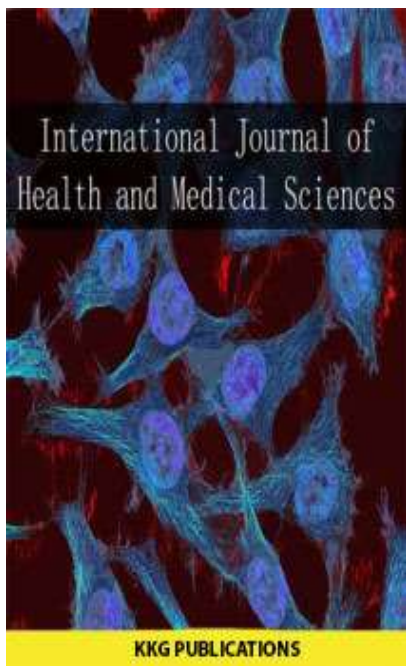


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Published online: 21 Jun 2015

To cite this article: Suhadi., Rais, M. K., Maidin, Z., Alimin., Palutturi. 2015. Fraud prevention in implementation in national health insurance kendari city, Indonesia. International Journal of Health and Medical Sciences 1:1 17-21.

DOI: <https://dx.doi.org/10.20469/ijhms.30003>

To link to this article: <http://kkgpublications.com/wp-content/uploads/2015/12/IJHMS-30003.pdf>

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FRAUD PREVENTION IN IMPLEMENTATION IN NATIONAL HEALTH INSURANCE KENDARI CITY, INDONESIA

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Keyword:

Prevention
Fraud
National Health Insurance

Received: 14 March 2015

Accepted: 12 April 2015

Published: 21 June 2015

Abstract. By enacting the National Health Insurance (NHI) on January 1st, 2014, the fraud incident potential will be found. If the premium of NHI is approximately 38.5 trillion with the estimation of the fraud figure of 5 %, the amount of loss will reach 1.8 trillion. The Indonesian Corruption Watch (ICW) finding between 2006-2008, there were 54 cases with the state loss reached Rp.128 billion. The fraud mode is in the forms of fund mark-up, drug manipulation, data embezzlement, fund corruption, fictive drugs and health instruments, authority abuse, and bribery. In 2008, PT. Askes marked up the claim as much as Rp.1.2 trillion. In the Regional General Hospital of Bau-bau City, South East Sulawesi Province, it is obtained that the drug claim reached Rp.66 million for patients who were hospitalized in the long-stay ward for one day. The research used the qualitative approach. The research was conducted in the hospital, PHC, BPJS, private clinic, and patients in Kendari City in 2014. The research informants included the Hospital Director, PHC Head, BPJS head, clinic doctors, and patients. The research result indicates that the fraud potential and perpetrators are discovered in the Health Service Providers (HSP) and patients, while in BPJS, they do not exist. For the hospital fraud indications, 12 cases are discovered in Kendari City. They are not discovered in PHC. The discovery and prevention of the fraud indications can be carried out through administrative and medical verifications—for example, the repeated readmission, dual card charges between hospitals. The driving factor in the fraud incident is in the form of the HSP's ignorance because the medical officials have not been accustomed to the diagnosis system following BPJS guidelines, whereas the intentional factor is not found. The research concludes that the fraud potential is generally discovered in HSP and patients; it is not found in BPJS. The discovery and prevention of the fraud indications can be carried out through administrative and medical verifications. The driving factor of the fraud incident is in the form of the HSP's ignorance because the medical officials have not been accustomed to the diagnosis system, while the intentional factor is not found. Suggestion: It is necessary to control the expenditure systematically to prevent the fraud, either in the HSP or patients, the fraud socialization to the HSP and community.

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INTRODUCTION

National Health Insurance abbreviated as JKN, is one form of health insurance. The JKN is organized to provide health care and meet the basic health needs of the participants. The program was launched on January 1, 2014 as an effort to address various issues related to unfairness and low quality of health services. The program was implemented to follow the Law No. 24/2011 on the Social Security Board that would provide health insurance for the all Indonesian society.

In connection with the implementation of JKN, there was a fear of mishandling the fund. The finding of the Corruption Eradication Commission (KPK) in 2013 discovered the potential of fraud in the hospital to raise the classification or diagnosis of disease (up coding) and splitting the bill to enlarge the

replacement of the fund (unbundling). Therefore, it is necessary to supervise the organization of JKN in Indonesia.

The result of the study of [1] showed that the operational audit by National Health Insurance (DJSN) would provide valuable information to BPK on the achievement of membership payment-collection and claim-settlement-mechanism based on the procedure. It would also complete the final result of financial audit conducted by the Public Accountant Office. The study of [2] showed that fraud could be prevented by formulating risk policies; identifying vulnerable areas, creating a risk benchmarking, complying with the laws and regulations, controlling the effectiveness and the efficiency of existing procedures and conducting continuous improvement. The

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study of [3] showed that doing data audit could improve the detection of fraud, and conducting legal intervention as well as antifraud activities could reduce fraud significantly. The result of the survey from Transparency International Indonesia, in [4] showed that Indonesia was the most corrupt country number 6 out of 133 countries.

The Coalition against Insurance Fraud stated that fraud in the insurance business in the United States had reached to \$ 875 per-person per-year. It was estimated that the losses reached to 80 billion dollars per year, while the government's Medicare estimated the losses amounted to 179 billion dollars per year. Fraud in the life insurance reached up to 9.6 billion dollars per year in the United States. As a reference data, health insurance fraud in the United States in 2006 reached to 25% of the volume of the healthcare industry, which reached to US \$ 2 billion per year, equivalent to US \$ 500 billion. When it was calculated that the (25%) of the volume of the healthcare industry in Indonesia worth Rp 280 trillion per year (2007 data), then the possible fraud would reach to Rp 70 trillion. "A very large number that should not be paid by the government. The implementation of BPJS would potentially increase the fraud. The disagreement between BPJS and the health service provider would open the possible fraud. The risk of loss due to fraud was quite big. The estimated premi of BPJS reached approximately Rp 38.5 trillion in 2014, with an estimated fraud of (5%) then the amount of losses reached to Rp 1.8 trillion.

Health care fraud was the dominant factor that contributed to the rising of health service cost in the United States [5]. The investigation on the health care showed that there was a fraud in the health provider in the amount of (0.020%) of health care cost per year from 2006 to 2009. The money taken from the fraud was returned in cash to the company through the reduction of the claim payment [6]. The finding from the monitoring of Indonesian Corruption Watch (ICW) showed that there were at least 54 cases of corruption in the health sector in Indonesia. All the cases were being investigated by the Attorney General, the Corruption Eradication Commission (KPK) and the Police office from 2006 to 2008.

The total case of corruption had lost the state reached to Rp. 128 billion. Mode of corruption was conducted by making a fraud that lost the state reached to \$102, 9 billion, making data manipulation on medicine reached to Rp 9 billion, making data manipulation reached to Rp 6.4 billion, making misappropriation of fund reached to Rp 6.2 billion, making fictitious drug reached to Rp 1.9 billion, making fictitious health tools reached to Rp 699 million, doing abuse of authority Rp reached to 399 million, and conducting bribery reached to Rp 294 million [7]. The result of the analysis on Jamkesmas versus Askeskin by Hasbullah Thabrany, stated that PT Askes increased the claim or conducted fraud on outstanding claim to almost Rp 1.2 trillion in early 2008. The result of the audit from the Financial and Development

Supervisory Board together with the Inspectorate General of the Ministry of Health had indicated that there was a difference Rp 14 billion from the total claim by Askeskin, with the total budget Rp 1.145 trillion, in 2007.

These finding occurred at Bau-bau Hospital, Southeast Sulawesi. The finding showed that a hospitalized patient got the claim for his medicine Rp 66 million for one day only. In the patient's health claim was mentioned that he got 22 vials a day of Gammaras injection, an endurance drug after post-operation. Because there were many technical problems, then the Ministry Of Health stopped the Askeskin program with PT Askes. Instead, the government launched a new program: Community Health Insurance [8].

The result of literature-review of health insurance at national journal showed that there had no study yet on fraud in health insurance. The study on fraud in health care was conducted only on the topic of "logistic procurement in the Hospital".

The study conducted by [6] showed that there was an influence on the implementation of the environmental control, risk assessment, control activities, information and communication, as well as monitoring either partially or simultaneously to the prevention of fraud on procurement of equipment. The study of fraud in public sector except for the health sector [9] showed that there was an influence of the internal auditor, external auditor, and the Local Council to the prevention of fraud. The study of fraud by [10] found that the auditor should be an independent party, with the function of controlling the company and examining the company's operation to run well. Auditor had to actively participate and cooperate with various parties to help all member of management in carrying out their responsibilities and providing them with analysis, assessment, recommendation, and objective comment related to their activities that had been reviewed.

The study of fraud by [11] found that there was an influence of the implementation of Public Sector Accounting and the supervision of quality control of financial report on Government Agencies to Government Agencies Performance Accountability.

Objective

The objective of this study is to analyze the prevention of fraud during the implementation of national health insurance in Kendari city between Provider, BPJS and the patient.

RESEARCH METHOD

Research Design

This study used qualitative approach. This approach concerned with the decomposition of the observed phenomenon and the context surrounding the meaning of a reality. A qualitative approach took place in a natural setting, the researcher was the main instrument. The data collection was in the form of

descriptive data. It was more concern with the process rather than the result, and it used inductive data analysis [12].

Research Location

The research was conducted at the Hospital, Health Center, BPJS office, and patient in the Kendari Southeast Sulawesi Province. The reason, why we choose the location of the study because there had never been a case of fraud in the management of Askes in Southeast Sulawesi.

The Subject of the Research

The selection of informant was conducted by using purposive sampling technique i.e. by selecting the informant with the criteria: he/she had to understand the problem deeply, he/she would become a reliable source of data, and he/she would be able to express his/her opinions accurately.

The target of data collection used triangulation of source:

- 1) The Hospital (The hospital director, medical services director, and medical record officer/coder).
- 2) The health center (The head of health center, doctor, nurse and claim officer).
- 3) The BPJS office in Kendari (The head of BPJS, the head of primary care unit and referral-unit).
- 4) The Patient at the health center and hospital (In-patient and out-patient service).

Data Collection

Literature-review, the method was used to collect secondary data, especially the basic concept or theories related to the object of study. Field study, the researcher observes directly to the object of study to collect primary data. The data collection used a set of instrument, such as observation, interview. The data collection used triangulation, i.e. in-depth interview, observation and document review.

Data Analysis

The data analysis used qualitative analysis to analyze the problem. The qualitative analysis technique analyzed the problem descriptively i.e. the study that emphasized the analysis of inference process on the dynamic between the observed phenomenon by using logic and argumentative by using the formal way of thinking [13].

Data Presentation

Data presentation would be in narrative form with some explanations.

RESULTS AND DISCUSSION

According to Indonesian Dictionary, fraud means dishonest, not right, and unfair and unkind [14]. In the book of Black's Law Dictionary, the legal definition of fraud, which is a variety of tools that expertly worn and used by a person for the

benefit of others, by means of fake persuasion or by covering up the truth, and it covers all means of sudden deceit, such as trick, cunning, dissembling and any unfair manner so that the other can be tricked, deceived or cheated.

Fraud in the health service could not be avoided, and many factors that influence the fraud, then one of the prevention step was to verify all the activities. The actor of fraud could be found at PPK and patient, rather than in the BPJS. There had been an attempt of fraud that was found in the hospital with 12 cases. There was no case in the health center, whereas there were 10 cases in the patients. Here, the narrative of one informant:

"The number of fraud was 12 cases in the hospital, no case in the health center, there was 10 cases in which patient using other people's card and there was no case in BPJS ..." (KRI)

The claim filed by the hospital had the possibility to have a fraud or abuse, in other word the claim was not free from abuse and fraud. The hospital certainly would argue that they didn't commit abuse or fraud. Maybe there was some alleged fraud committed by the hospital, including the patients.

The word abuse and fraud referred to any indication of trick on the claim of health insurance by participants, PPK or both parties, whether they did it intentionally (fraud) or unintentionally (abuse). Up coding was one activity to input the billing claim based on the inaccurate code, i.e. by making more complex diagnosis or procedure or by using more resources. Fraud on the participant could be found by misusing other people's card as well as by giving false information. To detect the possibility of abuse and fraud was also the responsibility of the Verifier. Therefore, the Verifier of BPJS and cost control team had to have a good understanding and skill in verifying the report. To prevent the fraud could be carried out by administrative and medical verification.

For example, repeated readmission, dual card charges between the hospitals. Here, the narrative of some informants:

"We have done the claim verification several times and we found there is indication of fraud ..., and to prevent the fraud, we do the verification. In fact, there are repeated readmissions or there are multiple card charges between the hospitals, for that case, we reject it immediately. For example, a patient got a treatment in the out-patient service at the hospital A, and the patient is transferred in the out-patient service at the hospital B. Then, the INA CBGs will pay it as one episode, however the payment would be two times because the patient is transferred ..." (KBI)

If there was an indication of fraud, then the action would be to communicate to the PPK:

.....yeach, we will communicate and we will inform the hospital, maybe the hospital doesn't know the matter, the hospital doesn't understand that the action is a violation to commit fraud..." (KBI)

In preventing and detecting the fraud, there were several parties involved i.e. the placement of accountant expert (either as internal auditor, external auditor, or forensic auditor) and financial management.

The issue now was on the fraud management through the implementation of corporate governance. This action was conducted by management to eliminate or at least to reduce the possibility of fraud.

Corporate Governance had some activities such as institutional culture, policies, and delegation of authority, transactional level control process which was conducted by the internal auditor.

The basic idea was to focus more on the preventive process and to control as well as to ensure that only legitimate transaction that would get approval, which was recorded and protected from any lost. A retrospective examination conducted by external auditor was directed to detect the fraud before it couldn't be solved and endanger the institution, and the investigation and remediation would be conducted by forensic auditor.

The driving factor of fraud was in the form of PPK ignorance because the medical personnel were not familiar with the diagnosis system according to BPJS guideline, while the fraud due to intentional factor was not found. As stated by one informant:

"... Maybe they just don't understand, the hospital is not aware that the violation would be directed as fraud." (KBI)

The cause of fraud, according to [15] was the existence of concealment. There was undetected opportunity. The actor of fraud assessed the possibility to be detected and to be punished. Opportunity. The actor of fraud had to be in the right place, and at the right time in order to take advantage over the weaknesses of the system and to avoid detection.

Motivation. The actor of fraud had to have motivation to undertake such activities, a personal need such as avariciousness/greediness/covetousness and other tricky intentions. Attraction. The target of misconduct attracted the actor of fraud. Success. The actor of fraud assessed the chance of success that was measurable to avoid the prosecution as well as detection. In general, the indication of fraud was found in PPK and in the patient. The prevention of fraud could be carried out by administrative and medical verification.

The driving factor of fraud was the ignorance of PPK staff because medical personnel were not familiar with the diagnosis system according to BPJS guideline, while the intentional factor was not found.

Fraud as a deceitful action, whether intentional or not, was a form of criminal act that had lost our countries' budget. The effect on the health care would hamper the service because it would waste the budget. The indication of fraud could occur at all level of PPK such as card abuse by the patient, the recurrent diagnosis, falsification of documents, up coding of diagnoses, and so forth. The prevention act could be carried out by providing the claim guidance, doing a socialization, conducting administrative and medical verification, communicating dubious claim and

refusing the claim. Improving the monitoring and controlling of the cost, from the entrance of the patient to prevent card abuse, observing the claim administration, as well as monitoring and evaluation of TKBM.

JKN had run for one year, we could identify the review of utilization services, the review of financing, as well as the incidence of fraud and abuse. Fraud was the intentional doing against the truth for the purpose of getting something that deceive others or to get the advantages that against the law or deception of fact representation, either by word or action; allegation error (indicated a person to commit a crime), to cover something that should be fairly opened, accept wrong action, and plan to do wrong thing to someone else so that he acted against the law.

The act of fraud and abuse in the insurance business received great attention. This was because the fraud would be unfavorable to other parties in the implementation of the insurance business. Fraud could be committed by all the elements involved in the insurance business from health care provider, participant, as well as insurance office. Fraud in the health services related to health financing was to raise the price by up coding the tariff from INA CBGs. Financing department could commit fraud.

The condition was reinforced by the unwillingness of the hospital to get lost. At the beginning of the JKN, the hospital refused tariff policy from INA CBGs JKN. This was the underlying factor that dissatisfies the health care provider to cheat by making inappropriate claim and false claim. Currently, there are three agencies that oversee BPJS, namely DJSN, OJK and BPK. But the substance of supervision is still unclear. The recommendation of KPK is to conduct public scrutiny. Therefore, KPK requests that the CSO and academician are involved in the supervision of JKN. An information technology system needs to be strengthened. The finding of potential corruption, Director of BPJS Idris expressed his readiness to cooperate further with KPK, including the socialization of potential corruption to the entire staff. The role of prevention must be reinforced with supervision. Therefore, he agreed to revise Law No. 24/2011 on BPJS so that there would be clarity of the role of external supervisor.

CONCLUSION

The fraud was found in PPK and in the patient, whereas no case of was found in BPJS. The indication of fraud was found in the hospital with 12 cases. There was no case in the health center, whereas there were 10 cases in the patient. The prevention of fraud could be carried out by administrative and medical verification. The form of fraud i.e., repeated readmission, dual card charges between the hospitals. The driving factor of fraud was in the form of ignorance of PPK staff because they didn't realize that they had committed fraud, while the intentional factor was not found.

RECOMMENDATIONS

There is a need to do supervision and controlling systematically so that fraud could be prevented in the PPK as well as to the patient, this could be controlled by internal supervision through administrative and medical verification as well as the involvement of external supervision through independent board

such as KPK, OJK, the National Social Security Board, BPK, and cost control team. On the other hand, there is a need to revise Law 24/2011 on BPJS so that there is clarity on the role of external supervision and there should be socialization of fraud at PPK and community.

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