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CONCEPTUALIZING THE IMPACT OF HEALTH CARE CRIMES ON THE POOR

Brian K. Payne, Old Dominion University

ABSTRACT

Past research shows that a small percentage of health care employees commit an assortment of criminal acts while on the job. Missing from previous research, however, is an examination of the effects such acts have on the poor (i.e. the victims). This paper fills this void by considering the effects of three broadly defined health care crimes: Medicaid fraud, elder abuse, and prescription fraud. In addition to the direct victimization experiences of those served by the health care system, the physical, economic, and time losses are also considered. Implications for future research and policy are provided.

INTRODUCTION

The Medicaid and Medicare programs began in 1965 with the aim of expanding health care access for poor and impoverished populations. Medicaid operates at the state level serving the poor, and Medicare operates at the federal level, serving older Americans. Both programs have yielded positive and negative effects for citizens (Jesilow, Pontell, Geis 1985). On the positive side, access to various health care services would be virtually non-existent for the poor without these programs (Ehrenreich, Ehrenreich 1970). Alternatively, there is reason to believe that a small but significant percentage of health care professionals use the systems improperly and illegally, often for their own personal and financial gain (Geis, Jesilow, Pontell, O'Brien 1985; Payne 1995; Pontell, Jesilow, Geis, O'Brien 1985). These deviant acts have substantial financial and emotional costs for society (Pontell, Jesilow, Geis 1982).

Much has been written about the characteristics of and the criminal justice system's response to illicit acts committed by health care employees. For instance, research concurs that practitioners from all of the branches of health care commit a variety of criminal acts during the course of their daily routines (Geis et al 1985; Jesilow et al 1985; Payne, Dabney 1997). Missing from the literature, interestingly, is extensive consideration of the impact that crimes against the Medicaid and Medicare systems have on the individuals that these systems were designed to serve. The purpose of this paper is to address the potential victimization costs of crimes perpetrated against the Medicaid and Medicare programs. Specifically, a typology for recognizing and understanding the effects health care crimes have on the victims (i.e. the clients) of such offenses is presented. The purpose of the typology is twofold. First, by considering the victims of health care offenses and understanding the

lack of attention this group has received in the past, the need for future research can be stressed. Second, by recognizing the effects of health care victimization, a starting point from which the needed assistance can be provided to health care crime victims is formed.

While there are many offenses that can be harmful in the health care field, this paper examines the effects of three general Medicaid/Medicare offenses: Medicaid fraud, prescription fraud, and elder abuse in nursing homes. Table 1 defines the specific types of health care offenses as they have been defined in the literature (Dabney 1995; Dabney, Berg 1994; Jesilow, Pontell, Geis 1986; Jesilow et al 1985; Payne, Cikovic 1995; Payne 1995; Taylor 1992). These acts are not mutually exclusive meaning that one person may commit several of them. At the same time, however, these acts are in many ways distinct from one another suggesting that the effects of some of them could be different from the others. Nonetheless, they all occur in the health care system and can have serious effects on the victim. Rather than focusing on the *characteristics* of the acts, it seems more important here to focus on the *effects* of these acts. In order to fully understand these effects, brief attention must be given to the explanations provided for why these acts occur.

EXPLANATIONS FOR FRAUD AND ABUSE

Past research cites four related reasons explaining why crimes in the health care arena occur: training factors, lack of enforcement, structural influences, and victim-centered reasons. Training factors examine the training received by health care professionals and suggest that the offenders learn to commit such acts either during their medical school training (Keenan, Brown, Pontell, Geis 1985) or as a result of a lack

Table 1: Types of Crimes Committed Against Medicare/Medicaid

MEDICAID FRAUD	fraudulent acts committed against the Medicaid system with intent
Fee-for-service reimbursement	provider bills for service not given to client
Pingponging	unnecessary referrals to other practitioners
Gangang	billing for services provided to several patients when services were actually provided to just one person
Upgrading	provider bills for more expensive service than was actually provided
Double-billing	billing more than one agency for the same service
Unnecessary surgery	performing unwarranted operations
Drug theft	stealing drug supplies and billing Medicaid for the missing drugs
PRESCRIPTION FRAUD	fraudulent acts by pharmacists
Generic drug substitution	providing generic drugs but billing more expensive drugs
Short counting	billing for the amount prescribed but providing less medicine than the prescribed amount
Double billing	billing more than one agency for the prescription
Billing for nonexistent prescriptions	billing for prescriptions that were never authorized by doctor
Delivery of controlled substance	providing a controlled substance without authorization
Forgery	altering writing on prescription
Illegally buying prescriptions	buying prescriptions from various individuals and billing for them when they may or may not have been filled
Overbilling	charging more than regulations permit
ELDER ABUSE	broad term describing a host of offenses committed against older persons. In this case refers to offenses committed while in the health care system.
Physical abuse	making physical contact against individual with the intent to cause harm. Includes offensive touching, hitting, slapping, burning & a host of other acts.
Sexual abuse	sexually assaulting the patient
Duty-related abuse	performing health care tasks inappropriately in such a way as to cause harm to a patient. For example, changing a bandage in such a way as to cause harm to the patient.
Monetary abuse	stealing from institutionalized elderly persons
Sources of definitions: Dabney 1995; Dabney, Berg 1994; Jesilow, Pontell, Geis 1985 & 1986; Payne 1995; Payne, Cikovic 1995; Taylor 1992	

of training in needed areas (Pavelich 1994; Payne, Cikovic 1995). The central premise underlying training explanations is that the offender's credentials play a role in perpetuating the abuse.

Lack of enforcement explanations suggest that these crimes do not receive enough attention from the justice system. Part of this lack of attention stems from the fact that control agents, whether they are administrative review boards or agencies of the criminal justice system, experience an

array of investigatory and administrative dilemmas when dealing with such acts (Ford 1992; Payne, Berg 1997; Tillman, Pontell 1992). For example, the "high level of autonomy" provided to health care providers makes the detection of offenses challenging (Pontell et al 1982). Further, establishing intent with health records as the main type of evidence and convincing a jury to convict doctors is often difficult (Payne, Berg 1997). Making it even more problematic is the fact that "provable guilt" and "large dollar losses"

**Table 2: A Typology Describing the Effects of Medical Crimes
DEPRIVATIONAL EFFECTS**

A. Physical deprivations

1. Adequate health care
2. Lose peace of mind
3. Loss of physical abilities
4. Loss of life (suicide & homicide)

B. Time Deprivations

1. Time spent going to doctor, pharmacist, etc.
2. Time spent worrying about doctor visit
3. Time spent testifying against malfeasant doctors
4. Time spent making up for lost work

C. Individual Economic Deprivations

1. Manifest monetary losses--as a direct result of offense
2. Latent monetary losses
 - a. Time off from work visiting doctor
 - b. Time off from work testifying
3. Health care recovery losses--seeking additional treatment

EXPERIENTIAL EFFECTS

A. Physical Experiential Effects

1. Pain and suffering
 - a. From physical abuse
 - b. From sexual abuse
2. Physical harm from faulty drugs
3. Relatives pain and suffering

B. Mental Experiential Effects

1. Increased stress due to health problems may lead to more health problems
2. Destroys trust members of society have for health care employees
3. Mental anguish

C. General Economic Experiential Effects

1. Higher costs of health care for all
2. Family members will experience economic strain
3. Civil recovery costs
4. Economic stress may lead to additional health care needs

are typically needed before criminal charges are filed against a health care provider (Jesilow et al 1986).

Structural explanations focus on the structure of the Medicaid and Medicare systems and propose that something about the way the systems are designed allows these offenses to occur (Ehrenreich, Ehrenreich 1970; Jesilow, Pontell, Geis 1996; Wilson, Geis, Pontell, Jesilow, Chappell 1985). Ehrenreich and Ehrenreich (1970) point to the growing "health care empire" as creating more problems than it solves for the people seeking help. They suggest that "the most obvious function of the American medical system, other than patient care, is profit-making". In a similar fashion, Jesilow et al (1996) suggest that "the fee-for-service nature of Medicaid payments provides

dishonest doctors with ample opportunities" to commit various offenses. Further, the structure of the health care system contributes to the way patients (victims) are treated and perceived by the malfeasant health care professionals.

Victim-centered explanations center on the relationship between the criminal and the victim in addressing the existence of these crimes. For example, health care offenses are often ignored by the justice system because of the apparent lack of victims (Jesilow et al 1996). Whether it is a doctor billing for services never provided, an assistant sexually abusing someone who is on anesthesia, or an aide abusing an elderly patient who suffers from dementia, victims simply may not be aware of the crime. Jesilow et al (1996) point out that the provider's

awareness that the victim may not realize that the crime occurred contributes to the existence of these crimes.

More importantly, something about the design of the health care system may increase the vulnerability of the victim. Medicaid patients are often poor and less-educated than others. When searching for health care, they must locate a place where they receive "the appropriate care" (Ehrenreich, Ehrenreich 1970). Likewise, Medicare patients who are in nursing homes are in need of assistance with daily routines. Both groups are somewhat vulnerable to the actions that malevolent health care providers have been known to commit. As Ehrenreich and Ehrenreich (1970) note: "Health care is scarce and expensive to begin with... For many it is obtained only at the price of humiliation, dependence, or bodily insult".

Unfortunately, the vulnerability is increased by the fact that these victims have largely been ignored by researchers as well. The following typology addresses the "costs of victimization" and is presented as a starting point from which we can begin to understand the experiences of these vulnerable groups.

EFFECTS OF VICTIMIZATION

In this context, victims are those who experience some form of harm or injury as the result of crimes against the Medicare and Medicaid programs. The victims are the individuals the programs were designed to serve, specifically the poor and the elderly but also the general public. The victimization typology outlined in Table 2 shows the victimization costs and losses experienced by the poor, the elderly, and the larger society as a result of medical offenses. These effects can be characterized as either "deprivational effects" or "experiential effects." It is important to note that the typology is based solely on the experiences of the victim and has very little to do with the characteristics of the offense or the offender.

Deprivational Effects. The notion of deprivational effects refers to the possibility that certain groups are deprived of certain needs, goods, or services as a result of the offenses committed against the health care system. Of course, all victims encounter certain losses stemming from the criminal act. However, the losses the "medical crime victim" endures are slightly different. These

deprivational effects can be characterized as physical deprivations, time deprivations, or economic deprivations.

Criminal acts against the health care recipients may pose certain physical risks for the victims. Pontell et al (1982), for example, cite an ophthalmologist whose unnecessary surgeries left fourteen people with impaired vision. The loss of physical abilities for these patients is evident as is the losses experienced by some victims of elder abuse. For instance, the *Medicaid Fraud Report*² describes an incident involving a nurse's aide who scratched a patient's retina by hitting the patient with an open fist. The fraud report states:

[A]s a result of this incident, the patient who had previously lost her vision in her right eye due to glaucoma, has also lost vision in her left eye and is now totally blind. (March 1993)

The ancillary losses such as the loss of peace of mind are not as clear as the loss of physical abilities.

Nonetheless, losing peace of mind or emotional stress can be viewed as a physical deprivation associated with certain types of victimization in the health care system. Clearly, one would expect victims of violent abusive acts to experience some of these effects. However, indirectly, victims of many of the other health care offenses that are not necessarily "personal" offenses will also experience similar emotional stresses. Many people become stressed over routine doctor visits (Jackson 1991). Imagine the stress felt by victims of unnecessary surgeries, procedures, and referrals. The irony is that in most cases the patient does not know the procedure was unwarranted (Lanza-Kaduce 1980); yet he or she still experiences the stress that comes along with visits to the doctor (Jackson 1991).

On another level, it is likely that the mental anguish inflicted as a result of some of the abuse cases relates to loss of "peace of mind." Consider, for example, the renowned case involving the doctor from Tampa, Florida who cut off the wrong leg of a diabetes patient (Navarro 1995). This patient undoubtedly felt "mental anguish" as a result of the "mistake." Interestingly, this same doctor later cut off a woman's toe without her permission. In each case, the victims lost a part of their body without their consent. The doctor's license was suspended

after the second incident. The suspension likely did very little to minimize the mental trauma resulting from the acts.

Elder abuse cases reported in the fraud report also seem to support the notion that victims suffer mentally as a result of the victimization. Consider for example two incidents from the fraud report. In one a nurse's aide was prosecuted for

kicking residents in the buttocks and groin areas, striking residents in the face, twisting a resident's penis, placing a resident in a chokehold, and pointing a handgun at a resident. (*Medicaid Fraud Report July 1991*)

In another, the defendant "was sitting on the patient's lap pulling his ears and blowing in them" (*Medicaid Fraud Report March 1992*). Again, one would expect that these acts must lead to a loss of peace of mind for the victims.

Related to losing peace of mind, health care crimes deprive individuals of the quality of health care they deserve (Pontell et al 1982). Yet another irony: by committing violations such as providing unnecessary services to those who do not need the services, those who actually need certain services are overlooked. Thus, crime in the health care system

impacts on programs that must go unfunded due to lack of money, such as eye and dental care for the elderly, or programs that must be limited, such as the monthly prescription limit for Medicaid recipients. (Taylor 1992)

The deprivation of adequate health care is difficult to measure. Yet, it is still an important consequence of offenses against the health care system.

Perhaps the most serious physical deprivation resulting from health care violations is the loss of life. The statistical problem that arises centers on ways to determine whether the loss of life was actually caused by the actions of the practitioner or by the impairment of the sufferer. In some cases it may be clear that the provider clearly intended to cause harm to the victim. More often than not, however, cases resulting in death may be the result of inadvertent actions. For example, Cohle, Lang, and Kosek (1986) describe a homicide "brought about by the inadvertent substitution of regular insulin for NPH insulin by a pharmacist."

Rosoff, Pontell, and Tillman (1998) cite two separate incidents where two dentists' decisions to give a high level of anesthesia to child Medicaid recipients resulted in the deaths of a 3 year old girl and a 13 month old girl. In the case involving the 13 month old, the dentist "planned to put crowns on four of her eight teeth" (Rosoff et al 1998). While the extent of deaths caused by such actions is debatable, Reiman (1995) estimates that nearly 25,000 individuals die each year as the result of inadequate, inappropriate, or unnecessary medical care.

While physical deprivations are clearly consequences of violations in the health care system, time deprivations are somewhat "latent" consequences of the offenses. On the one hand, the patient must spend his or her time preparing for and visiting the health care provider. This preparation time often includes time worrying about the visit. The irony that once again surfaces is that the time is virtually wasted, particularly for those cases in which services were unneeded. Consider for instance a case involving a gynecologist who billed Medicaid for numerous sonograms for young male children (*Medicaid Fraud Report February 1991*). Obviously, the mothers who visited this particular provider would have had a more valuable use of their time with another provider. Also consider the suggestion that 1 in 6 surgeries is not necessary (*Changing Times* 1985). If this estimate is even close, then a substantial proportion of patients are clearly having their time wasted. Interestingly, Medicaid patients have operation rates two times higher than non-Medicaid patients; suggesting they are more likely to be victims of such practices (Lanza-Kaduce 1980).

The time deprivation is compounded when time waiting for services is considered. Describing waiting, Schwartz writes:

after a certain point, waiting becomes a source of irritation not only because it may in itself be wearisome, boring, and annoying, but also because it increases the investment a person must make in order to obtain a service...This loss to the waiter is related to the fact that time is a finite resource. (1974)

In fact, waiting only serves to strengthen the power the provider has over the patient who is already vulnerable (Schwartz 1974). Schwartz (1974) goes on to suggest that

those who are able to afford health care are not forced to wait as long as those who rely on governmental forms of assistance.

The time issue gets more complex when one considers that the clients have to alter their work schedule. Most employed Medicaid clients are in low paying jobs needing the entire paycheck simply to make ends meet. When work hours are missed because of health care visits, work schedules must be adjusted accordingly (Moskowitz 1989). Again, the possibility that some of the health care visits are unnecessary or result in violations by the provider is deeply troubling.

When providers are prosecuted, Medicaid recipients will also lose time engaged with the court system (Reid 1992). As Reid points out, time spent talking to law enforcement officers and lawyers, as well as testifying in court, alters work and family schedules drastically. In fact, the National Crime Survey recognizes these effects as some of the reasons that victims in general do not report crimes (Reid 1992). The loss of time spent with the justice system coupled with the fact that some law enforcement officials view Medicaid recipients as "less than ideal witnesses" only adds to the time dilemma (Payne, Berg 1997).

Related to time deprivations are individual economic deprivations which include manifest monetary losses, latent monetary losses, and health care recovery losses. Manifest monetary losses are the clearest economic deprivation. In cases such as these, health care professionals who take property directly from the client or the benefit programs cause the victim to experience a direct monetary loss. Cases where aides steal gifts, checks, and other goods from the elderly have been reported in the media and clearly represent a manifest monetary loss for the individual. In other cases, such as a case involving two doctors who billed Medicaid for more than \$1.3 million for "phantom psychotherapy sessions," the victim of the direct monetary loss is the Medicaid system (*Medicaid Fraud Report* December 1990).

Latent monetary losses refer to losses the recipient experiences indirectly. For example, when people have to take off time from work to visit the doctor or to testify against the malfasant provider, they lose money they otherwise would be making at their job (Reid 1992). Because this is an indirect cost, it has been largely overlooked in

past research. Yet it has significant consequences for the victims.

Health care recovery losses, as the third type of economic deprivation, point to yet another irony arising from violations in the health care arena. For some victims of health care violations, whether it is abuse at the hands of a nurse's aide, unnecessary root canals by a fraudulent dentist, sexual abuse committed by a trusted health care practitioner, or any of the other offenses, additional medical services may be needed. The irony is that the patient must then deal with all of the other economic, time, and physical costs on another level. As with the latent monetary costs, although these are indirect and immeasurable effects, they clearly present expensive costs for some victims.

Experiential Effects. Whereas deprivational effects include the physical, time, and economic losses stemming from health care crimes, experiential effects are the effects victims actually "experience" physically, mentally, and economically. Briefly, deprivations are things that are lost whereas experiences are things that are incurred. Though offense-based concepts might also be relevant, it is important to reiterate that this typology is based on the experiences of the victim rather than the characteristics of the offender or the offense.

Physical experiential effects are those physical effects experienced (or felt) by the victim. For example, cases of abuse and neglect against elderly diabetics have been known to cause gangrene in the victim (Zuzga 1996). In other cases of physical abuse or sexual abuse, the offense obviously will directly lead to pain and suffering on the part of the victim. One doctor, for example, molested nine female patients in a three year time frame (Pristin 1996). Pain and suffering unquestionably was experienced by each of the victims. In another incident, a nurses' aide "repeatedly slapped a 104 year old wheel-chair bound patient across the face, causing bleeding and swelling" (*Medicaid Fraud Report* Feb. 1991), and another "poured ice water on an 87 year old resident's buttocks and private areas" (*Medicaid Fraud Report* March 1990). In each of these cases, as well as other cases of abuse imposed by health care providers, the victims experienced some form of physical harm. Examples such as these lead Reiman (1995) to suggest "Health care may be

Given estimates such as these, it should not be surprising when total losses due to fraud and abuse are estimated at 50 to 100 billion dollars a year—10 percent of the health care budget (Cohen 1996; Ford 1992; Taylor 1992).

Of course, the economic costs resulting from health care offenses relate to many of the effects mentioned earlier. For example, increased costs may translate into less care for the poor and needy. Higher insurance rates for all, including those cut from the health care programs, are linked to fraud and abuse in the health care system (Borner 1997). Unable to pay for the needed health care, poor individuals are "re-victimized" by the fraudulent providers. For those who remain in the health care programs, fewer types of treatment and services will be covered by the Medicare and Medicaid.

Some victims of fraud and/or abuse will decide to seek damages in civil court. Here again, however, the victim will experience economic effects associated with the victimization. As Hankin (1996) points out

Abusers and their lawyers are aware of the financial pressures on the [victim] and may take advantage of that by dragging out litigation and making the victim's lawyers... devote more of their costly time to the litigation.

Hence, the victim is again "re-victimized." And another irony arises—the stress accompanying the lawsuit may yield additional health problems.

CONCLUDING REMARKS

This paper has considered a typology for examining the effects of health care offenses on the poor. This typology examines what are referred to as "experiential effects" and "deprivations." In one sense, "experience" is a misnomer in that deprivations are, at least in a sense, experienced by the victim. Two points should make the distinction clearer. First, "experiential effects" are concerned with what is actually experienced by the victim and deprivational effects are concerned with what is lost by the victim. Second, victims will almost always recognize that they have lost something (a deprivation) and they will usually know the source of the deprivation. For example, the woman whose toe was cut off without her consent understood that the loss occurred and that it occurred because the doctor did

something without her consent. On the other hand, victims may not be aware of the fact that they have experienced the "experiential effects" or they may not know the source of the "experiential effects." For example, one may experience pain and suffering from sexual abuse without understanding the source of the pain.

Three critical points are warranted. First, while there are significant financial and personal costs associated with these offenses, most health care providers do not violate the ethical and legal principles guiding their professional roles (Wilson et al 1985). Second, these offenses considered here vary in seriousness with some being devastating and others perhaps only slightly affecting the victim(s). Combining all of the offenses together conceptually may be flawed, but the cumulative effects are felt by all of the individuals the health care programs were designed to serve. Third, while most of the effects described here are based on previous suggestions in the literature, this typology is based in large part on conjecture and needs to be tested empirically.

Nonetheless, the implications are worthy of consideration. Most importantly, awareness of these offenses and their impact needs to increase among laypersons, legislatures, practitioners, and the academic community. There is a tendency among the medical and academic community to either overlook or look negatively on this group of victims. Rosoff et al (1998) describe one dentist's defense to physically abusing his patients as being that "he never turned away Medicaid patients—even though many of them are 'dirty' and 'smell bad'". Even if these negative views are not held by all, victims of medical offenses are often ignored in research as well as prevention and intervention programs.

Based upon this, more attention needs to be given to the victims of these types of offenses. Due to sampling problems, it would be impossible to assess the effects of each type of crime at once. Rather, specific studies focusing on each type of victim are needed so that a complete understanding of the problems faced by the victims is provided. The biggest problem, that partially explains why these groups have been ignored in the past, is locating individuals who would be capable of and willing to participate in such endeavors. Note that these victims have already been violated by trusted

dangerous to your health".

Victims may also experience physical harm from receiving improper prescriptions (Payne, Dabney 1997). This physical harm ranges from acute allergic reactions to death. In cases such as these, while the health care providers may not intend the results of their actions, they can still be held criminally or civilly liable if the way they provided the medicine was illegal. The difficulty for the victim and justice system is proving that the pain and suffering was caused by the improper and illegal drug prescription rather than the original ailment.

The relatives of the victims of health care offenses will also experience various degrees of pain and suffering. The fraud report describes the effects of one elder abuse case in the following way:

[A]fter this incident, the victim has been extremely withdrawn and [has] not responded in any fashion to family members. (*Medicaid Fraud Report* May/June 1987)

One can only imagine the pain felt by the relatives who could no longer communicate with their elderly relative as a result of the actions of an abusive health care provider.

In addition to physical experiential effects, some victims will experience mental experiential effects. On the one hand, the increased stress due to improper treatment could lead to increased health problems which could lead to increased anxiety, depression, or other forms of mental anguish from the offense. One abuse victim was intimidated "into performing the demeaning act of cleaning up his own excrement with his bare hands" (*Medicaid Fraud Report* September 1991). Another was teased as the nurses' aide "plucked" the patient's ears repeatedly (*Medicaid Fraud Report* April 1992).

A case involving a psychiatrist who had his patient give him oral sex as a part of her therapy is described by Jesilow et al (1996). The psychiatrist provided the patient with prescriptions after her first visit. By the third visit, the patient, feeling dependent on the prescriptions, performed fellatio in order to receive a new prescription. This "therapy" continued for seven years. The ensuing investigation revealed that the psychiatrist committed similar assaults against at least two other patients (Jesilow et al 1996). In a similar case, a psychologist billed Medicaid

for the time he spent having sex with his patient (*Medicaid Fraud Report* February 1988). While the mental anguish, like the physical pain in the previous acts, is difficult to measure, it will be a consequence experienced by victims of health care offenses such as these.

On another level, violations by health care professionals destroy the trust that members of society have in the health care system (Pontell et al 1982; Wilson et al 1985). In this context, lowering levels of trust is suggested as a mental experiential effect because trust is fundamentally based on mental emotions. Altering levels of trust has in fact been viewed as one of the most significant negative effects of white collar crime in general (Sutherland 1949). This is particularly significant for health care offenses when one considers that health care providers have traditionally been viewed as more honest than other types of employees (Wilson et al 1985). Pharmacists, for example, rate higher on trust scales than the clergy in public opinion polls (Wivell, Wilson 1994). Misdeeds by all health care professionals only lowers the trust the public has in the various health care occupations.

"General economic experiential effects" are also felt by victims of health care costs. These effects seem to be those that have received the most attention by the media and academic community, perhaps because they are the easiest to measure. General economic effects include the possibility that health care offenses lead to higher health care costs for all. Consider the following statements:

1. The Rand Corporation estimates quality problems increase health care costs an estimated \$75 billion to \$200 billion annually (Jasinowski 1991).
2. At least half the thousands of operations on Americans with ruptured discs were unnecessary...Americans spend more than \$3 billion annually on [the operations] (Wilstein 1988).
3. As many as 50,000 of the appendectomies that are performed each year are unnecessary...The price of each surgery is roughly \$4,700 (*Modern Medicine* 1997).
4. Unnecessary surgery and medication cost the public between \$20 and \$24 billion annually—far outstripping the \$15.1 billion taken by thieves that concern the FBI. (Reiman 1995).

Given estimates such as these, it should not be surprising when total losses due to fraud and abuse are estimated at 50 to 100 billion dollars a year—10 percent of the health care budget (Cohen 1996; Ford 1992; Taylor 1992).

Of course, the economic costs resulting from health care offenses relate to many of the effects mentioned earlier. For example, increased costs may translate into less care for the poor and needy. Higher insurance rates for all, including those cut from the health care programs, are linked to fraud and abuse in the health care system (Bomer 1997). Unable to pay for the needed health care, poor individuals are "re-victimized" by the fraudulent providers. For those who remain in the health care programs, fewer types of treatment and services will be covered by the Medicare and Medicaid.

Some victims of fraud and/or abuse will decide to seek damages in civil court. Here again, however, the victim will experience economic effects associated with the victimization. As Hankin (1996) points out

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Based upon this, more attention needs to be given to the victims of these types of offenses. Due to sampling problems, it would be impossible to assess the effects of each type of crime at once. Rather, specific studies focusing on each type of victim are needed so that a complete understanding of the problems faced by the victims is provided. The biggest problem, that partially explains why these groups have been ignored in the past, is locating individuals who would be capable of and willing to participate in such endeavors. Note that these victims have already been violated by trusted

figures. Therefore, in using health care crime victims as a source of data, extra caution must be taken so that they are not re-victimized by the research process.

The trend of focusing solely on the monetary costs of fraud and abuse also needs to be questioned. Research should also examine how academicians, legislatures, and health care professionals perceive the actual effects of these offenses. Policies stemming from the increased awareness and understanding will only help in the prevention and detection of these problems in the future. It is only through this increased attention that the "vulnerable" patients will be given the assistance they need to either prevent the offenses or to intervene to help them should they be victimized. In turn, the Medicare and Medicaid programs will be able to better serve those individuals for whom the programs were designed.

ENDNOTES

1. Elder abuse may seem out of place in this context. However, if the abuse is committed in a nursing home which receives support from Medicare or Medicaid, the act falls under the jurisdiction of Medicaid Fraud Control Units. Because the criminal justice system treats such acts as violations against the Medicare/Medicaid systems, I will do likewise.
2. The *Medicaid Fraud Report* describes health care crimes prosecuted by Medicaid Fraud Control Units across the United States.

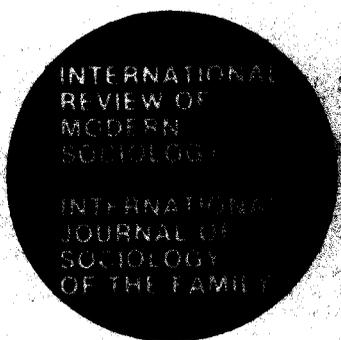
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