Medical aid efforts fail to keep fraud in check

MEDICAL scheme fraud, estimated at about R15bn annually, is not declining, despite greater sharing of information by medical schemes and a zero-tolerance approach by some of the bigger medical schemes such as the Government Employees' Medical Scheme and Discovery Health. Michelle David, a medical scheme specialist at law firm Eversheds, said although it had been estimated that fraud cost SA's schemes between R4bn and R15bn, she believed it to be more than R15bn. She said few medical schemes took part in surveys to determine the extent of fraud - only about eight schemes on average, and not the larger ones. Discovery Health CEO Jonathan Broomberg said that although figures bandied about were 'nothing more than guesswork" it was a "significant and growing problem". Discovery Health recovered about R250m from fraud it could prove every year, and the scheme spent "significantly more" than R10m a year to investigate and combat fraud, he said. Board of Healthcare Funders spokeswoman Heidi Kruger said 10 percent of the R90bn annual spend in private healthcare - covering only 16 percent of people in SA - could be attributed to fraud and wastage. A KPMG report showed that of the R145bn spent on medical treatments from 2007 to 2009, more than R67m was leakage due to fraud committed by members and almost R152m because of fraud by service providers. According to David, statistics from the South African Medical Association showed that R150 of a member's average contribution in 2002 went to combating and covering losses due to fraud. This increased to R400 in 2010. Lynette Swanepoel, manager of the Board of Healthcare Funders' forensic management unit, said she personally had little faith in surveys that indicated a decline in fraud. There had simply been a change in the methods used by fraudsters. She said there had been an increase in syndicated fraud by individual doctors or partnerships, and more and more with a hospital, doctor and pharmacy involved. David said the level of fraud was quite "ludicrous". Doctors were overbilling, pharmacists were dispensing medicine patients never asked for, and members were getting cash, groceries and even very expensive cooking pots through their medical schemes. She said that the introduction of National Health Insurance (NHI) would bring a whole new level of access. She said currently 16 percent of the population was covered by private healthcare and the balance was in the public hospital system and it was already riddled with fraud. David said a positive element of the NHI plan was that it would be "one bank of information" and would therefore not suffer the same level of manipulation as different schemes not eager to share information were suffering. Swanepoel said there were huge concerns about systemic fraud showing its ugly face in the NHI where the volume of service providers, members and claims were going to be multitudes of what the current situation was. All medical schemes and administrators were looking at ways to assist the government in setting up a system that could help combat fraud. David said the various laws that governed medical schemes, healthcare professionals and the criminal justice system did not "speak to each other". As a result, medical schemes were "toothless", and this raised concerns if the NHI scheme was to be run under the same laws. The government would have to be alert to the current shortcomings in legislation and enforcement, she said. Kruger suggested "systemic changes" in the industry to get rid of the wastage and fraud.

Amanda Visser: Business Day, 23 July 2012