

THE FINANCIAL COST OF HEALTHCARE FRAUD 2014

WHAT DATA FROM AROUND THE WORLD SHOWS

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FOREWORD

I am pleased to contribute a Foreword to this report. It highlights an important problem which has a significant adverse affect of the quantity and quality of healthcare around the world. The authors of the report are to be congratulated for their research – over 15 years – into this issue.

The World Health Organisation (WHO) has previously recognised the importance of countries improving the efficiency of their healthcare systems, thereby releasing resources that could be used to cover more people, with more services of high quality. WHO cited fraud as one of the ten leading causes of inefficiency in healthcare in its 2010 Report and it is good that this report provides detailed information about its extent. In particular, the volume of the healthcare expenditure where losses have been measured and the variety of types of expenditure covered make the report's conclusions – that an average of just under 7% of expenditure is lost - convincing.

However, having credible information about the problem of losses to healthcare systems is not a goal in itself. The most important reason to know about the nature and scale of the problem is because it can help countries to apply the right solutions – informing the prioritisation of work to counter fraud, the level of investment to be made and where best to focus action. Underlying research shows that most of these losses are high volume, low value – one off, large scale frauds are unusual, but

widespread low value fraud is common. The good news is that the report highlights examples where real gains have been made by reducing the cost of fraud – with up to a 40% reduction possible within 12 months and significant additional resources freed up for health promotion, disease prevention, treatment, rehabilitation and/or palliative care.

Fraud in any sector wastes scarce resources, but in respect of healthcare it has a direct negative impact on human life – with people waiting longer for treatment, people not being able to afford the treatment that they need, and some people never receiving the quality of patient care that is possible. It prevents appropriate forms of health promotion and prevention that allows people to take control of their own health.

Those leading healthcare organisations – in whatever country they are – need to read this report and to make sure that their organisations are properly protected against fraud. It is not good enough to simply hope that fraud doesn't happen and then to react – after losses have been incurred. As with healthcare more generally, pre-emptive action is needed to minimise the extent of the problem.

DR DAVID EVANS

Director of Health Systems Financing
World Health Organisation

UK PREFACE

I was very pleased to be asked to write the preface to a document which I hope will stimulate debate about an issue that is too rarely spoken about in the United Kingdom. Our colleagues in the USA are many years ahead of us in recognising and dealing with healthcare fraud. Over there, cases are prosecuted by the FBI, and the US government has in place a robust legislative framework protecting health funds not only against fraud but also against damaging practices that are currently perfectly legal here. One topical example of the latter is the payment of incentives to doctors, incentives sometimes linked to obligations to use a certain facility or based on the value of business generated. The recent Competition Commission investigation of private healthcare showed these to be endemic in the UK private sector.

The current healthcare environment is unfortunately one that is conducive to fraud. Medical services are provided in confidential circumstances, they are complex and there is a huge amount of money to be made. It is a tribute to the dedicated people who work in our health services that the problem is not much worse.

Having said that, there are undoubtedly people whose aim is to steal healthcare funds. I know this only too well. I started highlighting concerns nearly two decades ago, initially facing scepticism and disbelief from all sides – pockets of which still remain. But I also met people who really understood the issues and amongst them, I had the pleasure of working with Jim Gee, one of the authors of this document who helped our organisation set up professional training for our investigators.

As our government increasingly looks to private providers to treat NHS patients, I rather fear that some of the fraudulent practices which plague the US healthcare system will take root here. It worried me enormously when I recently read in the British Medical Journal that more than a third of members of GP Commissioning Groups have financial interests in organisations from which they will be commissioning healthcare, because there is a wealth of evidence that such relationships can and do lead to abuse. For example, a recent study from the Journal of the American Medical Association recorded that some tests were twelve times as likely to be ordered when the doctor ordering them had a financial interest in their provision.

I hope this document will be widely read and especially by those who have the power to make a difference. The UK has one of the best health systems in the world. But amongst all the providers and users of the system, there are a small number who would steal – a truth that needs to be faced, however uncomfortable – and it is essential that our funds, both private and NHS, are properly protected. As the authors rightly observe: in order to protect against a risk, it is necessary first to understand it and to quantify it and I hope that the information in this document will encourage readers to do so.

DR SIMON PECK

Health Insurance Counter Fraud Group (HICFG)

SOUTH AFRICAN PREFACE

Healthcare fraud is an issue for every country. None should pretend that they are not affected by the problem, indeed, as with other problems, avoiding being in denial about it is the first step to solving it.

The Board of Health Funders of Southern Africa (BHF) and its Healthcare Forensic Management Unit (HFMU) have made significant progress in both raising awareness of and tackling healthcare fraud. Despite this progress our work still mostly focusses on reacting after fraud has taken place and losses have been incurred – in other words viewing fraud as a series of individual adverse events to be responded to. This report will help us – and colleagues from other countries – to see it as it really is – an ever present and ongoing business cost suffered by all healthcare organisations of any size, which can be measured, managed and minimised.

The cost of healthcare fraud which is revealed across the world is shocking – on average 6.99% of expenditure is lost. In South Africa alone 376 billion Rand was spent on healthcare in 2011, the latest year for which the World Health Organisation has figures. The research revealed in this report means that, if South Africa is in line with the rest of the world (and some countries which have been fighting fraud for a lot longer) it would mean that over 26 billion Rand is lost each year.

However, the good news is that the report reveals that there are examples where organisations from around the world have cut the cost of fraud by up to 40% within 12 months. One of the authors, Jim Gee, himself lead such work in the UK's National Health Service. The key to cutting losses appears to be properly protecting healthcare organisations against fraud, so that it is pre-empted, rather than simply reacting after the event. By doing this more resources can be made available for better patient care.

This accords with the findings of 'The Resilience to Fraud of Medical Schemes in South Africa' report which BHF, the HFMU, and University of Portsmouth, jointly published with BDO LLP in 2013. As Dr Humphrey Zokufa, BHF's Managing Director, wrote at the time, 'South Africa is not immune from this problem. Medical schemes recognise that it is a serious issue and one that has far reaching consequences including the reduction in the availability and quality of patient care.' This new report highlights the need for more action to reduce this significant, avoidable cost.

LYNETTE SWANEPOEL

Manager, Healthcare Forensic Management Unit (HFMU)
Board of Healthcare Funders of Southern Africa

US PREFACE

It is both my honor and pleasure to contribute a Preface to this much needed, valued and welcomed report. I have dedicated my professional life of almost 30 years in both the public and private healthcare sectors to the detection and prevention of healthcare fraud, waste, abuse and improper payments. This report, its approach to studying and quantifying the problem of healthcare fraud and its findings are truly unique and like no other report in the healthcare industry today. I hope that its publication will bring much needed continued attention and overall awareness to this problem, a problem that is truly of global size, scope and impact.

Over the past few years I have been fortunate to know and work with one of the authors of this report, Jim Gee, and to have the benefit of the previous versions of this report as issued in 2009 and 2011. I have found Jim's (and of course Professor Button's) knowledge of this topic and insight into the problem of healthcare fraud to be on point and without bias as to the causes of the problem. Those causes are shared across the healthcare system and involve the Providers of service, the Insureds (Members), the Payors (Insurers) and the Regulators of the healthcare system and industry. It is my experience that by working together to examine the vulnerabilities that create the opportunities for fraud and improper payments to occur, we can successfully identify, investigate and stop it from occurring in the future. But to do that, we must first understand the problem, raise awareness and quantify the problem. **This report does just that.**

In the United States the annual expenditure on healthcare is approximately \$3 trillion. For the "fraudster" (those wishing to do financial harm to private and public sector Programs/Plans) this creates the financial incentive to find and maximize vulnerabilities. The US has made great progress in recent years in addressing the problem of healthcare fraud. For example, in a recent study it was reported that the "U.S. recovers \$16 for every \$1 it spends fighting civil healthcare fraud" and further that "combined civil, criminal and state recoveries from 2008

through 2012 total approximately \$18.3 billion." Additionally, federal prosecutions are up 9.9% from 343 in fiscal year 2003 to 377 in 2013, and US federal law enforcement reports that \$4.3 billion was recovered in 2013 through healthcare fraud enforcement. **This is wonderful progress!** However, if we consider again the total annual expenditure of \$3 trillion and either a conservative estimate of 3% or an average fraud loss rate of 6.99% that equates to **annual fraud losses equivalent to a range of \$90 billion to \$210 billion.** Clearly, more has to be done, and no matter how effective law enforcement is, they cannot do it alone.

For the solution to be truly effective we need the shared actions of the aforementioned Providers, Members, Insurers, Regulators and also the "Global Health Care Anti-Fraud Network" (industry anti-fraud associations: NHCAA, CHCAA, EHFCN, HICFG and HFMU) working together to increase awareness and develop strategies to identify and stop improper claims before they're paid. Healthcare Insurers and Payment Integrity companies responsible for developing advanced analytics, predictive modeling, social analytics, etc., can and are leading the way to help identify, investigate and stop these improper payments. Through the proactive application of these tools these entities are helping to reduce improper payments and thereby freeing up vital funding for better patient care that meets today's ever changing and evolving healthcare needs.

I applaud the work of Jim Gee, Professor Mark Button and thank them and their respective teams for this report and for continuing to raise awareness for this most important and globally impactful problem. Through their work and that of the key stakeholders mentioned herein, we can significantly reduce the losses related to healthcare fraud. Thank you for allowing me the opportunity to share my thoughts.

TED DOYLE

Accredited Health Care Fraud Investigator & Certified Fraud Examiner
Vice President, Healthcare Markets, Performant Financial Corporation

1

INTRODUCTION

- 1.1 This Report renews research first undertaken in 2009 and repeated in 2011, collating the latest, accurate, statistically valid information from around the world about the real financial cost of healthcare fraud and error.
- 1.2 The measurement of losses to fraud (and error) is an essential first step to successful action. Once the extent of fraud losses is known then they can be treated like any other business cost – something to be reduced and minimised in the best interest of the financial health and stability of the organisation concerned. It becomes possible to go beyond reacting to unforeseen individual instances of fraud and to include plans to pre-empt and minimise fraud losses in business plans.
- 1.3 The Report doesn't just look at detected fraud or the individual cases which have come to light and been prosecuted. Because there is no crime which has a 100% detection rate, adding together detected fraud significantly underestimates the problem. It is also the case that if detected fraud losses go up, does that mean that there is more fraud or that there has been better detection; equally, if detected fraud losses fall, does that mean that there is less fraud or worse detection?
- 1.4 The Report also doesn't rely on survey-based information where those involved are asked for their opinions about the level of fraud. These tend to vary significantly according to the perceived seriousness of the problem at the time by those surveyed. While they sometimes represent a valid survey of opinion, that is very different from a valid survey of losses.
- 1.5 The financial and economic damage resulting from healthcare fraud (and error) is surely the worst aspect of the problem. Yes, fraud is unethical, immoral and unlawful; yes, the individuals who are proven to have been involved should be punished; yes, the sums lost to fraud need to be traced and recovered. However, these are actions which take place after the fraud losses have happened – after the resources have been diverted from where they were intended and after the damage to the quality of patient care has occurred.
- 1.6 In almost every other area, healthcare organisations know what their costs are – staffing costs, accommodation costs, utility costs, procurement costs and many others. For centuries, these costs have been assessed and reviewed and measures have been developed to pre-empt them and improve efficiency. This incremental process now often delivers quite small additional improvements.
- 1.7 Fraud and error costs, on the other hand, have only very rarely had the same focus. The common position has been that organisations have either denied that they had any fraud or planned only to react after fraud has taken place. Because of this, fraud is now one of the great unreduced healthcare costs.
- 1.8 However, a cost can only be reduced if it can be measured, and a methodology to do this accurately has only been developed and implemented over the last decade.
- 1.9 Now that we can measure fraud and error losses, we can make proper judgements about the level of investment to be made in reducing them. Now that we can measure these losses, we can also measure the financial benefits resulting from their reduction.
- 1.10 In the current macro-economic climate, reducing these losses is one of the least painful ways of reducing costs. This Report identifies what the financial cost of healthcare fraud and error has been found to be and thus, the 'size of the prize' to be achieved from reducing it.
- 1.11 Of course, there is always more research to be done and any organisation should consider what its own fraud and error costs are likely to be, however, the volume of data which is already available from exercises now covering close to £2 trillion, points clearly to losses usually being found in the range of 3-8%.
- 1.12 We will continue to monitor data as it becomes available and publish further Reports as appropriate.



JIM GEE

Director of Counter Fraud Services, BDO LLP
and Visiting Professor and Chair of the Centre for Counter Fraud Studies

2

OVERVIEW

- 2.1 The original 'Financial Cost of Healthcare Fraud Report', published in 2009 identified and reviewed 69 exercises (of which 66 were successfully completed) to accurately measure healthcare fraud and error losses, undertaken across the world between 1997 and 2007.
- 2.2 The 2011 Report took account of a exercises undertaken during 2008 and 2009, and this 2013 report considers further exercises which took place during 2010 and 2011 and reports on a total of 92 exercises. The growth in the number of organisations which are accurately measuring the cost of fraud is marked.
- 2.3 As a result of the rapid increase in prevalence of this work the totality of the research published in this Report now covers 14 different types of healthcare expenditure totalling over £1.93 trillion (\$2.99 trillion), in 33 organisations from 7 countries. The value of the expenditure examined has not been updated to 2013 values. The losses referred to are a percentage loss of expenditure.
- 2.4 This Report is based on extensive global research, building on previously established direct knowledge, to collate information about relevant exercises. The data was then analysed electronically. Exercises were collated from Europe, North America and Australia and New Zealand. None were found in Asia or Africa, although the authors are aware of developments which should lead to this happening in the near future.
- 2.5 The Report has excluded guesstimates, figures derived from detected fraud losses, and figures resulting from surveys of opinion. It has also excluded some loss measurement exercises where it is clear that they have not met the standards described below.
- 2.6 It has included exercises which
- have considered a statistically valid sample of income or expenditure
 - which have sought and examined information indicating the presence of fraud, error or correctness in each case within that sample
 - which have been completed and reported
 - which have been externally validated
 - which have a measurable level of statistical confidence; and
 - which have a measurable level of accuracy.
- 2.7 There are a number of caveats.
- Some of the exercises have resulted in estimates of the fraud frequency rate, some of the percentage of expenditure lost to fraud, and some have measured both;
 - It is also the case that some exercises have separately identified measured fraud and error and some have not;
 - Sometimes, once such exercises have been completed, the organisations concerned have, mistakenly in the view of the author of this Report, decided not to publish their results. Transparency about the scale of the problem is a key factor in its solution, because attention can be focussed and a proportionate investment made;
 - In some cases, those directly involved in countering fraud have decided, confidentially, to provide information about unpublished exercises for wider consideration. In those cases, while the overall figures have been included in the findings of this Report, no specific reference has been made to the organisations concerned;
 - The authors of this Report are also aware of a very small number of other exercises which have been completed, but which have not been published and where nothing is known of the findings; and
 - Finally, it is important to emphasise that this research will never be complete. More evidence becomes available each year. However, the preponderance of the evidence does point clearly in one direction, as is explained later.
- 2.8 While it is necessary to make these caveats clear, the importance of the evidence collated in this Report should not be underestimated. It shows that losses to fraud and error in the healthcare sector represent a significant, damaging and, crucially, unnecessary business cost.

3

THE NATURE OF THE DATA WHICH HAS BEEN ANALYSED

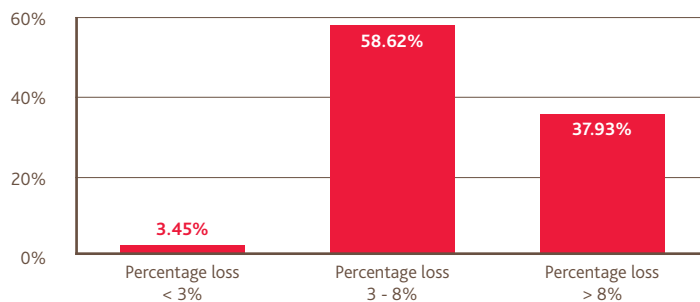
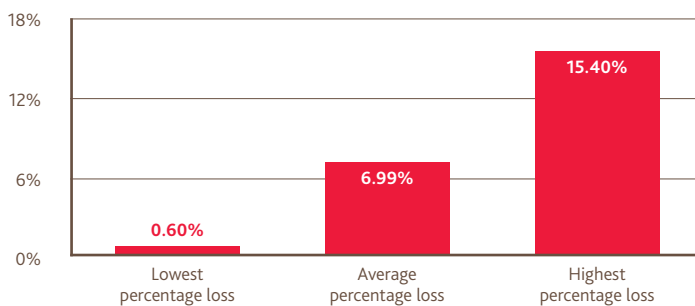


- 3.1 The six countries in which the authors are aware that healthcare loss analysis exercises have taken place are:
- the UK;
 - the United States;
 - France;
 - Belgium;
 - The Netherlands;
 - New Zealand.
- 3.2 By value of income or expenditure measured, the United States has undertaken the greatest amount of work in this area. This is a direct reflection of the Improper Payments Information Act of 2002 (IPIA) (now followed by the more recent Improper Payments Elimination and Recovery Act of 2010) which requires designated major U.S. public authorities to estimate the annual amount of payments made where fraud and error are present, and to report the estimates to the President and Congress with a progress report on actions to reduce them.
- 3.3 The guidance relating to the IPIA stated "The estimates shall be based on the equivalent of a statistical random sample with a precision requiring a sample of sufficient size to yield an estimate with a 90% confidence interval of plus or minus 2.5%". Many U.S. agencies undertake work to the higher standard often found in the U.K. and Europe – 95% statistical confidence and + or - 1%.
- 3.4 In other countries, while there has not hitherto been any legal requirement, there is a growing understanding that the key to successful loss reduction is to understand the nature and scale of the problem. For example, in Europe, the European Healthcare Fraud and Corruption Declaration of 2004, agreed by organisations from 28 countries called for "The development of a European common standard of risk measurement, with annual statistically valid follow up exercises to measure progress in reducing losses to fraud and corruption throughout the EU."
- 3.5 The range of types of income and expenditure, where losses have been measured, include fraud (and error) involving patients, healthcare professionals, staff and managers, and contractors.
- 3.6 The specific areas where losses have been measured include:
- the fraudulent provision of sickness certificates
 - prescription fraud by pharmacists
 - prescription fraud by patients
 - fraud and error concerning capitation payments to general practitioners
 - fraud and error concerning payments made to doctors to manage a patient's medical care
 - the evasion of dental charges by patients
 - fraud and error by opticians concerning the provision of sight tests
 - fraud and error concerning employees of healthcare organisations
 - fraud and error concerning payments for in-patient hospital services
 - fraud and error concerning long term care
 - fraud and error concerning home and community based services
 - fraud and error concerning the provision of services and supplies,
 - fraud and error concerning health insurance for children
 - fraud and error concerning foster care
 - fraud and error concerning child care.

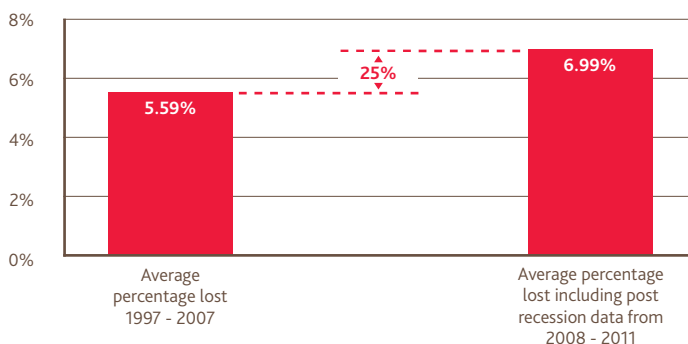
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HEALTHCARE FRAUD AND ERROR LOSSES

4.1 The range of percentage losses across all the exercises reviewed between 1997 and 2011 was found to be between 0.6% and 15.4% with average losses of 6.99% (almost 97% of the exercises showed losses figures of more than 3%).



4.2 This 2013 research also includes data from 2010 and 2011. Exercises across the period between 1998 and 2011 show average losses of 6.99%. This figure remains 25% higher than the pre-recession average of 5.59%.



4.3 It is clear that fraud remains a significant problem and one which involves a larger cost than previously thought. Where organisations have undertaken repeated exercises to measure their losses in the same areas of expenditure, then the evidence also shows that this has helped to reduce them.

4.4 The current global average loss rate of 6.99% - a running average taking account of 15 years of data - when taken as a proportion of global healthcare expenditure for 2011 (\$6.97 trillion, £4.48 trillion or €5.38 trillion), equates to \$487 billion, £313 billion or €376 billion.

4.5 This sum equates to

- three times the NHS's total expenditure for 2011-2012;
- two and a half times the total healthcare expenditure of Canada for 2011;
- fourteen times the total healthcare expenditure of South Africa for 2011;

4.6 It would fund almost a fifth of the United States total healthcare expenditure for 2011 and more than 27% of European Union countries total healthcare expenditure for the same period.

4.7 This is an enormous sum which is diverted from the provision of patient care.

4.8 Even reducing such losses by 40%, which individual organisations have achieved, would free up more than \$195 billion, £125 billion or €150 billion.

4.9 On the basis of the evidence, it is clear that fraud and error losses in any organisation should currently be expected to be at least 3%, probably more than 5% and possibly more than 10%. It would be wrong to go too much further in terms of predicting where in this range, losses for an individual organisation, will be, without some organisation-specific information about the strength of arrangements to protect it against fraud (its 'fraud resilience').

4.10 BDO LLP and the CCFS, in parallel research, have developed Europe's most comprehensive database of fraud resilience information, with data recorded concerning over 700 organisations. By combining the data which underpins this report and organisation-specific information about fraud resilience, we are able, for the first time, to

- predict the likely scale of losses;
- the key improvements which would reduce them; and
- the related cost.

4.11 We can also accurately measure losses or train client organisations to do this. The practical experience of BDO LLP specialists combined with the academic rigour of CCFS researchers provides an unparalleled expert resource.

5

CONCLUSION



- 5.1 This Report renews research into accurate information concerning the extent of losses to healthcare fraud and error. Without such information it is impossible for healthcare organisations to properly prioritise the problem or to invest proportionate sums in solving it.
- 5.2 The research demonstrates conclusively that it is possible to measure the nature and extent of healthcare losses. It may be embarrassing for some organisations to find out just how much they are losing but it is possible to do this.
- 5.3 Because of the direct, negative impact on human life of healthcare losses, it is never easy to admit they take place. However, the first step to reducing losses is to stop being in denial about them. If an organisation is not aware of the extent or nature of its losses, how can it apply the right solution and reduce them?
- 5.4 Where losses have been measured, and the organisations concerned have accurate information about their nature and extent, there are examples where losses have been substantially reduced. These include the UK's National Health Service (the second largest organisation in the world) between 1999 and 2006 where losses were reduced by up to 60%, and by up to 40% over a shorter period .
- 5.5 Three things are clear:
- losses to healthcare fraud and error can be measured – and cost effectively;
 - on the basis of the evidence it is likely that losses in any healthcare organisation and any area of expenditure will be at least 3%, probably more than 7% and possibly over 10%; and
 - with the benefit of accurate information about their nature and extent, they can be reduced significantly.
- 5.6 Countering fraud effectively would reduce these losses and free up massive resources for better patient care. The authors of this Report hope that it focuses attention on this problem and the potential benefits to be derived from starting to solve it.

ABOUT THE AUTHORS



Jim Gee is Director of Counter Fraud Services at BDO LLP, the leading accountancy and business services firm and Visiting Professor and Chair of the Centre for Counter Fraud Studies at University of Portsmouth.

During more than 25 years as a counter fraud specialist, he led the team which cleaned up one of the most corrupt local authorities in the UK – London Borough of Lambeth – in the late 1990s; he advised the House of Commons Social Security Select Committee on fraud and Rt. Hon. Frank Field MP during his time as Minister of State for Welfare Reform; between 1998 and 2006 he was Director of Counter Fraud Services for the Department of Health and CEO of the NHS Counter Fraud Service, achieving reductions in losses of up to 60% and financial benefits equivalent to a 12:1 return on the costs of the work.

Between 2004 and 2006 he was the founding Director-General of the European Healthcare Fraud and Corruption Network; and he has since worked as a senior advisor to the UK Attorney-General on the UK Government's Fraud Review. He has also worked with a range of healthcare organisations, companies and charities as well as delivering counter fraud and regulatory services to companies both in this country and internationally.

His work has taken him to more than 35 countries to counter fraud and he has recently been advising the Chinese Government about how to measure, pre-empt and reduce the financial cost of fraud. 2013 has also seen him jointly author a book – 'Countering Fraud for Competitive Advantage' – with Professor Mark Button, which was published by Wiley.



Professor Mark Button is Director of the Centre for Counter Fraud Studies. He has written extensively on counter fraud and private policing issues, publishing many articles, chapters and completing four books with one forthcoming: Private Security (published by Perpetuity Press and co-authored with the Rt. Hon. Bruce George MP), Private Policing (published by Willan), Security Officers and Policing (Published by Ashgate), Doing Security (Published by Palgrave), and Understanding Fraud: Issues in White Collar Crime (to be published by Palgrave in early 2010 and co-authored).

With Jim Gee he has recently written a book (published globally by Wiley) called 'Countering Fraud for Competitive Advantage'. This highlights the financial benefits to be obtained from countering fraud effectively. He is also a Director of the Security Institute, and Chairs its Academic Board, and a member of the editorial advisory board of 'Security Journal'. Mark founded the BSc (Hons) in Risk and Security Management, the BSc (Hons) in Counter Fraud and Criminal Justice Studies and the MSc in Counter Fraud and Counter Corruption Studies at Portsmouth University and is Head of Secretariat of the Counter Fraud Professional Accreditation Board (CFPAB).

Before joining the University of Portsmouth he worked as a Research Assistant to the Rt. Hon. Bruce George MP specialising in policing, security and home affairs issues. He completed his undergraduate studies at the University of Exeter, his Masters at the University of Warwick and his Doctorate at the London School of Economics. Mark has also worked on a research project funded by the National Fraud Authority and ACPO looking at victims of fraud.



ABOUT THE PUBLISHING ORGANISATIONS



BDO

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Our forensic services team offers counter fraud, forensic accounting, expert witness and litigation support services on a national and international basis including:

- Fraud resilience checks;
- Fraud loss measurement and reduction;
- Asset tracing and confiscations;
- Business intelligence;
- Forensic IT, including data mining, data imaging and recovery; and
- Fraud and financial investigations.

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THE CENTRE FOR COUNTER FRAUD STUDIES AT UNIVERSITY OF PORTSMOUTH

The University of Portsmouth's Centre for Counter Fraud Studies (CCFS) was founded in June 2009 and is one of the specialist research centres in the University's Institute of Criminal Justice Studies. It was founded to establish better understanding of fraud and how to combat it through rigorous research. The Institute of Criminal Justice Studies is home to researchers from a wide cross-section of disciplines and provides a clear focus for research, knowledge transfer and educational provision to the counter fraud community.

The Centre for Counter Fraud Studies makes its independent research findings available to support those working in counter fraud by providing the latest and best information on the effectiveness of counter fraud strategies.

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