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by Misnaniarti Misnaniarti2

Submission date: 16-Jun-2023 08:53PM (UTC+0700)
Submission ID: 2117310491
File name: onal_Health_Insurance_in_The_Health_Sector_Systematic_Review.pdf (456.19K)
Word count: 7988
Character count: 46398

Journal : *JMMR (Jurnal Medicoeticolegal dan Manajemen Rumah Sakit), 10 (3): 255-270, December 2021*
Website : http://journal.umy.ac.id/index.php/mrs
DOI : https://doi.org/10.18196/jmmr.v10i3.10825

Potential Fraud in The Implementation of National Health Insurance in The Health Sector: Systematic Review

Rizki Nurul Fatimah[1], Misnaniarti[2], Rizma Adlia Syakurah[3]*
** Correspondence Author: rizma.syakurah@gmail.com*
[1,2,3] Department of Public Health, Faculty of Public Health, Sriwijaya University, Jl. Raya Palembang-Prabumulih KM.32 Indralaya, Ogan Ilir 30662, Indonesia

INDEXING
Keywords:
Potential fraud;
National Health Insurance;
Health sector;
Health service;

ABSTRACT
Fraud in the national health insurance is a form of deliberate effort to create a benefit that should not be enjoyed by individuals or institutions and could harm other parties. This study aims to further analyze the potential for fraud in the implementation of national health insurance at health facilities. The method used a systematic review based on PRISMA with a qualitative approach through descriptive analysis. The articles selection based on the specified inclusion and exclusion criteria. The study found that the potential for fraud can occur in the primary care health facilities (*Fasilitas Kesehatan Tingkat Pertama-FKTP*) and secondary care health facilities (*Fasilitas Kesehatan Tingkat Menengah- FKRTL*) in the form of potency such as inappropriate capitation fund management, maximizing the number of claims, upcoding, dissatisfaction with the salaries received, and inadequate internal controlling/supervision. As the conclusion of this study, the potential fraud in the implementation of national health insurance in Indonesia occurs in the primary care health facilities and secondary care health facilities. The prevention of potential fraud can be done by implementing the principles of Corporate Governance and the implementation of fraud prevention based on the Regulation of the Minister of Health Number 16 of 2019.

Kata kunci:
Potensi Fraud;
Identdikasi Fraud;
Asuransi Kesehatan Nasional;
Sektor kesehatan;
Pelayanan Kesehatan;

Fraud dalam jaminan kesehatan nasional merupakan salah satu bentuk upaya yang disengaja untuk menciptakan manfaat yang tidak boleh dinikmati oleh individu atau lembaga dan dapat merugikan pihak lain. Penelitian ini bertujuan untuk menganalisis lebih jauh potensi kecurangan dalam penyelenggaraan jaminan kesehatan nasional di fasilitas kesehatan. Metode penelitian menggunakan tinjauan sistematis berdasarkan PRISMA dengan pendekatan kualitatif melalui analisis deskriptif. Pemilihan artikel berdasarkan kriteria inklusi dan pengecualian yang ditentukan. Hasil penelitian menemukan bahwa potensi kecurangan dapat terjadi di fasilitas kesehatan tingkat pertama (FKTP) dan fasilitas kesehatan tingkat menengah (FKRTL) berupa potensi seperti pengelolaan dana kapitasi yang tidak tepat, maksimalisasi jumlah klaim, upcoding, ketidakpuasan terhadap gaji yang diterima, dan pengendalian / pengawasan internal yang tidak memadai. Kesimpulan dari penelitian ini, potensi kecurangan dalam penyelenggaraan jaminan kesehatan nasional di Indonesia terjadi di fasilitas kesehatan tingkat pertama (FKTP) dan fasilitas kesehatan tingkat menengah (FKRTL). Pencegahan potensi fraud dapat dilakukan dengan menerapkan prinsip-prinsip Tata Kelola Perusahaan dan penerapan pencegahan fraud berdasarkan Peraturan Menteri Kesehatan Nomor 16 Tahun 2019.

Article History: Received 2021-09-12; Revised 2021-10-24; Accepted 2021-11-30.

INTRODUCTION

Health service is a very complex organization because it is engaged in the service sector that involves professional groups with various educational and life backgrounds (Siregar, et al, 2020). In performing every duty both in action and health services, nurses, doctors, and other medical personnel must comply with the rules of all legal aspects of health. In line with the faster global development nowadays, the health aspect becomes the basic human need for more a decent and productive life (World Health Organization, 2018).

Along with global development in the health sector, the World Health Organization

(WHO) states that the world has spent trillions of USD or about 6% of total expenditure on health services (World Health Organization, 2018). The expenditure on health exceeds more than economic growth (Global Health Care Anti-Fraud Network (GHCAN), 2017). The most influential aspect of the expenditure is cheating on health services globally (NHCAA, 2012). The National Health Care Anti-Fraud Association (NHCAA) estimates that the health costs resulting from fraud in the health sector are in the tens of billions of dollars (Aldrich N, Crowder J, 2014). Meanwhile, according to the estimation of the Federal Bureau of Investigation (BIF), health fraud on American tax payments is more than US$ 80 billion a year (Taufik, 2014).

Fraud in the national health insurance is a form of deliberate effort to create a benefit that should not be enjoyed by individuals or institutions and could harm other parties (Trisnantoro, L. and Hendrartini, Y, 2014). According to Black's Law Dictionary, the purpose of committing fraud is to get valuable things from the loss of another person as a cheating attempt to gain personal benefit (Djasri H, Rahma PA, 2018). Fraud in an agency or company is a deliberate act of cheating based on dishonesty that can be done by someone, both employees and leaders, which results in losses to the company, both financially and non-financially (Putri, 2012b). Company losses due to fraud can ultimately lead to bankruptcy (Putri, 2012b).

On January 1, 2014, the National Health Insurance Program (JKN) has started in Indonesia. In line with the increase in the number of participants in the National Health Insurance (JKN) and health facilities, there are more and more criticisms coming from various parties, including from the National Health Insurance (JKN) providers, namely community health center, hospital, and private clinic regarding suspected fraud (Djasri H, Rahma PA, 2018). The alleged occurrence of fraud not only occurs in Indonesia, where the health service system and financing system have not yet been properly organized but also occurs throughout the world which has an impact on various aspects. The impact of fraud can affect financial aspects, the quality of clinical services, and the image and reputation of the perpetrator (Badan Pemeriksa Keuangan Republik Indonesia, 2016).

In 2018, based on the Report to the Nations Acfe (RTTN) Association of Certified Fraud Examiners (ACFE) 2018, losses due to fraud in health services reached 5% of the total health service costs (Kemenkes, 2015). In 2015 in Indonesia, there were around 175 thousand claims from health services to BPJS with a value of Rp. 400 billion that was detected as fraud, and up to now there have been 1 million claims detected (Rahma et al., 2019). In 2016, the Supreme Audit Board (BPK) Audit Result Report (LHP) on the performance of BPJS Kesehatan showed that there were 9.767 community health centers and other primary care health facilities (FKTP) throughout Indonesia that received capitation funds worth Rp. 13 trillion. This fund was used to finance the services for the targeted 188 million participants. However, the management of community health centers was still poor, thus it increased the potency of fraud and vulnerability in the management of capitation funds (Badan Pemeriksa Keuangan Republik Indonesia, 2016).

A study revealed that in the 2014 to 2017 period there were 12 issues of cutting, diversion, and deviation from the JKN capitation fund in 12 regions in Indonesia (Tunggal, 2012). In monitoring 26 community health centers in 14 provinces from March to August 2017, 13 potential frauds were found occurred at Puskesmas (Tunggal, 2012). From those 13 potential frauds, 8 findings were related to capitation (Tunggal, 2012). Meanwhile, for corruption cases, the Indonesian Corruption Watch (ICW) found 8 cases of corruption in capitation funds that were revealed (Tunggal, 2012).

The increasing potential for fraud in health services becomes more visible in the health sector in Indonesia, but this has not been accompanied by a reliable control system[13] Vigilance against fraud in health services is very important (Tunggal, 2012). Therefore, the aim of this study is to analyze the potential fraud against national health insurance services in Indonesia by using a systematic review.

RESEARCH METHOD

The type of this research was a systematic review with a qualitative approach, which was named a meta-aggregation approach to the potential drivers of fraud in the health sector (Siswanto, 2010). The systematic review in this study was prepared based on Preferred Reporting Ite for Systematic Reviews and Meta-Analyzes (PRISMA). The basic theory of this research was the fraud triangle theory. Cressey states that there are 3 factors that support a person to commit fraud, namely the pressure that encourages the perpetrator to commit fraud (pressure), the opportunity to commit fraud, and the rationalization from the perpetrator (Dellaportas, 2013).

The searching process of articles was carried out in August to September 2020. The searching process of articles was carried out in the databases, namely PubMed, Google Scholar, DOAJ, and Springerlink by using keyword "fraud identification, potential fraud, health sector, National Health Insurance, health service" keywords. Here, "AND" was used in the searching articles. The articles obtained were from 2014 to 2020 published researches. Then, after obtaining the articles, the researchers then selected the articles that matched the specified inclusion and exclusion criteria. The inclusion criteria were the articles that discussed potential fraud in the implementation of national health insurance in Indonesia, published in the 2014-2020 period, written in Indonesian and English, and openly accessed research articles. From the results of articles selection, 10 articles were suitable and relevant in this study. The flow diagram and article selection are presented in figure 1.

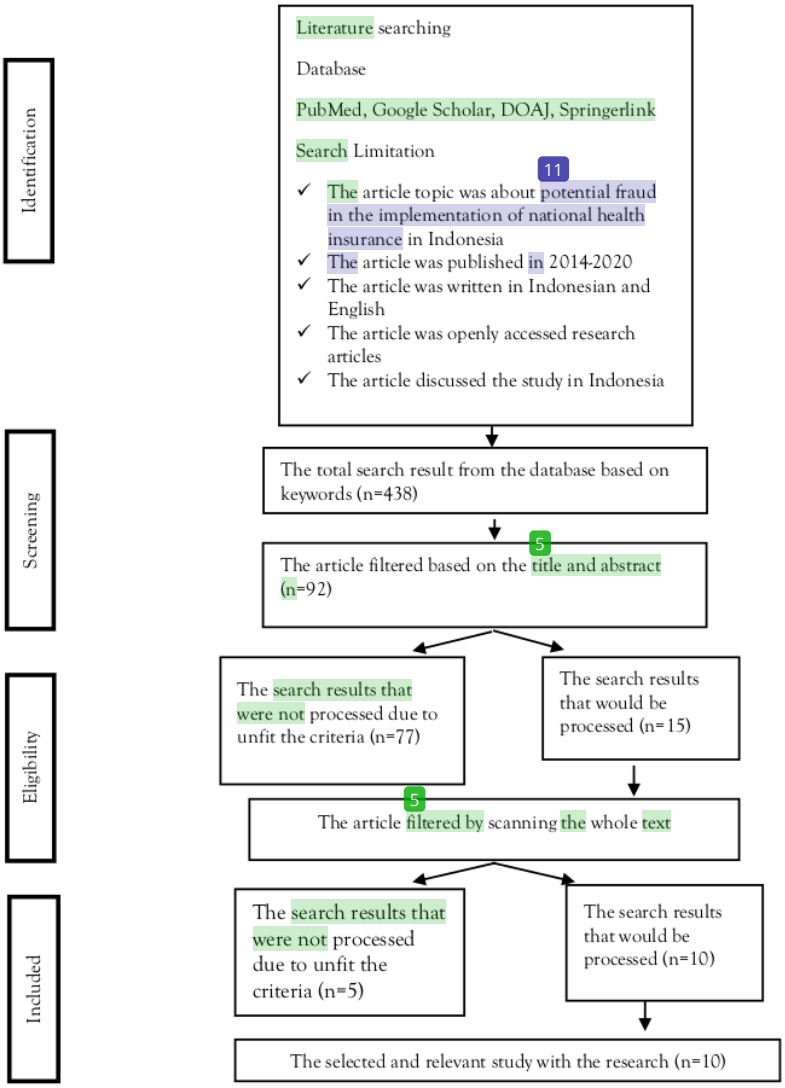

Figure 1. Flow diagram and article selection (PRISMA)

RESULT AND DISCUSSION

A total of 438 studies were obtained from electronic searches. The search strategies were presented in Figure 1. The article filtered based on the title and abstract, total of 99 articles were obtained. Seventy-seven studies were screened due to unfit the criteria. The article filtered by scanning the whole text and from the results of articles selection, 10 articles were suitable and relevant in this study. The summary of extracted data from selected studies were presented in Table 1. Based on the results of the literature review that had been conducted, it was found that the potential fraud could occur in the implementation of the national health insurance in Indonesia (Table 1). In table 1, it could be inferred that the potential fraud occurred due to various factors that involved the main party called the health service provider. This study shows

that most of the three stimulant factors, namely rationalization, pressure, and opportunity, greatly influence the potential fraud in the implementation of national health insurance at health facilities in Indonesia. The three potentials are related to one another.

Table 1. Potential Fraud in The Implementation of National Health Insurance

Author	Year	Method	Research result	Variable		
				Rationalization	Pressure	Opportunity
Fathurrohman, N. and Dewi, A.	2018	Qualitative with phenomenological design (in-depth interview/	The potential fraud in the FKTP was related to human resources (HR), health service management, leadership policies, capitation fund management, and operational audits (Fathurrohman & Dewi, 2018).	√	√	√
Himmayatul, W., Alim, M.N. and Prasetyono, P.	2017	Qualitative with case study design (interviews and observations)	The potential fraud of JKN in the community health center included the use of a capitation fund that was not in accordance with the provision of laws and regulations, the service distribution which was potentially moral hazardous, the operational costs of the community health center were allocated to additional activities from the health department and excessive stock of drugs in remote health centers. Additional costs occurred because the community health center ran out of stock of drugs so that they had to increase the costs for the purchase of drugs for patients. The potential fraud in the non-capitation fund was that the participants had to pay for the family planning program which actually could be claimed with the BPJS (Himmayatul et al., 2018) .	√	-	√
Abdullah, A.S.	2019	Qualitative descriptive (in depth interview)	There was a potential upcoding that occurred in hospital health service claims in Kota Ambon. Factors causing the potential upcoding that occurred were the internal hospital verification and feedback from BPJS Kesehatan that had not functioned properly as a fraud monitoring. As the result, coding accuracy required a long time for the claim input process due to the absence of SIMRS and Koder Motivation implementation. Changing primary diagnosis with secondary diagnosis or vice versa (coding needed to be selected). Error coding diagnosis, namely choosing a code that was not in accordance with the condition it should be (Abdullah, 2019).	√	-	√
Mitriza, A. and Akbar, A	2019	Qualitative descriptive (in dept interview and observations)	The potential fraud occurred due to the differences in payment systems. The INA CBGs payment system was a prospective payment system while the payment system of dr. Achmad Moechtar regional public hospital still used Governor's Regulation No. 58 the year 2015 about the health service fee of dr. Achmad Moechtar regional public hospital which used a fee for service payment system. There was a different understanding of the verifier, coder, and DPJP about diagnosis (Mitriza et al., 2019).	-	-	√
Adisasmito, W.	2016	Qualitative (in dept interview, study document and observations)	The potential fraud at the DR Cipto Mangunkusumo National Hospital could occur due to the weak internal controls. The potential fraud that occurred at the DR. Cipto Mangunkusumo National	√	√	√

Author	Year	Method	Research result	Variable		
				Rationalization	Pressure	Opportunity
			Hospital could occur in all parts based on the flow of admission of national health insurance patients. The potential fraud at the DR. Cipto Mangunkusumo National Hospital might occur due to pressure, opportunity, and rationalization. The potential fraud in DR Cipto Mangunkusumo National Hospital was also supported by a commitment from the top management to realize the budget and be responsible for it on time (Sadikin & Adisasmito, 2016).			
Khoiri, A, et al	2020	Qualitative with phenomenological design (in depth interview)	The potential fraud occurred due to job dissatisfaction. Based on the phenomenological studies, there were three elements that triggered fraud, namely the existence of pressure due to dissatisfaction with the salary received, rationalization by maximizing claims was not a fraud, and the opportunities that stated that the anti-fraud team at the hospital was not yet effective (Khoiri et al., 2020)	√	√	√
Saikhu, S. and Sugiharto, J	2017	Qualitative descriptive (focus group discussion and observation)	The potential of fraud occurrence was service fragmentation, unbundling, upcoding, and self-referrals in terms of 3 aspects, namely opportunities, pressure, and rationalization. The weak supervision and control in each stage of the service for BPJS Kesehatan participants. It was found that there was a policy that potentially led to fraud. The existence of a high disparity between the prevailing rates based on the regent regulation and the InaCBGs claim rates which also had the potential fraud. Diagnostic and action coding systems based on ICD-9 and ICD-10 were not well understood by doctors who treated patients (Saikhu S[illegible]ugiharto, 2017).	√	√	√
Nurfarida, I.	2014	Quantitive/cross-sectional design (medical records, check lists and questionnaires)	Potential fraud that might occur in mental hospitals includes efforts to extend or shorten the length of treatment, made fictitious bills for examinations and actions taken, and lodging patients for unclear [illegible]lications (Nurfarida, 2014).	√	√	√
Soputan, R., et al	2018	Qualitative with case study (in depth interview, observation and documentation)	The risk of fraud in the National Health Insurance capitation fund management system at the FKTP of the City Government of Bitung occurred due to the weak management system of the JKN capitation fund that was not in accordance with regulations. So, it could interfere with health services. The weak internal control was due to the absence of supervision from the Public Health Department and Inspectorate, the abnormality in management of the JKN capitation fund, and the pressure from the work environment (Soputan et al., 2014).	√	√	√
Sukma, D.P, et al	2018	Qualitative (in dept interview)	There was a potential fraud in Central Java due to an imbalance between the service system and the workloads provided. The potential fraud also occurred because Health Service Providers (PPK) did not provide adequate incentives. The supervision system must be further improved and make improvements to the system in Health Service Providers (PPK). The prevention system must be developed	√	√	√

Author	Year	Method	Research result	Variable		
				Rationalization	Pressure	Opportunity
			internally, reformed in the government, and developed for its own internal control system. Each province must form a BPJS Supervisory Board, and strict sanctions must be imposed for every when fraud occurred in health services (Sukma et al., 2018).			

Based on table 2 shows that there are 4 works of literatures that show the potential fraud in the implementation of national health insurance in Indonesia at primary care health facilities(FKTP) while in 6 works of literature, the potential fraud was found in secondary care health facilities (FKRTL).

Table 2. The Identification of Potential Fraud in Health Facilities

Author	Health Facilities	
	FKTP	FKRTL
Fathurrohman, N. and Dewi, A.	✓	
Himmayatul, W., Alim, M.N. and Prasetyono, P	✓	
Abdullah, A.S.		✓
Mitriza, A. and Akbar, A		✓
Adisasmito, W.		✓
Khoiri, A, et al		✓
Saikhu, S. and Sugiharto, J		✓
Nurfarida, I.		✓
Soputan, R., et al	✓	
Sukma, D.P, et al	✓	

The potential fraud

The success in health services is not seen from the facilities (output) but from the direct benefits of the existence of these facilities for the community (outcome). Performance supervision needs to be done as a tool to evaluate whether the health services and programs of the health service provider organizations are in accordance with what the community needed (Sukma et al., 2018). Trust in health service providers is measured by the presence of peaceful feeling that is felt by patients when visiting health facilities, namely feeling safe and protected (Bosler, 2015). Equivalently with the health service providers, if patients provide correct information and follow the procedures, it will be easier to provide good health services for patients. This trust can create loyalty to patients, health service providers, and health suppliers (Sukma et al., 2018); Bosler, 2015) .

According to the National Health Care anti-Fraud Association (NHCAA), health service fraud is an intentional mistake or misrepresentation by a person or entity who knows about it and can generate a number of illegal benefits to another individual, entity, or party (Aldrich N, Crowder J, 2014). NHCAA further notes that the common forms of fraud are false statements, false explanations, or deliberately omitting facts (Aldrich N, Crowder J, 2014). Fraud is an almost non-variable criminal act, although there may be variations in the specific nature or degree of crime between states (Taufik, 2014). In line with the Regulation of the Minister of Health of the Republic of Indonesia Number 36 of 2015, fraud is an act that is carried out deliberately by BPJS health officers, participants, health service providers as well as drug and

medical device providers to get financial benefits from the health insurance program and the National Social Security System (SJSN) through fraudulent acts that do not comply with the provisions (Kemenkes, 2015). According to Djasri, the actors involved in cheating are health service providers, health insurance staff, patients, and suppliers of medical devices or drugs (Indonesia Corruption Watch, 2018).

The potential fraud that involved the health service provider in this study in line with Samino's opinion in 2015 which states that fraud in health services generally has the same components as determined by the regulations. The difference in fraud in health services is the fraud element is related to health services, services coverage, and fraudulent payments in health services or products. In the health system, there are three main parties that commit fraud, namely administrator (health insurance), health service providers (in this case FKRTL, FKTP, etc.), and the beneficiaries or participants (patients) (Eldayana et al., 2015). Regulation of BPJS Kesehatan Number 7 of 2016 which states that fraud in the National Health Insurance can be carried out by health service providers.

Potential fraud could occur at primary care health facilities (FKTP) and secondary care health facilities (FKRTL). According to the Regulation of the Minister of Health of the Republic of Indonesia Number 36 (2015), cheating in health services can be done at primary care health facilities (FKTP), secondary care health facilities (FKRTL), providers of medicines and medical devices. The potential forms of fraud at primary care health facilities (FKTP) were potentially related to human resources (HR), health service management, leadership policies, capitation fund management, and operational audits. The JKN fraud potential at community health center included the use of capitation fund that was not in accordance with the provisions of laws and regulations, the service distribution which was potentially moral hazardous, the operational costs of the community health center were allocated to additional activities from the health department, and the potential fraud in the non-capitation fund was that the participants had to pay for the family planning program which actually could be claimed with the BPJS. The weak management system of the JKN capitation fund that was not in accordance with regulations. So, it could interfere with health services. The weak internal control was due to the absence of supervision from the Public Health Department and Inspectorate, the abnormality in management of the JKN capitation fund, and the pressure from the work environment.

While in secondary care health services (FKRTL), the potential fraud occurred in the hospital which was related to the hospital claims to BPJS Kesehatan. Due to the potential upcoding, the factors causing the potential upcoding that occurred were the internal hospital verification and feedback from BPJS Kesehatan that had not functioned properly as a fraud monitoring. As the result, coding accuracy required a long time for the claim input process due to the absence of SIMRS and Koder Motivation implementation. In this research, it was found the various cases of potential fraud occurred in the health services at primary, secondary, and tertiary levels. Overall, the potential fraud that occurred in the health sector was in the claim section such as fake claim, filing false claims, recurring billing, duplicate claims, card counterfeiting, and claiming services that were not provided, utilization of health service funds (recurring billing to patients), and not carrying out predetermined health service procedures and rules (readmission / adding care in this inpatient) with the aim of to make a profit (Clinard & Cressey, 1954; Mathews, 2015; Legotlo et al., 2018).

The types of potential fraud

The forms of fraud at the primary care health facilities (FKTP) are utilizing capitation funds that are not in accordance with the provisions of laws and regulations, manipulating claims on services which are paid on a non-capitation basis, receiving commission for referrals to FKRTL, collecting fees from participants who should have been covered in capitation and/or non-capitation in accordance with established standard rates, making patient referrals that are not in accordance with the purpose of obtaining certain benefits; and/or (Setiaji et al., 2015). Fraud at secondary care health facilities (FKRTL) can be in the form of writing excessive diagnosis codes/upcoding, plagiarism of claims from other patients/cloning, mark-up bills for drugs and medical equipment/ mark-up bills, fake claims/phantom billing, fake referrals/selfs-referrals, repeat billing, prolonged length of stay, services unbundling or fragmentation, manipulating the type of room charges, canceling services, taking unnecessary actions/no medical value, service standards deviation, unnecessary treatment, increasing the length of ventilator use, phantom visits, phantom procedures; as well as other fraudulent acts in the FKRTL (Setiaji et al., 2015).

The form of potential fraud in table 1 is similar to the Regulation of the Minister of Health of the Republic of Indonesia Number 36 of 2019 about the prevention and penalization of fraud (fraud) and the imposition of administrative sanctions for fraud in implementing the health insurance program which contains various forms of fraud that occur in the implementation of the national health insurance. The potential fraud does not only occur at primary care health facilities but also occurs at secondary care health facilities. The risk of fraud occurs because the management system of the National Health Insurance capitation funds in the FKTP is weak and does not comply with the regulations so that it can interfere with health services. The weak internal control is caused by the absence of supervision from the Public Health Department and Inspectorate, abnormality in management of JKN capitation funds, and the pressure from the work environment. The potentials for fraud are service fragmentation, (unbundling), upcoding, and self-referrals. Upcoding means an activity trying to make diagnostic codes and actions of existing services to be higher or more complex than what is actually done in health service institutions or vice versa. Unbundling/fragmentation is a claim for two or more diagnoses and/or procedures that should be a package of services in the same episode, to get a greater claim value for one episode of patient care. Self-referral is a health service provider who refers to himself/herself or his/her colleagues to provide services, which is generally accompanied by monetary or commission incentives.

Factors that affect the potential fraud

Based on the research conducted by Cressey (1953), there are 3 stimulant factors that must occur simultaneously when someone commits fraud (Rahman, 2017). First, it is the pressure which is the first factor that motivates a person to commit the fraud (Rahman, 2017). Second, it is the opportunity which is the situation that allows a criminal act to be committed. Third, it is a rationalization which is the justification for criminal acts committed. In table 1, the result was obtained by grouping the factors that caused potential fraud based on Cressey's theory (1953) (Mansor, 2015).

The incentive factor/pressure is an incentive that encourages someone to commit fraud caused by a strong level of competition and financial problems (Abdullahi & Mansor, 2015).

The pressure also occurs because of lifestyle demands, financial helplessness, gambling behavior, trying to implement the system, staying away from criticism due to the decreasing income levels, and job dissatisfaction (Abdullahi & Mansor, 2015).

The opportunity factor occurs because of the existence of a situation that gives the opportunity for management or employees to commit fraud (Putri, 2012a). The opportunity is a chance that causes the perpetrators to freely carry out their actions due to weak internal control, indiscipline, weakness in accessing information, the absence of audit mechanism, and apathy (Putri, 2012a). The laxity of internal control and the lack of monitoring in a company can trigger employees to commit fraud, inadequate external control systems, and indiscipline (Putri, 2012a). From the laxity of control and the lack of monitoring, employees feel that they have the opportunity to commit fraud (Putri, 2012; Amaliah et al., 2015).

The rationalization factor is the character, nature, or a set of ethical values that justifies certain parties to commit acts of fraud, or people who are in an environment that is sufficiently oppressive to make them rationalize the act of fraud. Rationalization causes the perpetrators to find the justification for their actions. The rationalization occurs because the income is not on target and profit orientation (Rini & Achmad, 2012). The three stimulant factors according to Cressey (1953) are in line with the result of this study that fraud occurs because of the existence of the pressure, the opportunity to commit fraud due to the lack of internal and external monitoring and the rationalization to commit fraud. In this research, it was found the various cases of potential fraud occurred in the health services at primary, secondary, and tertiary levels. Overall, the potential fraud that occurred in the health sector was in the claim section such as fake claim, filing false claims, recurring billing, duplicate claims, card counterfeiting, and claiming services that were not provided, utilization of health service funds (recurring billing to patients), and not carrying out predetermined health service procedures and rules (readmission / adding care in this inpatient) with the aim of to make a profit (Clinard & Cressey, 1954; Mathews, 2015; Legotlo et al., 2018) The potential fraud in the health sector arises due to pressure from the newly implemented funding system, the opportunities due to limited supervision, and the justification for carrying out such actions (Legotlo et al., 2018). In addition, there is an imbalance between the health service system and the workload imposed, service providers do not provide adequate incentives, inadequate supply of medical equipment, system inefficiency, lack of transparency in health facilities, and cultural factors (Legotlo et al., 2018).

Prevention of potential fraud

If the potential fraud is not prevented, it will continue to occur in the health sector (Rini & Achmad, 2012; Suhat et al., 2017) according to Anugerah (2012) fraud has caused the collapse of world-class companies such as WorldCom. Inc and Enron. Inc. in the USA in the early 2000s, and according to previous studies, this was due to the failure of the Good Corporate Governance (GCG) mechanism (Rini & Achmad, 2012). Fraud prevention management in the health sector is very important because it is able to regulate organizational governance so that fraud does not occur. The corporate governance structure recognizes 2 (two) governance mechanisms, namely internal governance and external governance (Rini & Achmad, 2012). Internal and external governance have elements where all the external and internal governance elements can function properly, so fraud can be reduced or prevented (Rini

& Achmad, 2012). In addition to the corporate governance mechanism, the principles and functions of corporate governance are also known. The five principles of corporate governance are transparency, accountability, responsibility, independence, and fairness. Corporate governance has 7 functions, namely supervisory function, managerial function, internal audit function, legal and financial advisory function, external audit function, and monitoring function (Suhat et al., 2017).

Prevention of fraud according by Anugrah (2014) can be done through the implementation of corporate governance which is abbreviated as "TARIP" including transparency; disclosure of information, both in the decision-making process and in disclosing material and relevant information. Accountability; clarity of functions, systems, structures and organizational responsibilities so that organizational management is carried out effectively. Responsibility; conformity (compliance) in the management of the organization to the principles of a healthy corporation and applicable laws and regulations. Independency; a condition in which an organization is managed professionally without conflict of interest and influence / pressure from any party that is not in accordance with the regulations. Fairness, which is a fair and equal treatment in fulfilling stakeholder rights (Anugerah, 2014).

According by Priantara (2013), effective fraud prevention has 5 (five) objectives, namely prevention, detterence, disruption, identification and civil action prosecution (Priantara, 2013). Prevention, namely preventing the occurrence of real fraud at all organizational lines. Detterence is deterring potential perpetrators and even trial and error, because potential actors see that the fraud risk control system is effective and that they are given strict and thorough sanctions. Disruption, namely making it difficult to move the steps of the fraudsters as far as possible. Identification is identifying high-risk activities and weaknesses in control and Civil Action Prosecution, namely making demands and imposing sanctions in kind or to the perpetrators (Wicaksono & Suyanto, 2019).

In implementation national health insurance in the health sector, each the primary care health facilities (FKTP) and secondary care health facilities (FKRTL) must have adequate internal and external controls (Natasya et al., 2017). Internal control structure is a term that has been generalized and widely used in various purposes (Amin, 2014). Internal control is a process carried out by the board of commissioners, management, and other personnel of an entity which is designed to provide adequate assurance about the effectiveness and efficiency of operations, the reliability of financial reporting and compliance with applicable laws and regulations (Amin, 2014; Santoso et al., 2019). Based on the results of research by Anggita Purwitasari (2013) entitled The Effect of Internal Control and Organizational Commitment in preventing procurement fraud. The results showed that internal control and organizational commitment have a significant effect on fraud prevention (Anggit, 2013). According to COSO (2013), internal control includes five components, namely control environment, risk assessment, control activities, information and communication, and monitoring (COSO, 2013). Organizational commitment is an attitude that reflects employee loyalty to the organization and a continuous process where organizational members express their concern for the organization and its success and continuous progress (Luthans, 2010).

One of the factors that influence fraud prevention is internal audit. The role of internal audit can trigger the implementation of management risk control, internal control, and the audit committee which has an important role in various aspects of the organization including

fraud prevention (Suginam, 2017). One of the internal controls to prevent fraud in a company is the implementation of a whistleblowing system because by implementing a whistleblowing system, employees and parties who will commit fraud will feel reluctant because of the existence of an effective reporting system for reporting fraud (Semendawai & Haris, 2011). Whistleblowing system is a guideline for employees or other people to be able to complain about symptoms of cheating (Setianto, 2008).

In 2019, the Ministry of Health issued the Regulation of the Minister of Health Number 16 of 2019 which is a renewal of the Regulation of the Minister of Health Number 36 of 2015. According to the Regulation of the Minister of Health Number 16 of 2019, the guideline of the prevention and penalization of fraud (fraud) and the imposition of administrative sanctions for fraud in implementing the health insurance program aim to provide a reference for participants, BPJS Kesehatan, health facilities or health service providers, providers of drugs and medical devices, and other stakeholders in carrying out efforts to prevent and penalize fraud in a systematic, comprehensive, and structured manner so that the implementation of the Health Insurance program can run effectively and efficiently. With an understanding of the fraudulent actions (fraud) in Health Insurance, it is hoped that all parties involved in a series of health insurance processes can avoid acts of fraud and the losses of the National Social Security Fund due to fraud can be prevented, so that it can maintain the sustainability of Health Insurance program (Peraturan Menteri Kesehatan Republik Indonesia Nomor 16, 2019).

The implementation of fraud prevention by FKTP and FKRTL according to the Regulation of the Minister of Health Number 16 of 2019 as follows: First, the implementation of fraud prevention policies and the preventive guideline. The first is the implementation of the principles of Good Corporate Governance and Good Clinical Governance such as determining the authority and job descriptions of health and non-health workers, establishing and implementing Standard Operational Procedures (SOP). The SOP for clinical services refers to the National Medical Service Guidelines (PNPK), Clinical Practice Guidelines (PPK), Clinical Pathways (CP) and/or other guideline set by the Minister. The establishment of internal procedures for filing non-capitation claims and health insurance fund management is in accordance with applicable regulations. The second is the implementation of prevention, detection, and resolution of fraud, including the public complaint mechanism (whistleblowing system) and its follow-up. The IT system as the support (on-line/integrated automation). Checking the completeness and validity of claims submitted by midwives and network laboratories. The third is the implementation of fraud risk management by building commitment from all parties in managing the risk of fraud. Identifying and assessing the risk of fraud comprehensively. Establishing the fraud risk control plan. Communicating identified potential fraud. Carrying out corrective actions in dealing with fraud quickly and precisely. Evaluating the performance of risk management implementation regularly (Peraturan Menteri Kesehatan Republik Indonesia Nomor 16, 2019).

Second, the development of fraud prevention culture in the Health Insurance program consists of signing and implementing integrity pacts for all FKTP and FKRTL employees including the line of the FKTP and FKRTL leaders. Implementing the ethical code and standards of behavior for FKTP employees. Implementing anti-fraud culture education for all FKTP and FKRTL employees and Health Insurance participants. Socialization of fraud

prevention activities in the FKTP and FKRTL (Peraturan Menteri Kesehatan Republik Indonesia Nomor 16, 2019).

Third, the development of quality control and cost control-oriented services. The first is the implementation of the quality management concept in the health services implementation such as creating an effective and efficient service flow, utilizing electronic information systems optimally for service effectiveness and efficiency, implementing continuous quality improvement through accreditation and service satisfaction surveys for example. The second is implementing a clinical audit and utilization review (Peraturan Menteri Kesehatan Republik Indonesia Nomor 16, 2019; Taslim et al., 2020). By implementing a fraud prevention system in in the primary care health facilities (FKTP) and secondary care health facilities (FKRTL), it is hoped that it can inhibit the potential for fraud in national health insurance services in the health sector in Indonesia.

CONCLUSION

The conclusion of this study is that the potential fraud in the implementation of national health insurance in Indonesia occurs in primary care health facilities (FKTP) and secondary care health facilities (FKRTL). There are various forms of potential fraud in health facilities. The stimulant factors that influence the existence of fraud in health facilities are due to pressure, opportunity, and rationalization. The prevention of potential fraud can be carried out through the principles of Corporate Governance, namely transparency, fairness, accountability, responsiveness, internal control, external contol and independency as well as aiming to the implementation of fraud prevention according to the Regulation of the Minister of Health Number 16 of 2019. It is better to improve internal and external monitoring for health service providers so that potential fraud can be prevented. In addition, the audit committee always monitors the internal and external control systems.

ACKNOWLEDGMENT

The author would like to express deep gratitude to the advisors and friends of the Master Program of Public Health Sciences, Sriwijaya University, for their assistances and encouragements so that I can complete this research.

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