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The Private Healthcare Insurance sector: A victim of fraud

Abstract

Regardless of the jurisdiction research has repeatedly highlighted that the ‘public’ see the insurance sector as an acceptable business to defraud. This article builds on this work but is different in that we draw on primary research, of which there is little, into the private healthcare insurance sector as a victim of fraud. We start by highlighting the types and volumes of fraud that the insurance sector encounters. This is followed with an examination of policing private insurance fraud in a neo-liberal context where individuals and organisations are responsible for risks. Then, we consider if the private healthcare insurance sector is precipitating and participating in its own victimisation. The methods used in this research to secure data are then explained. Finally we analyse how the key elements of the data might point to the private healthcare insurance sector potentially precipitating and participating in its own victimisation.

Key Words: Fraud, Private healthcare, Insurance, Technology, Victimisation

Authors

Professor Graham Brooks: Professor in Criminology and Anti-Corruption, University of West London, SHSS, Paragon House, Boston Manor Rd, Brentford TW8 9GA

Dr. Peter Stiernstedt: Head of Subject for Criminology, Forensic Science and PIR, University of West London, SHSS, Paragon House, Boston Manor Rd, Brentford TW8 9GA

Introduction

Healthcare fraud is an international issue. Most of the literature, however, highlights public sector ‘welfare’ fraud (Banerjee, Duflo & Glennerster, 2007; Brooks et al., 2017; Chaudhury et al., 2006; Francis, 2010; Gill & Randall, 2015; Goddard, 2015, Prenzler, 2020) and is often concerned with the measurement of losses to fraud (Brooks et al., 2017, Brooks, Button & Gee, 2012, Gee & Button, 2015, 2017, Sparrow, 2000) characteristics of fraud and its prevention (Gill & Randell, 2015, Ryan, 2017, Stowell, Schmidt, & Wadlinger, 2018) and state policing of fraud (Button & Brooks, 2016).

Global healthcare expenditure reached 8.3 trillion (US dollars) in 2018 (WHO, 2020). Of this 8.3 trillion (US dollars) 41 percent was spent on private healthcare insurance schemes. Broad estimates of healthcare expenditure lost to fraud range between 3 to 10 percent (Gee & Button, 2015). Due perhaps to the volume of private healthcare insurance and estimated losses to fraud there is also now a developing body of literature on the private policing of insurance fraud (Ericson et al., 2003, King, 2013, Stenstrom 2020, Wilcock, 2019). This literature examines why the private healthcare sector is a victim of fraud. But instead of employing the approaches mentioned above, it considers ways in which the insurance sector controls fraud, examines its thresholds of tolerance for fraud and potential for precipitating and participating in its own victimisation (Cross, 2013, Pertherick, 2017). Placed in a Foucauldian framework, Stenstrom (2020) highlights how the technologies of power shape the plurality of policing (Bowling, Reiner & Sheptycki, 2019) and the private healthcare insurance sectors approach to fraud. This paper is a contribution to this body of knowledge.

This paper will therefore start by highlighting the types and volume of fraud that the private insurance sector encounters. This is followed with an examination of policing insurance fraud in a neo-liberal context where the responsabilisation (Garland, 1996, 2001) of individuals and organisations are liable for personal and organisational risks and threats. Then, we examine if the private healthcare insurance sector is precipitating and participating in its own victimisation where its power to define fraud downplays the levels of fraud it incurs to maintain its own legitimacy and profits. Then we inform and reflect on the methods used in this research to secure data. Finally we analyse how the key elements of the data fit the neo-liberal view of policing the private healthcare insurance sector and how it might potentially be precipitating and participating in its own victimisation.

The Private Health Insurance sector: Volume and Types of fraud

There is a significant body of research that shows that the ‘public’ see the insurance sector as an acceptable business to defraud (Button, Pakes & Blackburn, 2016, Crocker & Tennyson, 2002, Tennyson 2008). There is also research highlighting the involvement of the middle classes in a range of white ‘insurance type’ collar crimes (Button & Brooks, 2016, Weisburd & Waring 2001,) with substantial estimates of national and international funds lost to insurance fraud (Gee & Button, 2015, Flynn, 2015).

Rather than consider all losses to different types of insurance fraud here we attempt to highlight losses to private healthcare insurance fraud only. The boundary between the public and private sector, however, is increasingly blurred with enrolment of people on either or a combination

of mandatory and voluntary schemes that are based on risk, coverage of a community of people (transfer between healthy and sick) or income (transfer between income brackets) such as commercial for profit or non-profit sectors (Sekhri, Savedoff & Thripathi, 2005). Therefore, clear measurement of losses to private healthcare fraud is difficult. Consequently we highlight a combination of public and private losses where relevant. The NHS estimates that £1.27 billion (British pounds) are lost to fraud each year (NHSCFA, 2020). This seems a conservative estimate when the cost of NHS for 2019/2020 was £150.4 billion. The National Health Care Anti-Fraud Association in the USA estimates that \$68 billion (US dollars) is lost to healthcare fraud alone each year but considers this also to be a conservative estimate of actual losses. Global estimates of healthcare fraud are considered to be in the region of \$260 billion (US dollars) (WHO, 2020) a year.

The jurisdictions mentioned above have different approaches to healthcare provision with a substantial difference in the role private healthcare plays within a country, the health system itself, and the size and function of different healthcare insurance markets (Colombo & Tapay, 2004, Mossialos & McKee, 2002; Thomson, Foubister & Mossialos, 2009, Thomson & Mossialos, 2006). Healthcare coverage is diverse rather than a monolith ‘one size fits all’ approach. This diversity makes it difficult to define what is meant by private healthcare insurance and hence its role in potentially preventing, precipitating or participating in its own victimisation.

What is far more common, however, is the type of fraud that the private healthcare sector encounters regardless of the jurisdiction. A sample of these are:

- Upcoding – submitting claims for healthcare services/procedures/diagnosis that were (or partially) performed
- Unbundling—submitting claims for each step of a service/procedure as if it was distinct and a separate part of the service that increases costs
- Unnecessary medical intervention/tests etc – these are diagnostic tests, x-rays, etc conducted for the sole purpose of generating insurance payments
- Misrepresentation – engaging in cosmetic surgery but claiming it as necessary medical intervention and treatment
- Fraud - alter all or part of patients records to claim for a medical intervention and treatment that was unfulfilled

These threats and risks are wide-ranging and often come from individual patients, professionals such as doctors and dentists and organisations such as hospitals etc. A few examples should help highlight the seriousness of the problem. In England, Ian Paterson subjected more than 1000 patients, predominantly women, to needless and harmful breast surgery for approximately fourteen years. Ian Paterson worked in the NHS and private sector and exaggerated or invented the risk of breast cancer to conduct surgery (Campbell & Topping, 2020) and was eventually sentence to 20 years in prison. In Australia, the proprietor of a medical clinic defrauded Medicare of \$3.3 (Australian dollars) in 2018 by claiming rebates for non-existent services to patients. The proprietor deleted claims from the clinic’s management software after submitting them in the hope of avoiding detection and was sentence to six years in prison (The Office of the Commonwealth Director of Public Prosecutions, 2020, Vian, 2020).

With the volume of estimated funds lost to healthcare fraud, and the range of threats and risks it encounters, it seems appropriate to examine why the private healthcare sector is unable to prevent such losses to fraud?

Policing Insurance Fraud

Insurance shapes a sense of protection, a safety-net, particularly in healthcare. But while insurance offers a sense of protection and mitigation of risk and harm, it also produces its own risks and avenues for criminal conduct. For example, moral hazard (Cohen & Siegalman, 2010) Ericson, Barry & Doyle, 2000) can increase the occurrence and/or severity of losses due to the attitude of the person(s) view of insurance and personal healthcare. In a neo-liberal context individuals and organisations are responsible for personal risks and threats (Garland, 1996. 2001). In this context, the private insurance sector offers coverage for potential healthcare risks, at a cost, and covers future healthcare needs whilst strengthening public faith, particularly for those that pay private insurance, that it can control and deal with threats to its organisational existence. This, though is also a risk (Stenstrom, 2020); zero tolerance policing or inflexible application of rules might disclose too much fraud and damage organisational legitimacy to offer secure healthcare services.

The private insurance sector, or those that work in it, have the power to define what is a risk and threat. Risks and threats are handled without always engaging state law enforcement (Meerts, 2020) where the 'architecture' of organizational, sectoral and state control (Stenstrom, 2020, Wilcock, 2019) impacts on how organisations deal with risks. Fraud is downplayed or seldom disclosed (Ericson et al., 2003) or defined as a problem in the private sector. Instead, and placed in a Foucauldian framework, Stenstrom (2020) highlights how the technologies of power shape the plurality of policing (Bowling, Reiner & Sheptycki, 2019) and the private healthcare insurance sectors approach to fraud.

Primarily concerned with statistical analysis of events rather than disciplining individuals (Headworth, 2021) the private insurance sector works to secure profit. Wilcock (2019) and (Stenstrom, 2020) highlighted that the insurance sector is engaged in promoting a 'system' that allows individuals to 'cheat' within a set 'bandwidth' of desirable and undesirable behaviours (Foucault, 2009:6) or financial margins where profit is maintained (Ericson, 2007). Private insurance then considers customers satisfaction and expediency of service important, placing controls, and a boundary on special investigators to prevent threats to organisational profit.

There are thus different methods to determine the truth of an act (O'Malley & Valverde, 2014) in the public and private sectors, and types of control - discipline of bodies (Headworth, 2021) or financial risks. This is a crude distinction yet the work cited here emphasizes the need to move beyond research on the characteristics of fraud and notions of state controlled policing (Button & Brooks, 2016) and understand how power is exercised in the private healthcare insurance sector to shape definitions of what is considered acceptable and unacceptable levels of fraud (Wilcock, 2019). This is part of the plurality of policing, a network of state and private sectors that has the power to shape practice and thus sanctions in a neo-liberal context of responsibilisation (Garland, 1996). With the power to shape a bandwidth of acceptable and unacceptable levels of fraud then, is private healthcare insurance sector precipitating and participating in its own victimisation?

Precipitating and Participating in Fraud

An ideal victim of crime (Duggan, 2018) is viewed as weak and vulnerable while the private

insurance sector is seen as able and acceptable to defraud (Button & Brooks, 2016; Button et al., 2017, Gill & Randall 2015). Most of the literature on health insurance fraud analyses the public ‘welfare’ sector at the expense of the private sector. There is, however, exceptional work on the how public and private insurance frame fraud (Stenstrom, 2020, Wilcock, 2019). Drawing on these authors work, we suggest that a private health insurance company has definitional power to establish and determine what is a fraud in its own organisation.

A company is able to withstand partial loss – as a victim of a crime - and still function. In a neo-liberal context, the private healthcare sector has to consider customers’ satisfaction and quality of service. It has no need to pursue all potential cases of fraud, instead it has to ‘talk and act tough’ regarding fraud (Stenstrom, 2020) and instead accept a tolerable level of losses. In this sense we suggest that the insurance sector is precipitating and participating in its own victimisation (Cross, 2013, 2020, Pertherick, 2017). Accepting losses will embolden some offenders to commit fraud. But we suggest that labelling fraud as abuse, or redefine the fraud as abuse, engage in limited policing of fraud, unless inside the organisation, is thus to precipitate and participate in its own losses. Framed within its own responsibilization (Garland, 2001) the organisational pursuit of profit downplays its victimisation whilst precipitating in its victimisation and participating in company losses to fraud.

Methods

In 2018 we sent a pilot survey to five private sector healthcare insurance organisations in different jurisdictions in the northern and southern hemispheres. The survey contain four different sections: these were number of dedicated employees to tackle fraud, skills, qualifications and numbers of people that worked in a SIU, pre and post payment integrity systems used, claim line risks and threats and application of technology and data analytics to prevent losses. The survey examined fraud, abuse, waste and error (FAWE) but our concern is with fraud data only here.

The survey was distributed via a private sector healthcare insurance networkⁱ. The number of organisations involved is small and based in advanced democratic nations. They are therefore representative of all organisations based in democratic nations or having a branch in a developing nation, but less so those based in an emerging nation with a limited customer base set within specific geographical and national borders. These later organisations, whilst interesting to survey, lacked the infrastructure to respond to all sections of the survey. A second survey encompassing all members is the second stage of the research.

We sought, with guidance from a private sector healthcare insurance network its members that would engage in the pilot, were willing to respond as fully as possible, had a clear fraud prevention and measurement systems in place and were able to provide data on FAWE. The organisations in this pilot then were those that offered the ‘gold standard’ of private healthcare services. All these organisations provided detailed responses to a number of questions on FAWE. These organisations covered a total of 8.7 million people between them ranging from the 871,000 to 3.7 million clients per organisation. Whilst the number of organisations is limited the numbers of people covered and data obtain in the survey is extensive as are the issues the organisations encountered.

Prior to sending out the survey we discussed with the private sector healthcare insurance network the problem of how to define fraud. Whilst all the jurisdictions could be bluntly

described as ‘western’ democratic states the definition of fraud or those working in the private healthcare sectors have the definitional power to define fraud (Strenstrom, 2020, Wilcock, 2019) and thus establish ‘bandwidth’ of desirable and undesirable behaviours (Foucault, 2009:6) and record of fraud. A legal definition from one jurisdiction was therefore considered unacceptable, as laws are socially constructed (Goode & Ben-Yehuda 2010) and reflect historical, political and social influences.

The issue of an understandable definition therefore became of paramount importance. To establish definitions and how these should inform the design and distribution of the survey, we used a modified Delphi method. This is a useful method that helped enable a structured communication between individuals and organisations in order to secure a consensus of opinions confronted with multifaced complex problems (de Loe 2016). To secure a consensus the iFHP sought its members views on how FAWE should be defined.. In total there were four iterations before reaching a satisfactory consensus. Note that this did not mean having complete convergence of opinions, but rather that the variability of responses had decreased to a point where the core definition remained the same. Accordingly, the definition we settled on was: Fraud as a deliberate attempt to deceive an entity (individual or organisation) to secure a financial benefit now or in the future.

We are aware that this definition can, despite methodological rigour be contested, but in order to progress the research a ‘workable’ definition was required. The reasons for this include inter alia organisations operating within different regulatory frameworks and applying tools and technology that also have a normative influence on definitions. With advice from the private sector healthcare insurance network that had direct contact to the organisations the above definition was placed at the start of the survey with a caveat regarding competing definitions of fraud inter alia other definitions such as abuse, waste and error.

From establishing working definitions, we designed each section of the survey to capture quantitative and qualitative data with the measurement of data in mind. However, as repeatedly highlighted by Gee & Button (2013, 2014, 2015, 2017, 2018) measurement is possible yet not always employed as part of a fraud strategy (Brooks, 2016; Levi & Burrows, 2008; Stiernstedt, 2016; Tombs 2009; Urra, 2007). We are aware of the limitation of surveys but present this original research as a window into how the private healthcare sector is under threat from fraud and thus a victim of fraud and as a mission to understand and record contemporary and future issues that the healthcare sector will encounter and how it deals with past, present and future threats.

Discussion

Drawing on the information above and empirical data secured, we reflect on the definitional capacity of the private healthcare sector. This is followed with an analysis of the numbers of dedicated employees employed to tackle fraud. This leads on to a consideration of the composition of SIUs. Then we explore the payment claims systems used by these organisations and finish with a section on the application and use of technology and data analytics to prevent fraud.

Definitional Capacity

The definitional capacity of what is fraud is wide-ranging (Button, Pakes & Blackburn, 2016)

in the insurance sector and the organisations surveyed in this research confirmed this view. We discovered that an act of fraud defined by one organisation was recorded as abuse by others. Furthermore, if fraud was recognised but of such a low value and below a financial threshold where investigation costs outweighed the return of funds, there was the possibility the case was dismissed as was indicated in the policing and precipitating and participating sections above (Stenstrom, 2020). The definition of what was considered fraud, however, was often dependent on the location of the individual. There was a zero tolerance for employees while customers, depending on the type and level of fraud, were ‘tolerated’. This highlights the capacity for how the insurance sector is engaged in promoting a ‘system’ that allows individuals to ‘cheat’ within a set ‘bandwidth’ of desirable and undesirable behaviours (Foucault, 2009:6).

Even with a modified Delphi method in our research we still encountered the problem of how private sector healthcare insurance organisations defined fraud. This, however, is not unique to this sector (Brooks, 2016; Gardiner, 2002; Graycar, 2015; Graycar & Prenzler, 2013; Heywood, 2015). This research indicated, as others has done (Stenstrom, 2020, Wilcock, 2019) that the definition of fraud and threshold of information that could lead to investigating a claim is subject to change. This change is subject to the ‘architecture’ of organizational, sectoral and legal control (Stenstrom, 2020, Wilcock, 2019) of the sector.

Factors shape and affect past and present private insurance healthcare definitions, systems and jurisdictional context. A major concern highlighted in this research was the changing landscape where cosmetic surgery was presented as medical need. The organisations surveyed primarily viewed this as abuse. This is perhaps an illustration of the definitional power to decided how to view and record incidents and the set the bandwidth of desirable and undesirable behaviours (Foucault, 2009:6) or financial margins where profit is maintained. While a healthcare system checks claims and payments that should be dispensed to a healthcare professional, hospital, or individual claimant, it should correct claim errors and reject claims if the provider(s), recipient, or procedure is ineligible. The processing of claims is, however, a combination human and technical interaction. Sparrow (1996) advocated that the ‘human touch’ is still needed to assess ‘suspicious’ claims where ‘systems select: humans inspect’ to reduce its losses to fraud but within this interaction the power to define or reject a case as fraud offer different methods to determine the truth of an act (O’Malley & Valverde, 2014) and types of control. This control, however, is potentially dependent on the definition of fraud and the number and type of employees dedicated to preventing this ‘crime’.

Dedicated Fraud Employees

The data highlighted that internal employees dealt with a range of issues rather than fraud alone. This is perhaps understandable where employees, as part of an investigation unit had numerous roles. The number of employees dedicated to preventing and recovering losses to fraud, however, was low. This perhaps lends credence to the view that the private insurance sector shapes definitions of what is considered fraud where it is downplayed or seldom disclosed (Ericson et al., 2003) or defined as a problem, and hence the need for a low number of dedicated employees. For example:

- One organisation employed one dedicated employee for fraud
- One organisation employed seven dedicated employees for fraud
- One organisation employed nine dedicated employees for fraud
- One organisation employed fourteen dedicated employees for fraud
- One organisation claimed to have no dedicated employees for fraudⁱⁱ

The low-level of dedicated employees here appears to suggest that it has no need to pursue all potential cases of fraud (Stenstrom, 2020) and instead accept a tolerable level of losses. One organisation claimed to have 20,970 ongoing investigations. No doubt a small percentage of these ongoing investigations had an element of fraud. Yet employing such a low number of dedicated employees, is, we suggest perhaps an example of the insurance sector precipitating and participating in its own victimisation within a bandwidth of tolerance.

Investigation Units

The numbers of employees and composition of the investigation units differed too. Four organisations had employees with professional qualifications, the fifth failed to disclose the composition of its SIUs. Since a process or procedure can be circumvented to some extent, the employment of people with a range of skills is needed. From the survey, we discovered that the private healthcare insurance sector employs a wide range of professional people; ex-law enforcement, nurses, data analysts and counter fraud specialists. All offer a range of knowledge on the healthcare market. Whilst the survey highlighted the importance of professional qualifications as relevant and valuable caseloads differed substantially. For every dedicated employee, which is one that works in preventing fraud, abuse, waste and/or error, we calculated that the standard caseload for each dedicated internal employee is 122 cases per year. As such there is the potential that if fraud is unearthed, and defined as such, the time to conduct a full and professional investigation is limited. This current context appears to confirm the view that the private sector has no need to pursue all potential cases of fraud (Stenstrom, 2020) and instead accept a tolerable level of losses. This, we suggest, as above is potentially an example or precipitating in its own victimisation (Cross, 2013, 2020, Pertherick, 2017).

Payment Integrity Systems

Each organisation in this research made it clear it had a pre/post payment split as part of its process in investigating payment claims for services. All organisations conducted pre-payment internal assessments, with only one organisation also conducting external assessment. In addition all organisations conducted some kind of internal post payment analysis. Both pre and post payments are subject to types of fraud: up-coding, claims for 'excessive' treatment, cosmetic surgery presented as medical need. Pre-payment has the capacity to help reduce losses (Button & Gee, 2013) whilst post-payment is problematic (Gee, Button & Brooks, 2011; Gill, 1998; Levi & Burrows, 2008) where costs need to be recovered.

The percentage of pre and post payments system in place across the organisations were substantially different. These were:

- One organisation had a pre/post payment split of 80/20 percent
- One organisation had a pre/post payment split of 35/63 percent
- One organisation had a pre/post payment split of 40/60 percent
- One organisation had a pre/post payment split of 15/85 percent
- One organisation c pre/post payment split of 20/80 percentⁱⁱⁱ

A retrospective post-payment system regardless of the split is problematic in that it leaves the sector vulnerable to manufactured, and/or inflated claims. Once more these pre/post payment percentages highlight how the private healthcare sector is perhaps engaged in precipitating its own victimisation (Cross, 2013, Pertherick, 2017). As we noted above a company is able to withstand partial loss – as a victim of a crime - and still function. In a neo-liberal context

customers' satisfaction and quality and speed of healthcare service - and hence the pre/post payment percentages above - might suggest that it is precipitating and participating in its own victimisation. Profit is still maintained and punitive and symbolic language used for public consumption, and yet such a system appears to denote a level of tolerance for fraud (Stenstrom, 2020) in the name of customers' satisfaction.

Technology and Data Analytics

With technical advances in healthcare in medical procedures or new and expensive medication released on to the market patients, public and private, clamour for the latest and most expensive treatment. The most expensive, however, should not be translated into the best treatment (Ryan, 2017). This is a problem for the public and private sector where managing expectations and demand or low level care (i.e. limited or no impact of care provided for the patient) increase the costs of healthcare.

Survey data indicated that 'new' treatments could be subject to up-coding and embolden overuse and/or misuse/abuse of medication. This seems part of the context, environment of the healthcare sector that might precipitate losses (Cross, 2013, 2020, Pertherick, 2017). One organisation suggested 'dynamic pricing' as a way to counteract these issues. This is where payment - state or private insurance - only pay for an intervention if the impact is superior to prevailing standards of care. This, however, is only part of the armoury needed to help reduce fraud but as already discussed is dependent on what is considered fraud and the bandwidth of acceptable losses.

Developing technical software and hardware has had an impact on the healthcare sector. The capacity of the private healthcare sector to utilise equipment and subsequent analysis of data is important. Due to varying technical progress, national infrastructure and costs, the uptake and use of artificial intelligence in the private healthcare sector is diverse. This is another reason why we restricted our analysis to a small number of well-established, advanced organisations in the private healthcare sector.

Data analysis is a useful tool (Zhihan & Qiao, 2020) in trying to uncover fraud. Unless used carefully though, can lead to false positives or false negatives. Regardless of the potential errors a private insurance healthcare organisation has recourse to a payment system as either a dedicated analytical software system, part of package of systems or external system for payment processing. However, it is possible to alter and adjust data to evade suspicion and subsequent detection in a payment system (as was seen in the case above). Small, consistent frauds often fall in line with 'expected' payment claims, and is a cause of substantial funds lost to fraud as the section on volume and types of fraud highlighted. These small and consistent frauds or 'dripping tap' effect (Brooks, Button & Gee, 2012; Brooks, Tunley, Button & Gee, 2017; Gee, Button & Brooks, 2011) though might fall within an acceptable bandwidth of losses (Foucault, 2009:6). Technical capacity of an organisation is perhaps potentially misleading on its capability to prevent fraud. If, as we suggested, there is a bandwidth of acceptable fraud losses a system can either be set to reject cases that fail to reach a threshold of interest even though all indications point to a fraud or if established dismiss the 'suspicious' claims where 'systems select: humans inspect' (Sparrow, 1996, 1998).

The definitional capacity to set parameters of fraud impact on the definitional capacity to determine risks and threats. We thus sought information on past, present and future threats to the provision of private healthcare insurance services. These are highlighted in Table 1:

Table 1: Claim Line Risks and Threats

Claim Lines	Past	Present	Future
Hospital	Needless consumption of resources (i.e. waste)	Manipulating/upcoding and pricing of services/products	Excessive psychiatric and rehabilitative claims
Medical	Upcoding and cosmetic surgery	Upcoding and cosmetic surgery	Upcoding and cosmetic surgery
Ancillary	Submitting claims for each step of a service/procedure and services, tests, diagnosis and medication not provided	Submitting claims for each step of a service/procedure and services, tests, diagnosis and medication not provided and 'alternative treatments' (i.e. cosmetic dental treatment)	'Alternative treatments' (i.e. cosmetic dental treatment)
Members/customers	Fraud: altered all or part of claims and employee or providers collusion	Fraud: altered all or part of claims and employee or providers collusion and organised crime	Fraud: altered all or part of claims and employee or providers collusion and organised crime
Employees	Processing and adjudication of claims and counterfeit membership	Processing and adjudication of claims and counterfeit membership	Processing and adjudication of claims and counterfeit membership

This table is a snapshot of risks and threats. Recurring themes are included in the table. Individual risks and threats were discounted as we sought common themes within the sector. For hospital claims the major risks and threats in the past were waste of resources, with manipulating/upcoding and pricing of services/products in the present and psychiatric and rehabilitation services in the future. For medical claims the major problem in the past was upcoding, cosmetic surgery and the manipulation of costs. These were also stated as current and future threats to the provision of healthcare services and organisational survival. For ancillary services i.e. ambulance services, the major problem in the past was unbundling claims for tests, diagnosis and services. This was the same for current risks and threats but with the added threat of 'alternative medicine,' with cosmetic dental work and alternative treatments/natural therapy as future risks.

For members and customers the claim line risks in the pass were frauds: altered all or part of claims and employee or providers collusion, and in the present and future all of these continue to be a problem with the addition of organised crime. Due to the interconnected world in which we now live the risks and threats from organised crime were of some concern to the sector. It appears that organised crime and its ability to use technology (Graycar 2015; Hughes,

Chalmers & Bright, 2020; Levi, 2015) is now seen as a substantial future threat and whilst we have no clear systematic data feedback suggested the threat from organised crime is beyond the acceptable bandwidth of losses (Foucault, 2009:6) and victimisation.

For employees the past, present and future risks and threats were all processing/adjudication of claims and counterfeit membership and theft. Internal fraud committed by or arising from employees is difficult to uncover relying on technology alone. As mentioned above, the human element is needed, and depending on the sophistication of the act, the position of power held by the individual or network of people, an investigation can be thwarted. This, however, is the one part of the research where there appears to be no room to suggest that the private healthcare sector might have an acceptable bandwidth of losses (Foucault, 2009:6) and be precipitating and participating in its own victimisation (Stenstrom, 2020). All organisations made it clear that internal fraud is completely unacceptable, and where possible a conviction will be sought to deter others from engaging in fraud.

As indicated in the research the private sector deals with past, present and future events concurrently. Some of these risks and threats are constant such as up-coding of treatment. These up-coding episodes cut across hospitals, medical, ancillary, members and employees alone or in collusion. Furthermore, noticeable in this research was the private healthcare sectors concern regarding current threats such as cosmetic surgery presented as medical treatment, with future threats and risks such as an increase in psychiatric claims, alternative medicine, and threats from organised crime. To counteract these threats the private healthcare needs sophisticated payment systems and data analysts, medical professionals, law enforcement and counter fraud specialists perhaps in excess and/or with enhanced skills and knowledge of the numbers of people employed unearthed in this research.

However, framed within a neo-liberal context and responsibilisation (Garland, 1996) a private healthcare insurance company is still able to withstand partial loss, as a victim of a crime, and still function. Profit is secured as risks and threats are redefined or dismissed. The problem is that with ongoing threats - upcoding and altered claims – joined by the ‘new’ threat of organised crime, research is needed to assess to what extent private insurance healthcare sector can continue to function where it might be precipitating and participating its own victimisation (Cross, 2013, Pertherick, 2017).

Conclusion

Even though the insurance sector is seen as acceptable to defraud (Button & Brooks, 2016; Button et al 2017; Gill & Randall 2015), it is rarely seen as a victim. It is, however, potentially a precipitating and participating victim (Cross, 2013, Pertherick, 2017). To maintain continuous and substantial losses, and still survive perhaps suggests a bandwidth of losses is acceptable. It is understandable, however, that a private healthcare insurance organisation is unable to prevent and control all fraud and is concerned about the threats from organised crime.. It is not our intention to suggest that the sector willingly puts it self forward as a victim, it is to suggest that its definitional power helps shape what is considered fraud and/or abuse and acceptable and unacceptable levels of fraud (Ericson, 2007, Wilcock, 2019). The private healthcare sector is unable and has no need to pursue all potential cases of fraud and yet by behaving in this way leaves itself open to the challenge that it is precipitating and participating in its own victimisation. This paper is a contribution to this literature and we advocate a call to those that fall under the broad heading of criminology to conduct research into the private

healthcare sector to help highlight its role in fraud in the healthcare sector and course of action it needs to take to reduce the risk and threats it will encounter in the future.

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ⁱ This private healthcare insurance network is primarily a CEO network that seeks to discover solutions to common risks and threats in the private healthcare sector. Due to commercial reasons, confidentiality and anonymity, however, we are prevented from naming the network here.

ⁱⁱ Due to commercial reasons, confidentiality and anonymity we are prevented from naming individual organisations in this research

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