

## Potential fraud and its' prevention in the implementation of national health insurance at Dadi Regional Hospital

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### ABSTRACT

The National Health Insurance program started running in Indonesia on January 1, 2014. Along with the increasing number of National Health Insurance participants and health facilities, more criticism has emerged from various parties, including from National Health Insurance providers regarding the alleged fraud. Fraud can have a negative effect on finances, the standard of medical care, and the perpetrator's reputation. This study's goal was to assess the likelihood that fraud may occur at Dadi Regional Hospital in Makassar, Indonesia. The study also explored the procedures and policies in place for preventing the fraud. This qualitative study employed phenomenological design. The results of the study show that there is a fraud prevention system at Dadi Regional Hospital in the form of policy and guideline formulation, a culture of prevention, implementation of quality control, and cost control. Even though they already have a prevention system in place, there is still some lack of information being disseminated about the fraud prevention team established. There are still frequent discrepancies between the diagnosis code input in the National Health Insurance system and the patient's diagnosis. Hence, the Internal Monitoring Unit is still in the process of establishing a fraud prevention system.

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## 1. INTRODUCTION

In order to realize global commitments, as mandated in the 58th World Health Assembly (WHA) resolution in 2005 in Geneva, many countries have implemented Universal Health Coverage (UHC) for their entire populations, including Indonesia. The term "UHC" refers to a concept involving the reform of health services that covers all communities in terms of accessibility and equity of health services, quality and comprehensive health services that include preventive, promotive, curative to rehabilitative services and reduce financial barriers to obtaining health services for every citizen. There are several problems that may arise in order to realize UHC, one of which is fraud [1]. Fraud is a deliberate attempt to obtain a benefit that neither individuals nor institutions should have enjoyed, which has the potential to cause indirect harm to other parties. According to Li *et al.* the purpose of committing fraud is to get something valueable at the expense of other people as a fraud attempt to obtain personal gain. All aspects of health services, which can result in elements of fraud, are related to elements of fraud in the healthcare field [2].

The number of cases was obtained from research at several hospitals in Indonesia, Germany, Malaysia, and Portugal by reviewing medical records and data also obtained from Social Security Administrative Body (BPJS). Most fraud cases were readmissions, with a total of 4,827 incidents [3]. Thus, there were 4,600 cases of upcoding. This is similar to the research results from Thompson *et al.* [4], which indicated that the most frequent forms were upcoding, phantom billing, and kickbacks. Moreover, in 2015, there were around 175 thousand claims from health services to BPJS with a value of 400 billion rupiah that were detected as fraudulent in Indonesia, one million claims have been discovered thus far. According to Baranek [5], the various types of health service fraud were comprised of ten schemes, which include: claiming services that were never provided; claiming services that were not covered by insurance as being covered by insurance; falsifying service times, locations, and providers; claiming bills services that patients should pay for; reporting inaccurate diagnoses and incorrect procedures; providing excessive service; accepting corruption (bribes); and prescribing unnecessary drugs under the national health insurance (JKN) in Indonesia. The alleged fraud undoubtedly cannot be separated from the implementation of the national health insurance, which is conducted in an effort to equalize access to health services in Indonesia.

National Health Insurance fraud is an intentional act committed during the implementation of the health insurance program by the Healthcare and Social Security Agency (BPJS *Kesehatan*) officers, participants, health service providers, as well as drug and medical device providers, with the goal of obtaining financial benefits from the health insurance program in the national social security system through fraudulent acts that do not comply with the provisions. In addition, fraud is more commonly associated with secondary (advanced) health care, specifically hospitals [6]. In Indonesia, there are three forms of fraud with the highest potential, including upcoding, which has the most potential for fraud with a value of 50%; then there is unbundling, which has a value of 25%; and reading, which has a value of 6% [7]. Indonesian Corruption Watch (ICW) together with 14 monitoring organizations discovered 49 frauds in the JKN program committed by government or private hospitals, one of which was related to BPJS *Kesehatan* bill claims where the hospital limited hospitalization by diagnosing the patient as not having the disease. They discovered BPJS patients were always informed if there were hospitalization restrictions of up to 4-5 days, false claims, excessive medicine and medical equipment bills, or self-referral patients; extending the course of treatment period may be accomplished in various ways. Meanwhile, drug suppliers frequently do not meet the needs of medicines and or medical devices [8].

In 2019, the government issued Regulation of the Minister of Health of the Republic of Indonesia (*Permenkes*) No. 16 of 2019 concerning the prevention and handling of fraud and the imposition of administrative sanctions against fraud in the implementation of the health insurance program. The *Permenkes* is a revision of the previous anti-fraud regulations. It is only that there are still a number of issues arising from the inefficiency of BPJS *Kesehatan* services. Therefore, efforts to prevent fraud are needed to minimize the potential for and control fraud incidents in health care facilities [9]. According to a report obtained from one of the BPJS participants at Dadi Regional Hospital in Makassar City, there was an alleged fraud by health workers by directing BPJS patients to purchase medicines from their pharmacy because the hospital's supply of medicines had run out, but even after the patient had purchased the medicine, the patient was still given the same type of medicine from the hospital as the BPJS claims. This demonstrates that the potential for fraud remained high at Dadi Regional Hospital in Makassar City that year. In addition, one of the national health insurance experts stated that the amount of Indonesia Case Based Groups (INA-CBG) rates that hospitals receive in the JKN era has the potential to lead to fraud.

According to research conducted by Matloob *et al.* [10], hospitals have a tendency to make fraudulent claims due to the absence of a fraud prevention system, the absence of sanctions against fraud perpetrators, the lack knowledge among coders regarding disease coding and procedures in accordance with INA CBGs, and the lack of understanding among medical staff regarding the INA-CBG payment system. For this reason, further research is needed to investigate the susceptibility of health providers to committing fraud in the implementation of national health insurance. Previous studies conducted at Dadi Regional Hospital in Makassar City discovered that the implementation of clinical pathways that have not been carried out optimally has led to discrepancies amongst doctors in how they administer medicines, which has an impact on the expenses that BPJS must pay. Based on the aforementioned description, health care facilities are parties with a high potential for committing fraud. Therefore, the authors were interested in conducting research on the analysis of fraud potential in the implementation of national health insurance at Dadi Regional Hospital in Makassar City and an in-depth investigation of the stakeholders needed to create a hospital fraud prevention team. It is necessary to regulate anti-fraud policies by analyzing the possibility of fraudulent activity in health care facilities. There should be an anti-fraud monitoring team to prevent health workers at health care facilities from engaging in fraud [11].

## 2. METHOD

This study used a qualitative method with a phenomenological design to explore the experiences and awareness of the research subjects. In this study, the authors investigated what research informants experienced, heard, saw, and thought about their daily experiences with the implementation of the national health insurance program at a hospital. It was intended that by doing this investigation, the underlying causes of the fraud phenomenon would be clearly explained and preventative solutions to address them would be obtained. This study made reference to the fraud hexagon theory proposed by Vousinas [12] and the Regulation of the Minister of Health of the Republic of Indonesia (*Permenkes*) No.16 of 2019 concerning the Fraud Prevention System. These two references have become a standard measure of the potential for fraud at Dadi Regional Hospital in Makassar City by examining the variables listed as follows: i) ability as determined by the position occupied at the job; ii) pressure, iii) formulation of policies and guidelines, iv) prevention culture, v) hospital cost control and quality control; vi) formation of a fraud prevention team.

The purposive sampling method was used to select research informants. This method allowed for the contact of several potential informants, who were then asked whether they knew other people who met the characteristics intended for research purposes. The informants in this study were two people from the hospital's internal supervisory unit (SPI), 2 BPJS coders, 1 BPJS verifier, 1 specialist doctor, 1 hospital public relations officer, 1 pharmacist, and 2 BPJS patient families. Only those informants related to policy implementation were interviewed in accordance with the research objectives.

These informants are a significant component since they supervise and participate most in the implementation of the national health insurance fraud prevention policies in hospitals. In this case, each of the informants plays different roles, such as coders, who play an important role, especially for coding INA-CBG; clinicians (specialist doctors) as parties who deal directly with patients; BPJS verifiers, whose job it is to verify hospital BPJS claims; the hospital's internal supervisory units as supervisors in the JKN implementation process; pharmacists as parties who participate in program implementation; as well as a hospital public relations officer and patient families to add to the amount of information gathered from program implementation at Dadi Regional Special Hospital in Makassar City. The informants provided written informed consent and that the study protocol was approved by the institute's committee for human research. This study has received approval from the Health Research Ethics Commission (HREC) of the Faculty of Public Health, Hasanuddin University, with protocol number: 01322012036 and letter number: 2503/UN4.14.1/TP.01.02/2022. Furthermore, when conducting qualitative research, both primary and secondary data were collected. The data obtained from the results of the interviews were then analyzed using the content analysis method. In addition, the authors triangulated the data to ensure that the information collected was accurate.

## 3. RESULTS AND DISCUSSION

In-depth interviews and document reviews conducted at the Dadi Regional Hospital in Makassar City based on the fraud hexagon theory and Regulation of Minister of Health of the Republic of Indonesia (*Permenkes*) No. 16 of 2019 concerning the Fraud Prevention System showed that the hospital already has a fraud prevention system. However, there are still some inadequacies in the system's implementation as shown in Table 1.

Tabel 1 shows the analysis of research results based on informant statements. Thematic analysis was used to examine informants' statements to find compatibility between the theory and the regulation of the Minister of Health regarding fraud prevention and program implementation at Dadi Regional Hospital in Makassar City. The results of the research and analysis are described as follows.

### 3.1. Ability

The informant's ability can be determined by the influence of the informant's position on the informant's potential to commit fraud. Based on the results of the content analysis of the interviews conducted, it is known that every informant involved in the implementation of the national health insurance (JKN) at the Dadi Regional Hospital in Makassar City had the ability to commit fraud but chose not to do so. The informant chose to cultivate the work ethics outlined in Dadi Regional Hospital's rules in Makassar City. Ethics can be defined as the agreed-upon standards of what is desirable and undesirable conduct, as well as the right and wrong behavior of an individual, group, or entity. Individual ethical values are influenced by behavior and what is perceived as right or wrong. Therefore, having high ethical standards (competence, confidence, and professionalism) will decrease the possibility of employees engaging in fraudulent behavior while performing their duties [13]. This demonstrates that, despite the fact that anyone can commit fraud, individual ethics have a big impact on preventing it.

### 3.2. Pressure

Fraud is a result of pressure, including financial pressure, bad habits, and other harmful habits, depending on individual conditions [14]–[16]. This study showed that the informants, particularly coders and verifiers, did not experience any pressure as they carried out their duties due to the hospital's lack of supervision. This is obviously contradictory because periodic monitoring is needed to ensure the service process complies with the rules. Internal control for preventing fraud in companies has an effect that can result in a decline in the performance of service companies such as hospitals, as well as in manufacturing companies and the general performance of the national economy. The creation of effective management within a company or organization can be a strength for the long-term sustainability of the business itself. According to Mackey *et al.* [17], internal controls and information systems can be used to identify, analyze, and communicate organizational events. The organization will become strong and successful when its control and management are conducted properly. Meanwhile, weak internal control in an organization can lead to various frauds. This demonstrates how crucial internal control is in protecting companies against fraud and abuse [18], [19].

Table 1. Analysis of potential fraud at Dadi Regional Hospital in Makassar City based on fraud theory and *Permenkes*

Fraud prevention system in the health insurance program	Implementation at Dadi Regional Hospital in Makassar City	Conclusion
Ability The effect of position on potential fraud	Every part and person involved in the implementation of JKN at Dadi Regional Hospital in Makassar City has the opportunity to commit fraud but instead chooses not to do so and upholds the work ethics that have become the institution's rules.	No effect
Pressure Dissatisfaction with organizational systems and workload	According to informants at Dadi Regional Hospital in Makassar City, due to the lack of hospital supervision, coders and verifiers in particular did not feel excessive pressure to perform their duties.	No effect
Formulation of policies and guidelines The implementation of fraud prevention policies with the principles of good corporate and good clinical governance.	A decree has been issued at the Dadi Regional Hospital in Makassar City regarding the duties and authorities of the fraud prevention team, in this case, the hospital's internal supervisory unit, and the application of clinical pathways; however, the implementation of this policy still needs to be improved.	Correspond
The establishment of fraud risk management guidelines.	Fraud risk management at Dadi Regional Hospital in Makassar City is guided by the regulation of the Minister of Health as well as several additional guidelines tailored to the needs of the hospital.	Correspond
Culture of fraud prevention Establishing a culture of integrity, ethical values, and standards of behavior and educating all parties related to health insurance about anti-fraud awareness	The culture implemented by Dadi Regional Hospital in Makassar City includes providing patients with proper diagnoses, upholding ethical values, and double-checking the files that will be claimed by the coder. However, specialized training for fraud prevention (inadequacy) is still offered infrequently at Dadi Regional Hospital in Makassar City.	Correspond
Quality control and cost control The formation of a quality control and cost control team	Dadi Regional Hospital in Makassar City has a quality control and cost control team that is appointed by BPJS	Correspond
The implementation of the concept of quality control management in health services	Dadi Regional Hospital in Makassar City has implemented service standards, monitoring and evaluation, coordination establishment, and service improvement.	Correspond
Fraud prevention team The formation of a fraud prevention team that is tailored to the needs of the hospital	Dadi Regional Hospital in Makassar City has formed a fraud prevention team based on regulations from local regulation (PERDA) and the regulation of the Minister of Health in the form of a hospital's internal supervisory unit. Furthermore, it is necessary to form a special team with the responsibility of preventing potential fraud, especially when national health insurance is implemented in the hospital	Correspond

Source: Primary Data, 2022

### 3.3. Policies and guidelines

The formulation of policies and guidelines was guided by concepts and principles that served as the framework and basis of plans for the implementation of fraud prevention with the principles of good corporate governance and good clinical governance. The formulation of policies is essential as the underlying principle of a management process and mechanism based on statutory regulations for the prevention of fraud in the implementation of the national health insurance program. The Dadi Regional Hospital in Makassar City has formulated and implemented guidelines in accordance with the needs of the hospital, which are strongly attributable to both local regulations and the regulation of the Minister of Health. According to the authors' analysis of the documents related to the management of the policies and guidelines that are being implemented in hospitals, additional socialization is required for the policies that have been formed.

The authors also discovered that the implementation of the policy had not gone well because several informants reported that the fraud prevention team had only been formed as a formality and that its members had continued to work in accordance with their respective fields as before the decree on fraud prevention was issued, despite the fact that the team had been formed. It has not been possible to prevent fraud effectively, one of the reasons for fraud is the inadequacy of socialization regarding fraud prevention policies [20]. Furthermore, fraud may also result from miscommunication between the coder and the doctor in charge of service (DPJP), as well as the BPJS verifiers' problems with an uncoordinated fraud prevention system and the absence of strict sanctions for fraud. As a result, it is highly recommended that Dadi Regional Hospital in Makassar City regularly conduct hospital policy socialization for all parties involved in the implementation of the national health insurance [21], [22].

### 3.4. Culture of prevention

Culture is a developed way of life that a group of people share and that is passed down from generation to generation. The implementation of a professional code of ethics and standards of behavior to achieve institutional goals is a standard for measuring potential for fraud in an analysis of the potential for fraud based on the prevention culture at Dadi Regional Hospital Makassar City. According to the informant, the coordination and adherence to ethical and professional values when diagnosing, as well as double-checking the results of the diagnosis to prevent fraud, were important components of the culture performed. Based on the research results, there are still frequently discrepancies between the diagnosis code entered into the national health insurance system and the patient's diagnosis, but this is not yet regarded as fraud because the coding team continues to coordinate with the BPJS, the agency that provides the national health insurance service, and the internal supervisory unit is still in the process of creating a fraud prevention system. This demonstrates that the culture of prevention has been properly implemented through coordination and supervision. Moreover, upcoding refers to the possibility of fraud occurring in hospitals as a result of inaccurate coding. Upcoding is not necessarily considered fraud; there must be an element of intent to earn financial gain. Upcoding can increase the value of claims [23]–[25].

According to research conducted by Timofeyef and Mihajlo [26], organizational culture has a significant effect on fraud prevention. Organizational culture may also be used as a management tool to achieve efficiency, effectiveness, productivity, and work ethic, as shown in various companies in Japan, the United States, and other European nations. It turns out that this can effectively help companies succeed. Furthermore, based on the research results, it is known that socialization about the risks and methods for preventing fraud is still infrequently conducted at Dadi Regional Hospital in Makassar City. Meanwhile, it is necessary to cultivate this in order to routinely educate employees about the negative effects of fraud and the significance of putting a professional code of ethics in place. Uneven socialization among all coders may lead to fraud by enabling coders to encode the diagnosis of patients in a way that does not comply with the rules [27]. In addition, fraud can occur as a result of employees' dishonesty regarding their health, such as manipulating the birth weight of babies to get higher costs [28].

### 3.5. Quality control and cost control

The hospital has formed an internal team for quality control and cost control. In addition to this team, a quality control and cost control team was also formed by the BPJS and professional organizations. The implementation of quality control and cost control has resulted in the socialization of the authority of health workers in the performance of their duties, the implementation of monitoring and evaluation service standards, the writing of complete and clear medical records, the maintenance of claims procedures, the execution of clinical audits, and the implementation of quality management concepts. In order to anticipate the spread of fraud in the health sector, the government of Indonesia, through the Ministry of Health, issued Regulation of the Minister of Health No. 36 of 2015 concerning Prevention of Fraud in the Implementation of the Health Insurance Program in the National Social Security System. Moreover, a national health insurance (JKN) fraud prevention team was established at the advanced referral level health facilities, and

evidence-based information technology was used to construct service-oriented quality control and cost control. The fraud prevention team is responsible for detecting potential fraud through the analysis of claim data [29]. However, Wibowo *et al.* [30] stated that the detection of potential fraud is currently done manually by comparing an allegation of fraud with the regulations issued by the Ministry of Health and the BPJS Kesehatan.

### 3.6. Formation of a fraud prevention team

In order to optimize fraud prevention, it is considered very important in every hospital to form a fraud prevention team as one of the controls under the Regulation of the Minister of Health No. 16 of 2019. There is currently no fraud prevention team at Dadi Regional Hospital in Makassar City; instead, this responsibility is under the authority of the hospital's internal supervisory unit. The only obstacle encountered while carrying out its duties and functions was a discrepancy in the time scheduled for meeting the person to be supervised. It is necessary to form a fraud prevention team at Dadi Regional Hospital in Makassar City. In addition, based on the expectations of the informants, the team will later consist of representatives from the hospital program department, hospital finance, BPJS as the national health insurance distribution agency, and the legal or academic division.

## 4. CONCLUSION

The study revealed that Dadi Regional Hospital has implemented a fraud prevention system in the implementation of the national health insurance, in this case in collaboration with the BPJS, in the form of policy and guideline formulation, a culture of prevention, quality control implementation, and cost control. Even though the hospital already has a fraud prevention system, there are still some inadequacies in its implementation, including a lack of socialization regarding the fraud prevention team (internal supervisory unit); the fact that there are still frequently discrepancies between the diagnosis codes entered into the national health insurance system and the patient's diagnosis, but this does not include fraud because the coder team continues to coordinate with the BPJS as the national health insurance service provider agency; and the implementation of the clinical pathway policy, which created obstacles in several parts of the service. Furthermore, the authors offer some suggestions for this hospital. The suggestions are to form a specific team for preventing health insurance fraud, consisting of representatives from the hospital program department, hospital finance, BPJS as the national health insurance distribution agency, and the legal or academic department.




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