



FORENSIC

South African Medical Schemes' Anti-Fraud Survey

ADVISORY



*Please note that for some questions respondents could indicate more than one response.
In these instances the percentage totals will exceed 100%.*



Foreword

Welcome to the first KPMG Medical Schemes' Anti-Fraud Survey. KPMG is proud to offer this survey as part of our service to our clients in their endeavours to reduce the costs and losses resulting from fraud.

Fraud is certainly not a new phenomenon. What is disturbing, however, is the increase in the occurrences of such crimes. The purpose of this survey is to assess the perceptions, as well as the impact of fraud on the Medical Scheme industry of South Africa and to identify trends in combating fraud.

This survey is achieved through the co-operation of the Medical Scheme Administrators and the Board of Healthcare Funders. For this we thank them.

I sincerely hope you find the insights provided by this survey to be of value. For further information, to access KPMG fraud surveys in other parts of the globe, or for advice on dealing with fraud issues, please do not hesitate to contact us.

Petrus Marais

Managing Partner – KPMG Forensic Africa

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About this survey

Introduction

KPMG Forensic is pleased to present the results of the South African Medical Schemes Anti-Fraud Survey.

In July 2004, KPMG circulated an anti-fraud survey questionnaire to medical scheme administrators in South Africa. The survey was conducted on a confidential basis with the undertaking that no information would be released pertaining to 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.

Survey participants were asked questions relating to:

- Their opinion on the extent of fraud within the medical schemes sector
- Fraud experienced by their organisations
- Specific experiences of fraud
- Action taken on the detection of fraud
- Their organisations' vulnerability to fraud
- Their opinion on information security within their organisations and the level of fraud prevention measures in place.

Responses were received from 10 administrators representing 2 294 914 principal members out of a total of 2 802 815 principal members, as published in the 2003-2004 annual report for the Council of Medical Schemes – approximately 82% representation. The ten administrators that responded were:

- Discovery Health
- HDS Medical trading as Multimed
- Medihelp (self-administered)
- Medscheme
- Metropolitan Health Group
- Naspers Medical Fund
- Old Mutual Healthcare (Pty) Ltd
- Sizwe Medical Services
- Spectramed
- Umed (self-administered)

The returns were completed by divisional directors, forensic managers, internal auditors and financial managers.

The analysis of the survey responses has been based on the average number of principal members represented by each respondent.

The respondents represented medical schemes serving principal members from the following industry sectors:

- Manufacturing
- Mining and construction
- Finance and insurance
- Professional and service industries
- Government and parastatals
- General public

For the year under review, respondents collected contributions to the value of R36 billion and paid out claims to the value of R28 billion. The contributions collected by respondents represented 75% of the contributions collected by all medical aids during the year as reported in the Council for Medical Schemes' annual report for 2003-2004. The average monthly contribution per principal member was R1 459.

Claims paid as a percentage of contributions averaged 82%, as opposed to the CMS report which indicated an average claims ratio of 71%.

Fraud

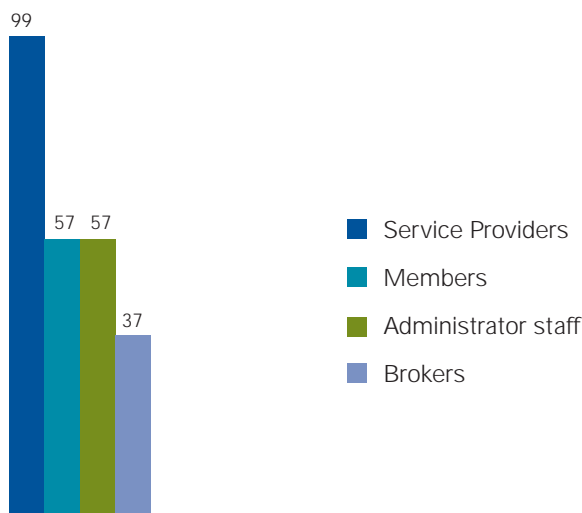
The average amount of investigated fraud as a percentage of claims was 0.7%.

Schemes representing 99% of principal members acknowledged having experienced fraud between 2001 and 2003.

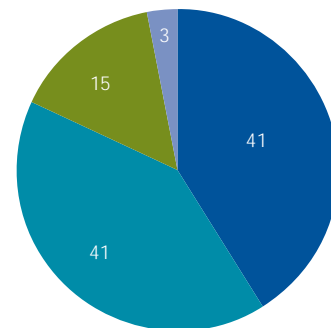
The number of cases investigated exceeded 28 000 over the 3 year period. However, respondents indicated that the number of fraud cases investigated in 2003 was less than those investigated in 2001 and 2002 respectively.

Despite the respondents reporting fewer cases investigated in 2003, the value of fraud investigated had increased from R157 million in 2001 to R213 million in 2003, an increase of 36%.

The average amount of *investigated* fraud, as a percentage of claims for the three years ended 2003, was 0.7%.



% of perpetrators of Investigated fraud



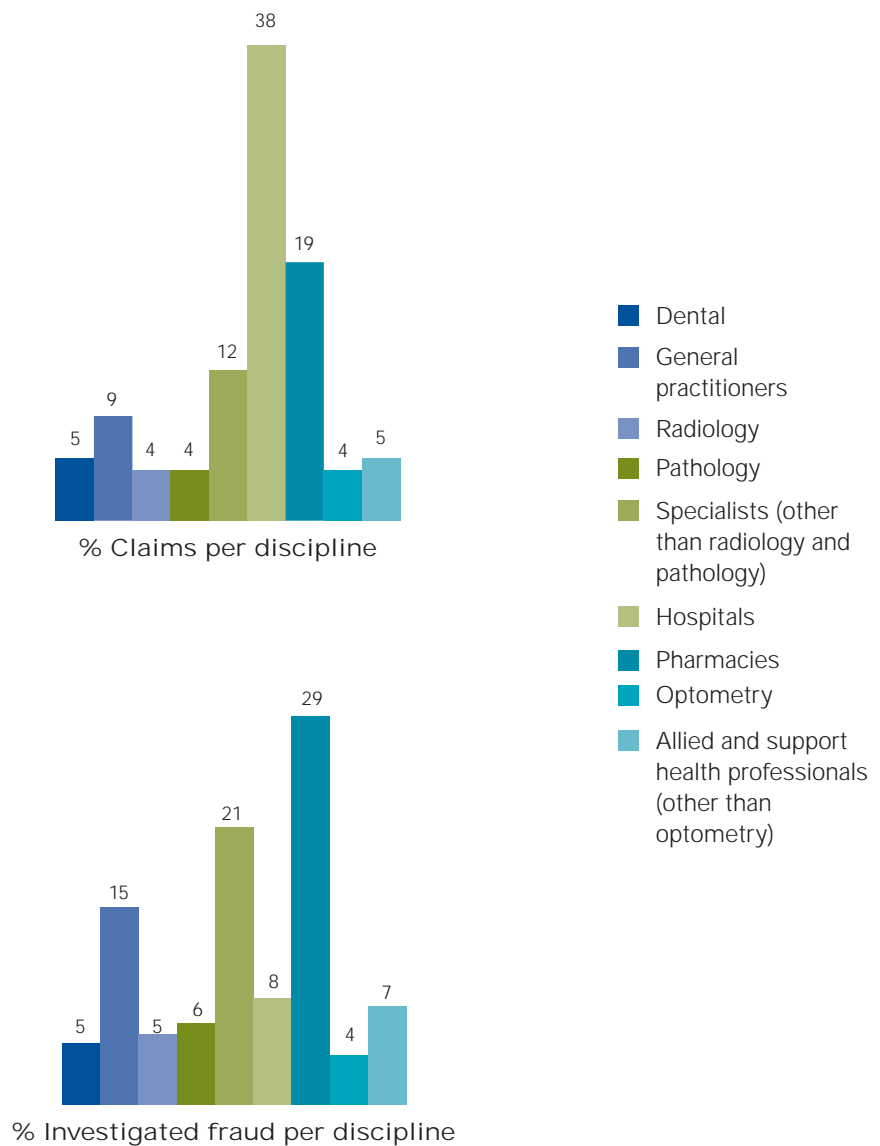
% of Investigated fraud by value

One of the respondents did not supply the relevant data for investigated fraud per service provider discipline. The resultant percentages, shown below, are based on investigated fraud in respect of service providers totalling R46.5 million, as opposed to the reported total of R87 million.

The largest value of investigated fraud was in respect of Pharmacies and represented 29% of the total value. The next highest was in respect of Specialists (other than Radiology and Pathology) at 21% and then General Practitioners at 15%.

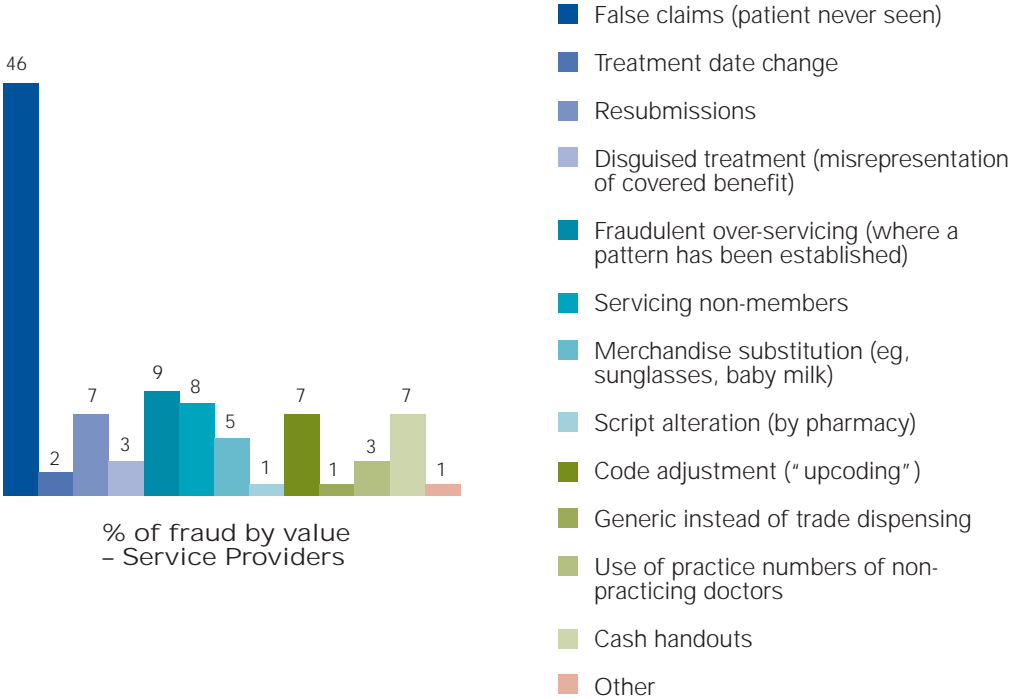
When the ratio of investigated fraud per discipline was compared to the ratio of Claims per discipline the results of the survey indicated that investigated fraud in respect of Pharmacies (29%) was much higher than the claims (19%) as was Specialists (other than Radiology and Pathology) 21% versus 12%. In respect of Hospitals, the trend was reversed, with Hospitals representing 38% of claims but only 8% of investigated fraud.

Ratio of investigated fraud to claims per discipline – service providers



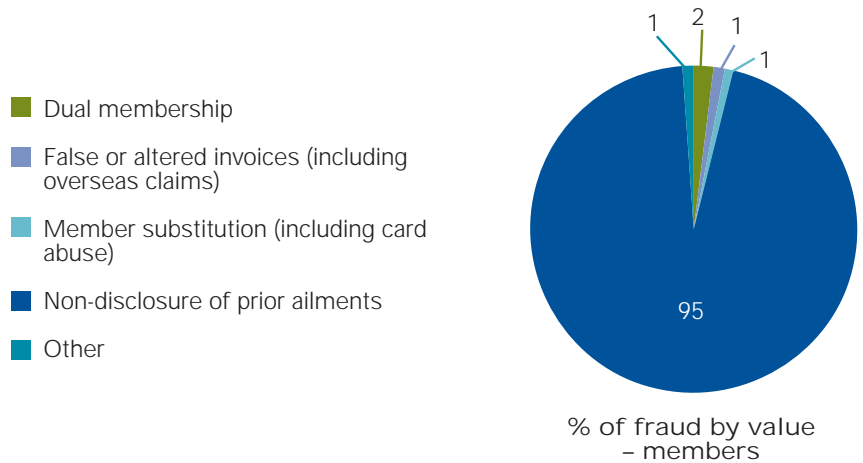
Value of fraud per category perpetrated by service providers

Respondents indicated that by far the greatest value of service provider fraud had been by way of false claims where patients had not consulted with service providers (46%). Values associated with other types of service provider fraud varied between 1% and 9% of value investigated.



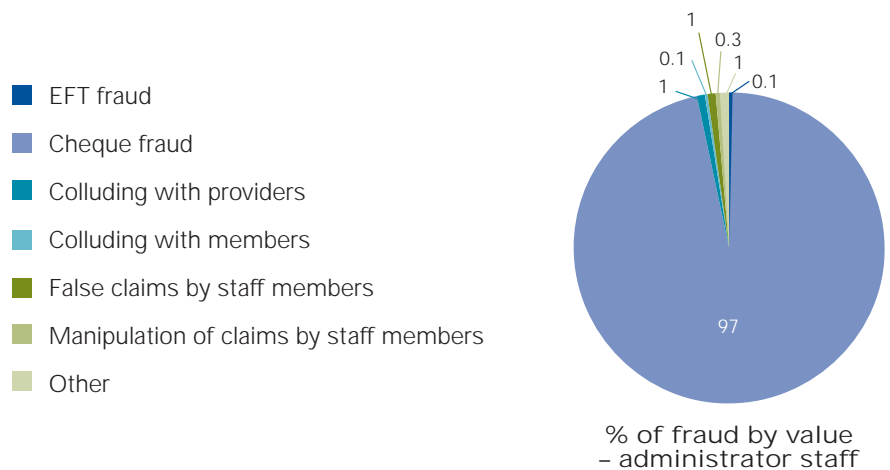
Value of fraud per category perpetrated by members

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



What was the type and value of fraud per category perpetrated by administrator staff

Administrator fraud appeared relatively low compared to member and service provider fraud. One administrator had experienced a large internal cheque fraud.



Response to fraud

What have you done regarding fraud?

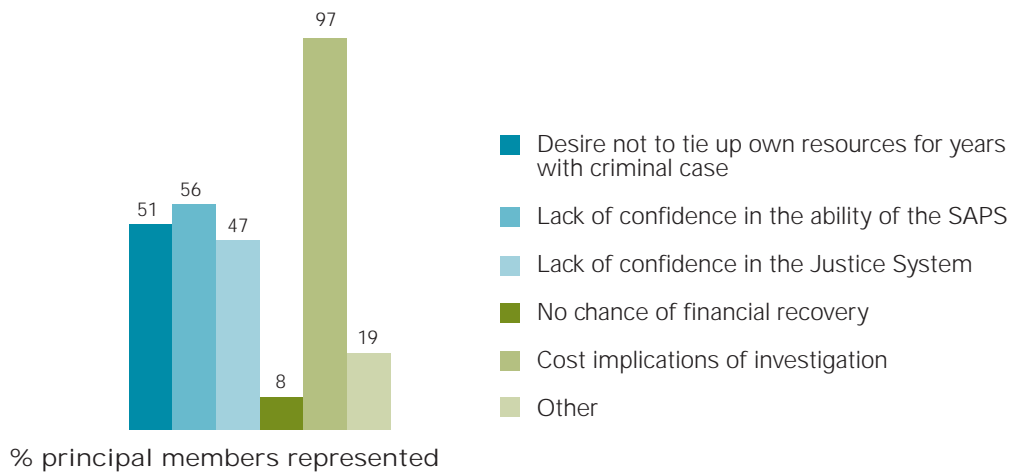
All respondents, except one, had a policy regarding the treatment of fraud perpetrators.

With regard to reporting fraud, participants responded as follows:

	Always	Sometimes	Never
% principal members represented			
Kept it quiet	0%	51%	49%
Reported to the applicable Governing Body (eg, HPC, Pharmacy Council, etc)	16%	84%	0%
Reported to South African Police Services (SAPS)	12%	86%	2%
Instituted civil action recovery	12%	79%	9%
Blacklisted the service provider	8%	46%	46%
Shared the information through the Board of Healthcare Funders' forum	48%	52%	0%
Negotiated a settlement	0%	93%	7%
Other	2%	7%	0%

Main reasons for not reporting fraud to the South African Police Services

None of the respondents selected the options "fear of negative publicity" or "inconvenience", as reasons for not reporting matters to the South African Police Services (SAPS). The major reasons for not reporting fraud to the SAPS were the cost implication of investigation, followed by the lack of confidence in the ability of the SAPS and the Justice System.



The responses to the above question were supported by indications that out of 28 000 cases, only 238 cases had been reported to the SAPS over the prior 3 years.

Of the 238 cases reported to the SAPS, only 17 had resulted in convictions. A further 140 cases were still subject to investigation.

Respondents indicated that over the prior three years, 380 cases had been reported to the relevant governing bodies. Only 10 such cases resulted in the governing bodies striking off the offending members.

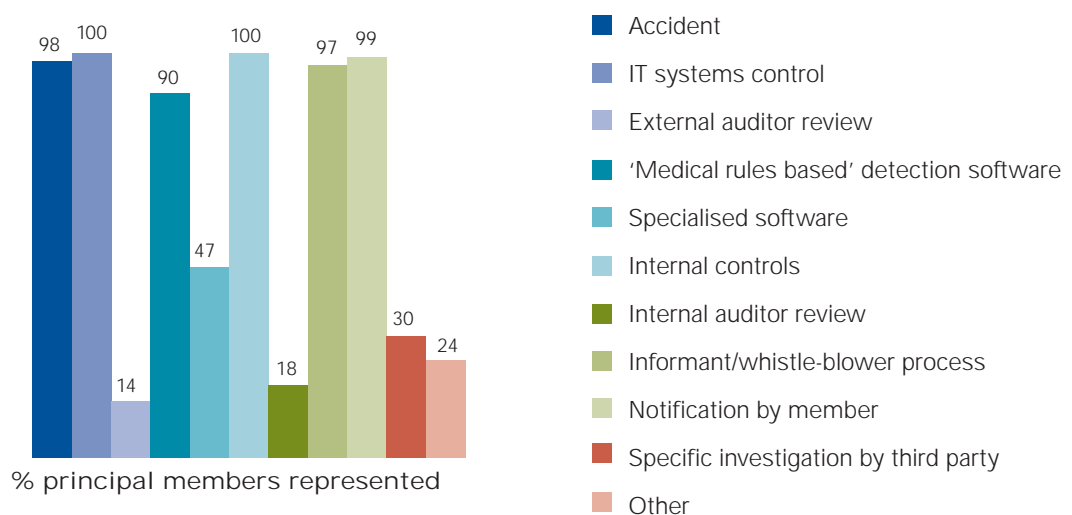
Respondents were generally positive in their responses to sharing information, regarding the perpetrators of fraud, with other medical scheme administrators through the Board of Healthcare Funders' Forum and other governing bodies.

Internal audit/controls

How was the fraud discovered?

Respondents indicated that fraud was uncovered most frequently by:

- IT systems control
- Internal controls
- Notification by members
- Accident
- Whistle-blower process
- 'Medical rules based' detection software

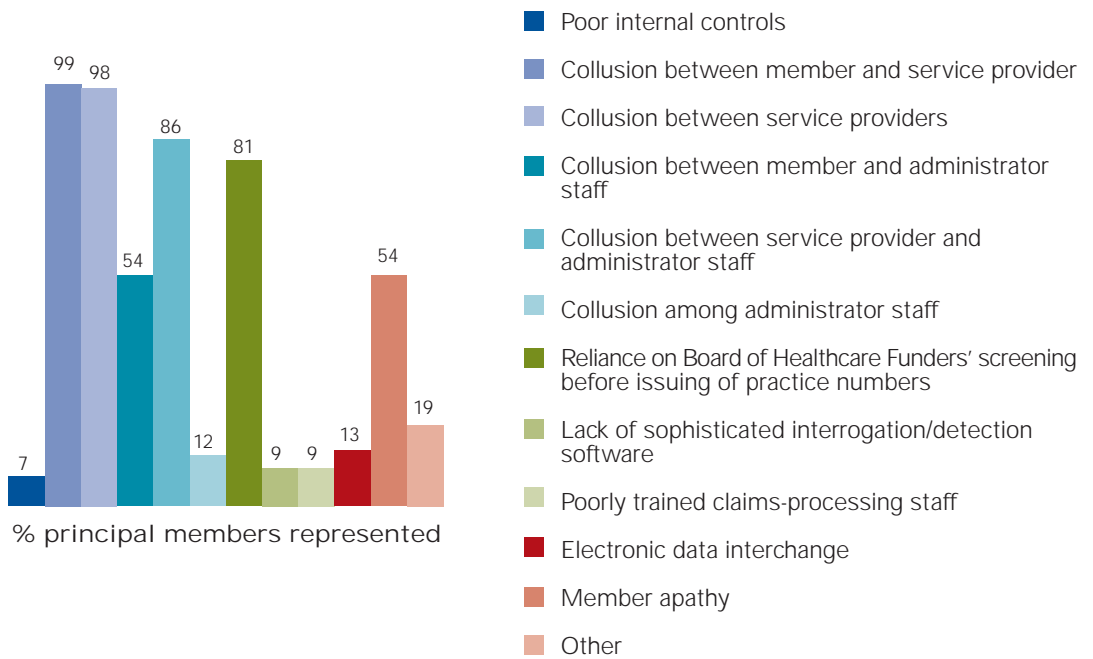


What allowed fraud to take place?

Respondents indicated that collusion was the main factor aiding the perpetration of fraud. Collusion between members and service providers was the primary cause. This was followed by collusion between service providers to the prejudice of the schemes, and then collusion between service providers and administrators.

The reliance of the medical schemes on screening by the Board of Healthcare Funders before issuing practice numbers to service providers was considered high risk exposure by the respondents.

Respondents representing 95% of principal members were positive that internal controls were effective. Respondents representing 54% felt that member apathy contributed greatly to fraud perpetration. With regard to the training of claims processing staff, 91% felt that staff were adequately trained and were not a reason for fraud taking place. Four of the administrators indicated that Electronic Data Interchange (EDI) facilitated fraud and the same administrators, with two more respondents, reported that between 60% and 80% of claims were submitted via EDI.



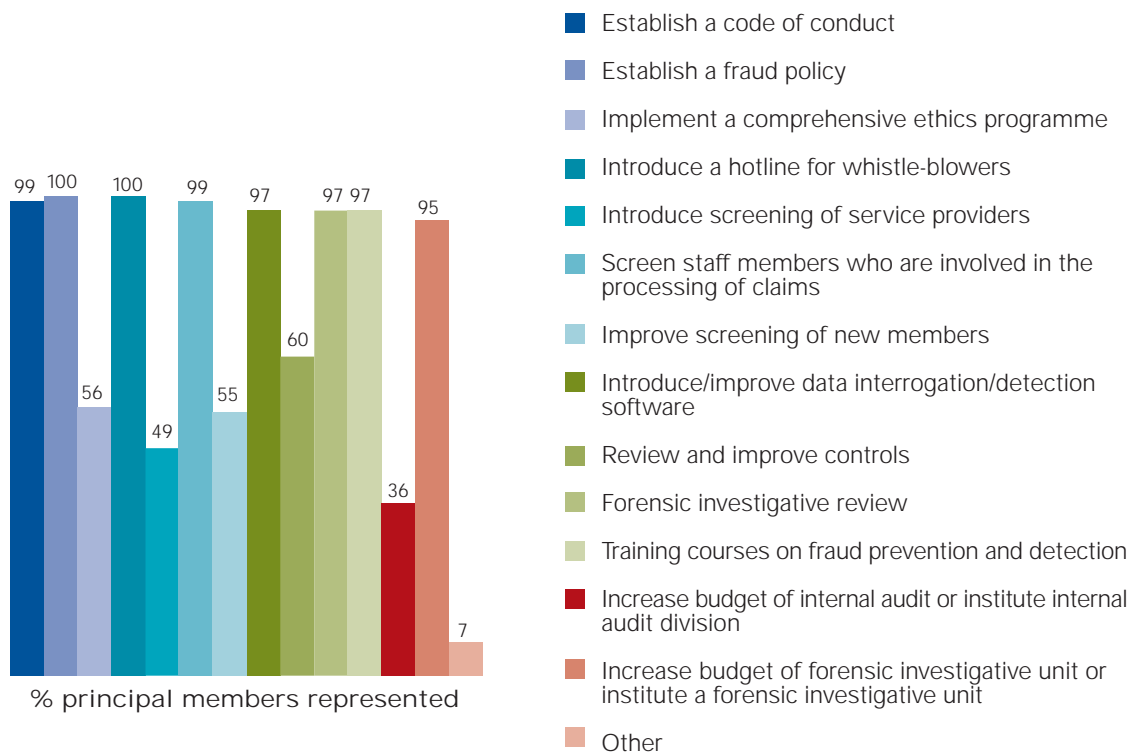
What steps are you taking or planning to take to reduce the possibility of fraud in your organisation and in the medical schemes under your administration?

Respondents indicated that steps to reduce the possibility of fraud in their medical schemes included:

- Introducing a hotline
- Establishing a code of conduct
- Screening staff members
- Introducing/improving data interrogation/detection software
- Forensic investigative review
- Training courses on fraud prevention and detection

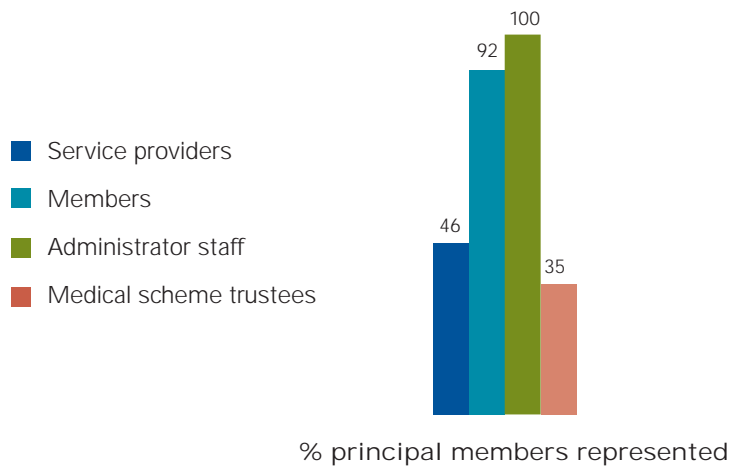
Most respondents indicated the need to increase expenditure on their forensic investigative units.

Almost 50% indicated that they were going to introduce the screening of service providers.



Do you or the medical schemes under your administration have screening procedures for the following categories?

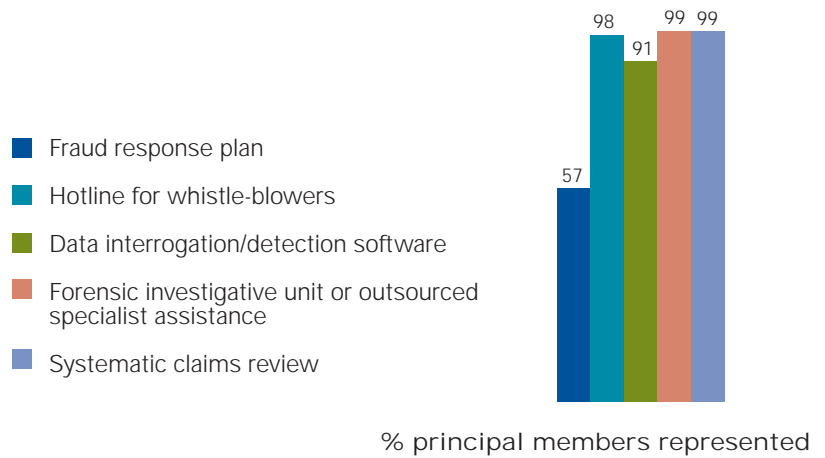
Most respondents indicated that the communication of ethical standards to employees, members and service providers was taking place. Ethical standards were communicated by way of brochures, public displays in the workplace, training workshops, newsletters and Intranet/Internet.



The majority of respondents indicated that they had screening procedures in place for members and staff. Screening procedures for service providers, however, were only indicated by four of the respondents.

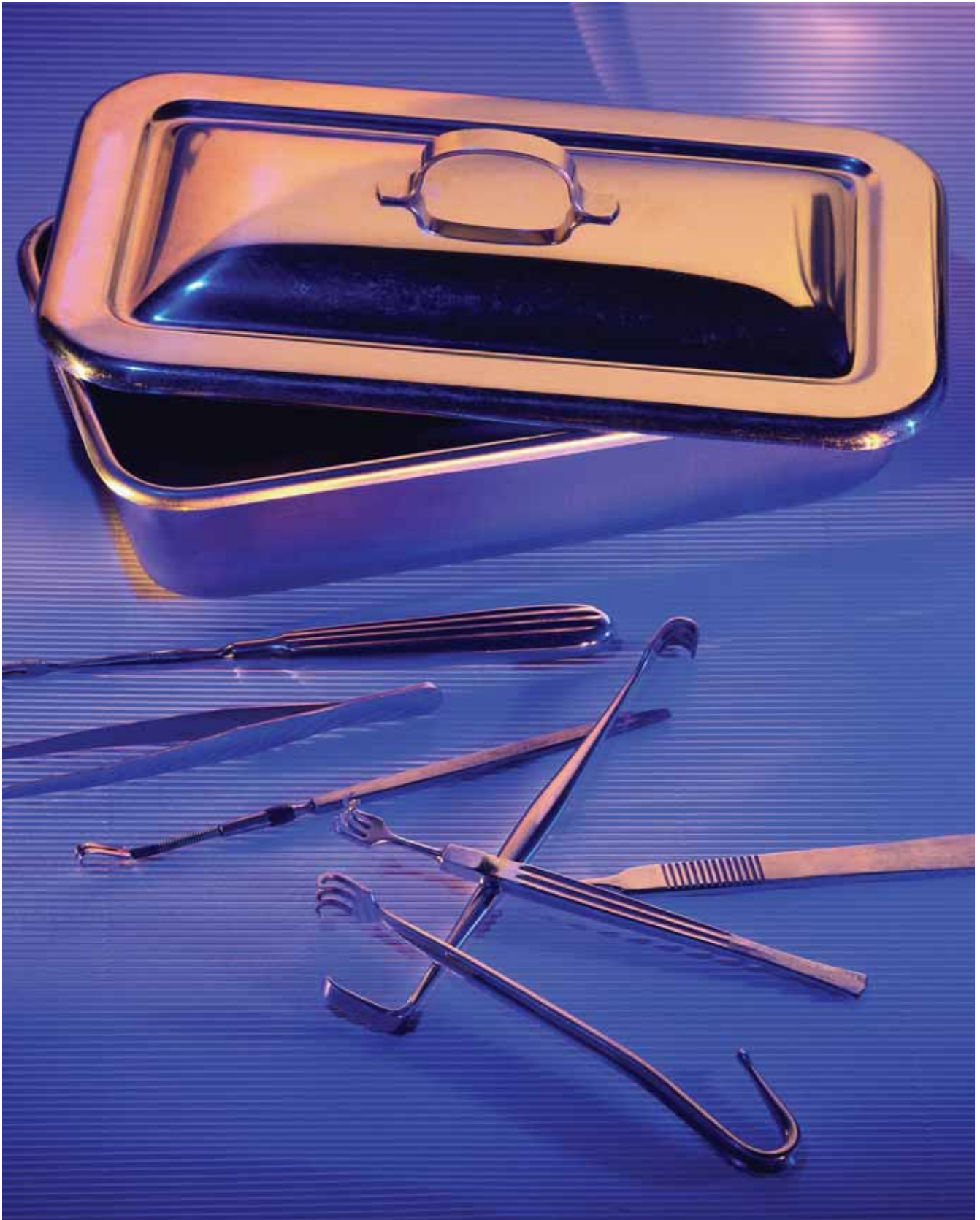
Do you have any of these fraud risk management mechanisms?

With regard to Fraud Risk Management mechanisms, most respondents indicated that they followed a systematic claims review process, outsourced forensic investigations and made use of whistle-blower hotlines. Six of the respondents indicated that they had fraud response plans and data interrogation/detection software.



With regard to Medical Rules Based software, five of the respondents indicated that the software had been developed in-house and two indicated that they had purchased the software from external sources.

All but one of the respondents indicated that there were systems in place to ensure that all claims run the possibility of being audited before being paid.

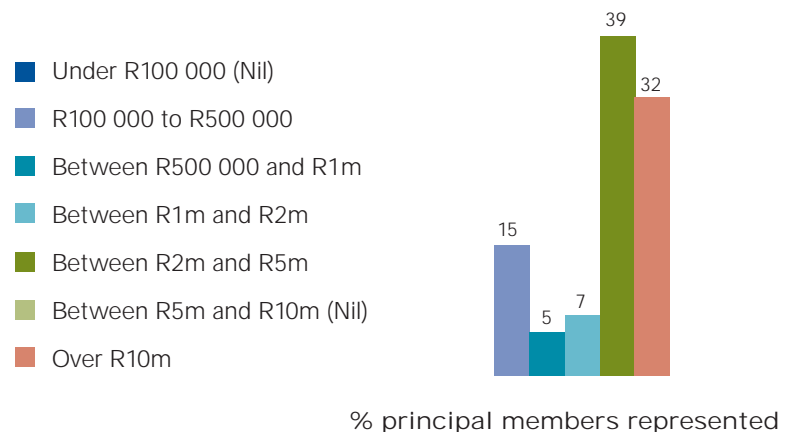


Forensic unit

What was the annual budget for your forensic investigative unit?

Only two respondents indicated the non-existence of a dedicated forensic investigative unit. All others indicated that forensic investigative units had been in existence for a number of years. Three of the respondents indicated that, in addition to their own investigative units, external investigators were employed.

Established forensic units indicated by respondents generally comprised between 3 and 30 staff members. For the most part, respondents indicated that their forensic units had representation at management meetings and operated on a separate budget.

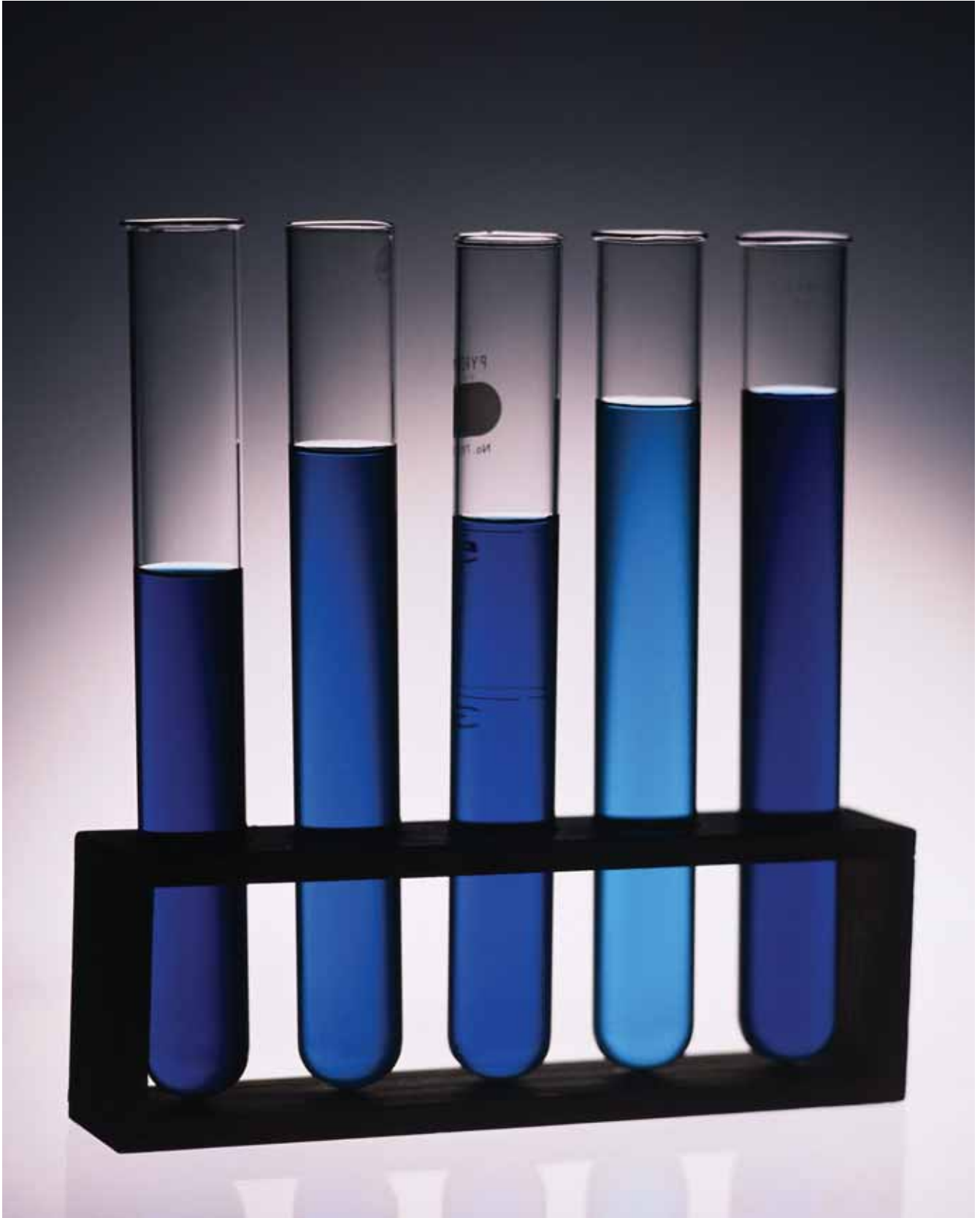


With regard to the funding of forensic investigative units, five respondents (representing 86% of principal members) indicated funds being sourced from a combination of schemes and administrators, two, representing 12%, indicated funding from the schemes alone and one, representing 2%, indicated funding from the administrator. In addition, one respondent, representing 39% of the members, indicated that funding had been supplemented from recoveries.

With regard to recoveries by the forensic investigative units, seven respondents (representing 97% of principal members) indicated that recoveries had been made during the year under review. One respondent had not made any recoveries.

As to quantum of recoveries for the year, one respondent indicated recoveries in excess of R50 million, one between R10 million and R50 million, and the balance under R2 million.

Respondents indicated that recoveries had been retained by the medical schemes.



General

Do you think that fraud is a problem for you as an administrator of medical schemes?

Seven respondents indicated that fraud was a problem, two were not sure and one declined to express an opinion.

In future, do you think that fraud will...

	Number of respondents	% principal members represented
Increase	5	16%
Decrease	1	0.2%
Stay the same	1	30%
Not sure	2	51%

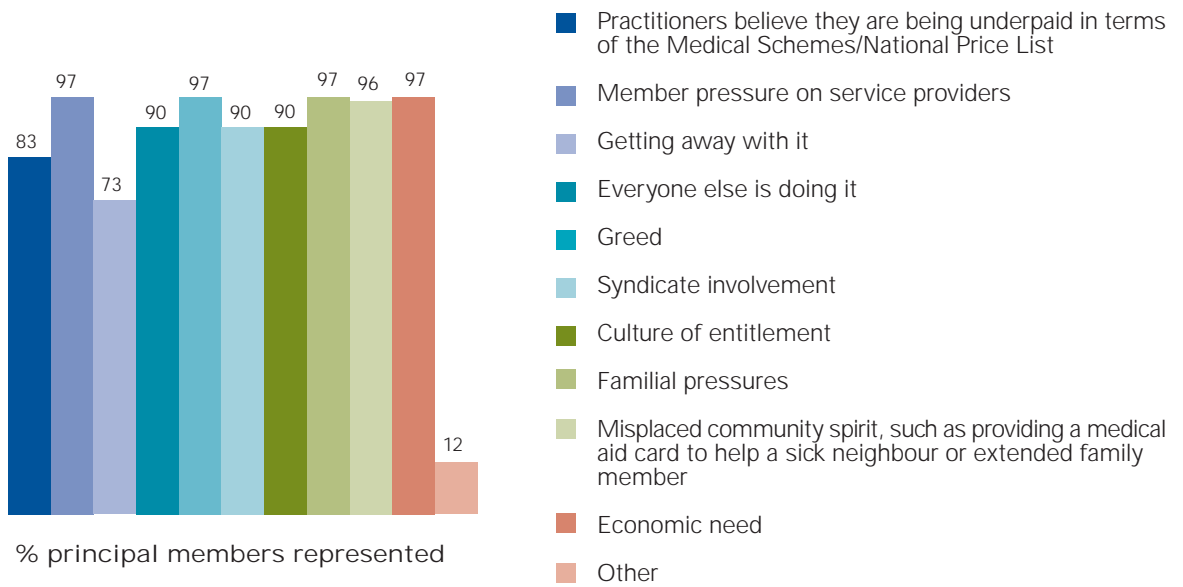
Five respondents opined that fraud will increase, one that it will decrease, one that it will stay the same, two were not sure and one declined to answer.

If you think fraud will increase in future, what do you think are the reasons for this increase?



% principal members represented

In your opinion what motivates the perpetrators of fraud against medical schemes?



The highest number of respondents indicated that the strongest motivators of fraud against medical schemes were:

- Greed
- Member pressure on service providers

Familial pressures, economic need and misplaced community spirit were indicated as secondary motivators for the perpetration of fraud.

The information contained herein is of a general nature and is not intended to address the circumstances of any particular individual or entity. Although we endeavour to provide accurate and timely information, there can be no guarantee that such information is accurate as of the date it is received or that it will continue to be accurate in the future. No one should act on such information without appropriate professional advice after a thorough examination of the particular situation. KPMG and the KPMG logo are registered trademarks of KPMG International, a Swiss cooperative.

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