow for the segregation of duties may be more difficult to justify. It is important to weigh the benefits of any course of action with the potential cost and decide the best way forward. A good place to start is to look at what improvements a hospital can make with existing resources. Can staff be asked to do new duties outside their current job description? Can the hospital form an Internal Controls Team whose duties would be to ensure that the existing controls are followed? New charts showing side-by-side revenue and volume of services for each department would require little time investment and yet would quickly alert to any major discrepancies.

## Conclusion

Fraud takes place in hospitals if the environment is such that the perpetrator perceives little risk of being caught. This is particularly so, if cashiers, accountants and stores clerks think that nobody is looking at what they do: there is no demand for reports; no comparisons between revenue and service volume reports; no regular checking of service registers or cash books. Clearly the involvement of senior management in supportive supervision is important in sending the message that somebody is looking and is ready to take action. Strengthening internal control systems is important, and can start with making better use of existing resources before incurring additional costs.

3 See U4 Brief 3 (2006) "Anti-corruption in the health sector: Reducing vulnerabilities to corruption in user fee systems" for more details on the Kenya cash registers initiative. www.U4.no/themes/health

## Further reading

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This U4 Brief and more resources on Corruption in the Health Sector is available at www.U4.no/themes/health