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Evaluation of Fraud Prevention Policies in the National Health Insurance System in Indonesia: Narrative Literature Review

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ABSTRACT

Introduction: Fraud in the National Health Insurance System (JKN) in Indonesia is a serious issue that harms health services and financing. Fraud practices such as phantom billing and diagnosis manipulation threaten the goals of the National Health Insurance (JKN) to provide fair and quality health access. The latest data shows significant losses due to fraud, with a report by the Corruption Eradication Commission revealing the discovery of fraud amounting to IDR 35 billion in three hospitals. To address this issue, the Minister of Health Regulation Number 16 of 2019 is expected to enhance the management and accountability of the JKN Fund, while also encouraging more effective policy evaluation.

Objective: This research aims to evaluate the effectiveness of fraud prevention policies in the National Health Insurance System in Indonesia.

Method: This research employs a narrative literature review approach, starting with the inclusion of the keywords "Fraud Prevention" AND “National Health Insurance” AND “Method Fraud” AND "Health Care" in several data-based search engines, such as PubMed/Medline, ScienceDirect, Google Scholar, and Garuda. The inclusion criteria for this study are research conducted in Indonesia and published from January 2020 to August 2024, focusing on the evaluation of fraud prevention policies in JKN, resulting in a total of 17 studies.

Result: A review of 17 articles indicates a research gap in the fraud prevention policies of the JKN Program, including a lack of empirical studies measuring the impact of these policies on reducing fraud. In addition, research on the experiences and perceptions of stakeholders, particularly healthcare workers and patients, is still limited, as well as the lack of longitudinal analysis to monitor changes in fraud practices. The aspects of information technology and data management systems in fraud prevention have also not been adequately explored, even though they can significantly contribute to the detection and prevention of fraud.

Conclusion: Although the policies to prevent fraud in the JKN system have been implemented, their effectiveness remains low due to a lack of coordination among stakeholders, unclear definitions, and weak oversight. Fraud negatively impacts finances and service quality, while the research gap adds complexity to the issue. Therefore, a holistic approach is needed that includes better collaboration, strengthening regulations, and utilizing information technology to enhance the effectiveness of policies.

Keywords: Fraud Prevention; National Health Insurance; Method Fraud; Health Care

INTRODUCTION

Fraud in the National Health Insurance System (JKN) is a crucial issue that can harm both health services and health financing in Indonesia. The JKN system, designed to provide more inclusive health access for the community, aims to offer fair and quality health services for all citizens; however, fraudulent practices can undermine this objective. Ten percent of global healthcare spending is considered to be lost to fraud. (1-4). According to the latest WHO data, the world currently spends over 10 trillion US dollars each year on health. This means that more than 10% of the total wealth of countries around the world is allocated to the health sector. The growth of healthcare costs is very rapid, averaging 4% per year, far exceeding the global economic growth of only 3% per year (5). A total of 117 reported cases places the healthcare industry in fourth place, according to data from the Association of Certified Fraud Examiners (ACFE) global survey.

Data from the Corruption Eradication Commission (KPK) revealed that in July 2024, there was a fraud discovery amounting to IDR 35 billion across three hospitals in Indonesia, albeit in different provinces. The method used is phantom billing, which means a fraudulent practice where healthcare providers submit claims for medical services that were never actually provided to the patient. In addition, there is also manipulation of diagnosis, which involves altering or manipulating a patient's diagnosis to obtain higher payments from insurance or health care systems.

The audit results conducted by BPJS Kesehatan indicate that at least three hospitals are suspected of being involved in phantom billing. The first hospital is located in Central Java, with an alleged fraud amounting to IDR 29.4 billion from 22,550 cases. Additionally, there is a hospital in North Sumatra suspected of being involved in fraud amounting to IDR 4.2 billion from 1,620 cases, as well as another hospital in North Sumatra with an alleged fraud of IDR 1.5 billion from 841 cases (6).

Through the transformation of the fifth pillar in the health system, the Government is striving for the transformation of the fourth pillar in the health system, ensuring that financing is always available, transparent, effective, and equitable. However, efforts to achieve transparency require strong integrity from each stakeholder, making it important to understand the negative impacts that fraudulent practices can cause. The Minister of Health Regulation Number 16 of 2019 was established to regulate the management and accountability of the National Health Insurance Fund (JKN), encouraging researchers to focus on evaluating this policy in Indonesia.

METHOD

This research employs a narrative literature review approach, starting with the inclusion of the keywords "Fraud Prevention" AND “National Health Insurance” AND “Method Fraud” AND "Health Care" in several data-based search engines, such as PubMed/Medline, ScienceDirect, Google Scholar, and Garuda. The inclusion criteria for this study are research conducted in Indonesia and published from January 2020 to August 2024, focusing on the evaluation of fraud prevention policies in JKN, resulting in 17 articles. The exclusion criteria are articles published outside the 2020 to 2024 range, articles that are not full text, and content that is not related to the evaluation of fraud prevention policies in JKN.

RESULTS

Based on the search results through PubMed/Medline, ScienceDirect, Google Scholar, and Garuda, a selection was made according to the criteria established in the study, resulting in 17 pieces of literature that were used as references for analyzing the Evaluation of Fraud Prevention Policies in the National Health Insurance System in Indonesia. The selected literature analyzed by the researcher in the narrative literature review study is as follows (Table 1):

Table 1. Literature Review Results

No	Judul	Penulis	Metode	Hasil Tinjauan
1.	Analysis of the Policy and Implementation of the Minister of Health Regulation Number 16 of 2019 on the National Health Insurance Program.	Dina Anjayani, (2021)	Analysis Bardach's criteri	1. The implementation of PMK Number 16 of 2019 is still stagnant, marked by the main issue of a lack of concern and active participation from stakeholders, which has become the primary obstacle in the implementation of this anti-fraud policy. Ditinjau dari 3 aspek yaitu: a. Content Aspect: The operational definition of the category of fraud perpetrators and preventive actions is

				still unclear, hindering optimal implementation. b. Process Aspect: Gaps in policy implementation indicate that the existing legal basis has not been fully effective. c. Actor Aspect: Although the drafting team involved various parties, there are still shortcomings in the implementation of the policy. d. Policy option: optimizing the function of the Fraud Prevention Team (TPF) in the National Health Insurance (JKN) is considered the most relevant choice to enhance policy implementation.
2.	The Urgency of Criminalizing Fraud in the Implementation of Health Insurance Programs in Indonesia	Solehudin (2023)	Examine the documents and literature.	The goal of addressing fraud in the health insurance program is to provide guidance to participants, BPJS Kesehatan, health facilities, healthcare providers, and other stakeholders on how to systematically, structurally, and comprehensively prevent and address fraud. efforts to ensure that the health insurance program can be implemented effectively and efficiently. In Indonesia, the criminalization of fraud in this program is very important because currently, the prevention and handling of fraud are limited to administrative penalties.
3.	Phenomenon of Causal Fraud Health Insurance in Hospitals: Theory of Gear Fraud	Haruddin, Deddi Purwana, Choirul Anwar (2021)	Qualitative Research	Factors that contribute to health insurance fraud in hospitals include financial motives (the desire to obtain money or material benefits, economic or welfare advantages, high salaries, and poor services), behavioral motives (low integrity, lifestyle and habits of employees committing fraud), and social motives (closeness, interpersonal relationship factors, avoiding conflict, social status, and pressure), as well as internal controls (the health insurance monitoring system in hospitals), lack of transparency, National Health Insurance regulations (inconsistent regulations and failure to meet National Medical Service Guidelines, as well as a lack of readmission standards and fragmentation), the JKN financing system (inconvenience of the financing system and lack of transparency regarding hospital services), and leadership. (poor leadership and weak leadership style in the hospital).
4.	Analysis of The Implementation of The National Health Insurance Fraud Prevention Program	Auliya Safitri, Karlinda, Tiara Nurcihikita (2024)	Systematic Review	In Indonesia, health insurance fraud can have a significant impact on various aspects, including the economy, healthcare services, and public trust. Some impacts of health insurance fraud include false claims or inflated treatment costs, which lead insurance companies to experience significant financial losses. This can reduce the company's ability to provide the best services to its customers. Additionally, insurance companies may raise premiums to compensate for losses due to fraud, which adds a financial burden to honest customers.

				Fraud can also lead to inefficient resource allocation, diverting funds to pay for false or illegitimate claims. This can result in a decline in the overall quality of healthcare services, increased administrative burdens, and insurance companies needing to enhance fraud detection and prevention, which requires additional resources such as labor and technology. As a result, the operational costs of the insurance company may increase.
5.	The Influence of Puskesmas Efforts in Addressing Fraud on Health Services at Tanah Kampung Puskesmas	Susan Srinoveani (2021)	Quantitative Research	The efforts of the community health center in addressing fraud have a positive and significant impact on the improvement of health services at the Tanah Kampung health center, although its contribution can still be enhanced.
6.	Potential Fraud and Its Prevention in The Implementation of National Health Insurance at Dadi Regional Hospital	Amaliah Amriani Amran, et al (2023)	Qualitative Research	RSUD Dadi has a system to prevent fraud, including the creation of policies and guidelines, the implementation of a prevention culture, cost control, and the application of quality control. Despite the prevention system in place, there is not much information about the team formed to prevent fraud. There are still frequent discrepancies between patient diagnoses and the diagnosis codes entered into the National Health Insurance system. As a result, the Internal Monitoring Unit is still working on a system to prevent fraud.
7.	The role of Good Corporate Governance in Preventing Fraud in the Regional General Hospital of Makassar City in 2022.	Dian Ekawati, Mangindara, Nurmulia Wunaini Ngkolu, Muham-mad Nurhadi N, Indah Zulkartini (2022)	Qualitative Research	The Makassar City Hospital has implemented the principles of Good Corporate Governance, as evidenced by the provision of information that is open, clear, and timely. The functions of employee structure have been adjusted to their roles and responsibilities, and there is a legal basis for compliance in every activity. In addition, this hospital is professional and independent, without pressure from external parties.
8	Implementation of Fraud Prevention Policies in the Execution of the Health Insurance Program at Diponegoro National Hospital, Central Java.	Akha Pratila Sari, Sutopo Patria Jati, Zahroh Shaluhiyah (2022)	Qualitative Research with a Case Study Approach	The team's failure to collaborate effectively led to the failure of the fraud prevention policy implementation. This happened because the policy standards, policy objectives, standard operating procedures (SOP), and task distribution mechanisms have not yet been established. As a result, coordination regarding the division of tasks failed to take place. The Diponegoro National Hospital will create a team work guideline, conduct training, and enhance skills. Then, the team will carry out tasks such as identifying early fraud, socializing policies, regulations, and new cultures focused on quality control and costs, promoting the implementation of organizational governance and oversight, enhancing the capabilities of coders, doctors, and claims officers, and reporting fraud prevention measures.
9.	Development of Hospital Information Systems as an	Ubaidillah, Ermadiani, Abdul Rohman (2020)	Quantitative Research	The hospital has implemented a hospital management information system (HMIS), which has added features for JKN rates, types of services, and BPJS packages. In addition, the HMIS enhances

	Effort to Prevent Fraud in the Context of Improving Health Services in Government Hospitals			the governance of hospital services by holding monthly leadership meetings on fraud prevention, internal and external audits of the JKN program, and penalties for those found to be involved in fraud.
10.	Fraud in Healthcare Facilities: a Narrative Review	Mieke Nurmalasari (2021)	*Narrative Review*	Out of 12,736 cases of fraud, readmissions rank at the top, with 4,827 cases, or 37.9%. Therefore, it is crucial to identify the factors causing readmissions and to establish strict policies to stop these cases and impose strict penalties on healthcare workers who do not complete their medical records. In addition, BPJS Kesehatan must assess the average length of hospital stays and provide comprehensive healthcare services to patients.
11.	Legal Aspects of the Application of Administrative Sanctions for Fraudsters in the National Health Insurance Program	Andi Ashar (2022)	Qualitative Research	Administrative sanctions are far more effective than criminal sanctions in compelling individuals to comply with laws governing business, industry, and the environment; this is one way to prevent fraud.
12	Fraud Issues in the National Health Insurance (Causes, Legal Impacts, Dispute Settlement and Preventive Measures)	Yohanes Firmansyah, Imma Haryanto, Ernawati (2022)	Qualitative Research	BPJS Health and related parties must establish a comprehensive fraud prevention system through clear policies and guidelines, the development of an anti-fraud culture, quality control of health services, and the formation of a fraud detection and handling team, so that the effectiveness of the National Health Insurance can be achieved..
13	Prevention of Fraud in The Implementation of The National Health Insurance (NHI) Program (Case Study: Abunawas Hospital Kendari City, 2023) Southeast Sulawesi Province, Indonesia, 2023	Lade Albar Kalza, et al., 2023	Qualitative Research	As a budget user at the Kendari City General Hospital, the Audit Board, the Internal Supervisory Unit, the Public Accounting Commission, and the Hospital Director are involved in the implementation of the Minister of Health Regulation No. 16 of 2019 concerning Guidelines for the Prevention and Handling of Fraud and the Imposition of Administrative Sanctions for Fraud in the Implementation of the Health Insurance Program. Reports or complaints regarding suspected fraud in the JKN must at least include the following information: the identity of the reporter, the name and address of the institution suspected of committing JKN fraud, and the reasons for making the complaint. The Provincial Health Office or the Health Office/City can report JKN fraud to the JKN fraud mitigation team appointed by the Minister of Health in the event of a dispute regarding the determination of JKN fraud.
14	Fraud Prevention Legal Certainty Principle in Health Sector and Implementation of Health Insurance	Endah Labati Silapurna (2022)	Qualitative Research	The discussion on fraud prevention in the health sector based on Law No. 36 of 2009 and Minister of Health Regulation No. 16 of 2019 emphasizes the importance of good administrative management to minimize the potential for fraud. Fraud can occur not only due to malicious intent but also as a result of misadministration. It is recommended to use an

	Program in Indonesia			ad hoc court system involving judges with expertise in law and health to handle fraud cases. The principle of legal certainty serves as the foundation of this regulation, supported by the principles of justice, utility, religious norms, and Pancasila. In addition, regulations related to fraud must be clear, consistent, and stable to maintain the effectiveness of prevention and detection of criminal acts.
15	Application oof Criminal Sanctions in Cases of Manipulation of Demand and Collection of Health Services Fees for Patients Participating in the National Health Insurance Program	Hardy Hutahaean (2022)	Quantitative Research	This research found that there is no specific criminal sanction formulated for cases of manipulating service cost requests for patients registered in the National Health Insurance Program. The results indicate that criminalization of individuals who manipulate cost requests requires consideration of various aspects, including the repercussions of criminalization, both for the individuals involved and for the healthcare ecosystem registered in the National Health Insurance Program. To prevent this from happening, it is important for Good Corporate Governance and Good Clinical Governance to take action.
16	The Effect of The Role of Internal Audit Units on The Performance of Insurance Claim Services and Management Systems With The Fraud Prevention As Intervening Variables In Tarumajaya Hospital, Bekasi	Cut Eva Safitri, Freshly Hutapea, Yanuar Ramadan (2022)	Quantitative Reasearch	The results of the analysis and discussion indicate that the internal audit unit has both direct and indirect effects on the performance of services and the insurance claims management system at Tarumajaya Hospital, Bekasi, with fraud prevention serving as an intervening variable. Additionally, there are direct and indirect effects of the internal audit unit's role on the performance of services and the insurance claims management system. Research shows that optimal performance for services can be achieved.
17	The Effectiveness and Sustainability of Fraud Prevention Policies in Improving the Quality of Hospital Services in Malang	Puguh Priyo Widodo, Firdaus Hafidz Shidieq, Prawidya Putri (2024)	Qualitative Research	According to research, every hospital must have a Fraud Prevention Team as a technical requirement to further collaborate with BPJS Health. So far, the structure and function of the team have not been translated into regulations that explain the tasks, responsibilities, and authorities held by the team. In addition, the hospital does not have policies, guidelines, standard operating procedures, or work programs. The contextual-mechanism aspects of the outcomes of fraud prevention policies in the hospital JKN program are not functioning.

The creation of fraud prevention regulations, particularly in the National Health Insurance Program (JKN) in 2015, was driven by the increasing cases of fraud within the system, such as claim falsification, data manipulation, and misuse of funds by healthcare facilities as well as participants. With an increasingly large national scale, the potential for deviations in health budget management poses a serious threat to the sustainability of programs. To this end, BPJS Health, together with the government and related institutions, is implementing anti-fraud regulations aimed at strengthening oversight, transparency, and accountability, in order to ensure that public funds are used appropriately and optimally in providing health services to the community.

The results of the review above indicate that the implementation of policies carried out in healthcare facilities such as Kendari Regional Hospital, Tarumajaya Bekasi Hospital, Tanah Kampung Community Health Center, and Makassar City Regional Hospital have executed strategies that can prevent fraud from occurring in each institution. However, in some healthcare facilities, there are still those that are not operating optimally due to the main obstacle,

which is the lack of active involvement from internal oversight or fraud prevention teams in each institution. This is due to the fact that the team has not been provided with technical guidance, training, knowledge enhancement, and investigative techniques regarding fraud by the policymakers. In addition, this is also due to the fact that the SOP, guidelines, standards, and policy objectives have not yet been prepared.

Research conducted at Tarumajaya Hospital in Bekasi using quantitative research methods explains that the role of internal audit is very important in optimizing fraud prevention, where employee service performance, insurance claim management, internal supervisory units, and fraud prevention all receive high scores. An effective internal audit prepares management to face changes in customer demand and future restructuring fraud. (Alao & Amoo, 2014). Another study conducted at the Bekasi Regional General Hospital using qualitative research methods shows that the preventive measures taken have a very positive impact by involving the Internal Supervisory Unit (SPI), the Public Accountant Commission (KAP), as well as the active participation of the Provincial and City Health Offices. The SPI also conducts monitoring and evaluation every three months.

Research on the development of information systems in government hospitals also mentions that efforts are currently being made to enhance fraud prevention through technology. The ongoing innovation is the Hospital Management Information System (SIM RS), which includes features such as JKN rates that are integrated with INA-CBG's and SIRS. The Ministry of Health has also launched the Satu Sehat application, which simplifies various reporting program applications, including SIRS. However, currently, the Satu Sehat application has not yet been bridged to the JKN application.

DISCUSSION

The fraud described in the Minister of Health Regulation No. 36 of 2015 is an act carried out intentionally by participants, service officers and health insurance, as well as the healthcare providers themselves, with the aim of gaining financial benefits from the established healthcare service programs.

In the research conducted by Haruddin et al., the factors that lead to fraud in health insurance services at hospitals include financial motives, such as the desire to obtain higher material gains, behavioral motives, and social motives, which focus on individual aspects (7). This is different from the research conducted by Sholikatum & Makaryanawati, which focuses on company factors, where there is external pressure from the company and shareholders who expect the services provided to yield profits, as well as financial targets or profit amounts set for a specific period (8).

In a study conducted by Liu et al, it is stated that one of the efforts that can be made in the management and prevention of fraud in health insurance services is, first, it is very important to increase penalties for healthcare providers involved in fraudulent activities. Second, reducing moral hazard for healthcare providers by promoting fraud detection methods and systems, as well as implementing new oversight methods such as reputation penalty mechanisms. However, in the implementation of fraud prevention, active cooperation from the government is essential (9).

The stagnant implementation of policies in the National Health Insurance Program (JKN), particularly regarding Minister of Health Regulation No. 16 of 2019, indicates that despite regulations being established, their execution still faces various obstacles. One of the main obstacles is the lack of active involvement from various stakeholders, including the government, healthcare providers, and the Health Social Security Agency (BPJS Kesehatan). This has resulted in insufficient collaboration and coordination in implementing these policies. Without strong involvement from all relevant parties, as well as minimal communication and synergy in implementing the existing guidelines, the effectiveness of fraud prevention in this program is hindered, potentially reducing the quality of healthcare services and increasing the risk of fraud.

Patterns found in the literature regarding the effectiveness of fraud prevention policies in the JKN Program indicate that although the policies have been implemented, the results tend to be suboptimal. Many studies identify the lack of coordination and active involvement from stakeholders as a major factor hindering implementation, along with ambiguity in the operational definition of fraud and confusing prevention guidelines. In addition, weak monitoring systems and the insufficiently effective enforcement of sanctions also reduce the ability to detect and prevent fraud. Education and training must be conducted continuously and accompanied by evaluations to ensure that everyone receives quality education, where healthcare professionals need to be educated about the importance of adherence to standards and work ethics (10,11). Overall, although the policies are in place, the expected achievements in fraud prevention have not been effectively realized, indicating that these policies require significant improvements to meet the desired objectives.

Based on a review of 17 articles related to fraud prevention policies in the JKN Program, there are several significant research gaps. First, there is a lack of empirical studies that specifically measure the direct impact of policies on the reduction of fraud levels, which poses an obstacle in quantitatively assessing the effectiveness of these policies. In addition, in-depth research on the experiences and perceptions of stakeholders, particularly healthcare

workers and patients, is still limited, even though their insights could provide important contributions to policy improvement. Another gap is the lack of longitudinal analysis that monitors changes in fraud practices over time after policies are implemented, which is necessary to understand the dynamics of fraud. Lastly, the aspects of information technology and data management systems in supporting fraud prevention have not been adequately explored, even though technological innovations can play a crucial role in enhancing the detection and prevention of fraud in health systems.

The utilization of technological innovations in fraud prevention has been implemented in the research by Johnson & Khoshgoftaar, which involved data preparation techniques, provider level statistics, claim levels, and benefit levels. The researchers further utilized internet archives to obtain a historical list of healthcare providers, where the performance metrics and confidence intervals in this study reached 95%. Thus, this feature is proposed as a good indicator for detecting and preventing fraud attempts (12).

In addition, BPJS Kesehatan has made efforts to prevent fraud both in FKTP and FKRTL. Since 2020, BPJS Kesehatan has developed an antifraud system through smart collaboration and AI with digital claims in FKRTL, the enhancement of the JKN mobile application into a super app, and the implementation of AI for social health insurance. (13,14).

Policymakers need to recognize the importance of stronger collaboration among all stakeholders, including the government, healthcare providers, and the Health Social Security Agency, to enhance the effectiveness of implementation. Poor governance is the main cause of a country's failure and backwardness. Therefore, development requires support for innovation and bureaucratic reform and governance through the implementation of information and communication technology (15,16). The research findings indicate that existing policies need to be clarified and adapted, with a focus on clearer operational definitions and more structured procedures. Recommendations that can be made include strengthening the monitoring and accountability systems, implementing stricter sanctions, and utilizing information technology for fraud detection. In addition, it is important to conduct empirical studies that directly measure the impact of policies on reducing fraud and to gather input from stakeholders in the field to create more responsive and effective policies.

CONCLUSION

Various policies have been implemented, but their effectiveness is still far from optimal. Many studies reveal that the main factors hindering implementation include a lack of coordination among stakeholders, unclear operational definitions, and weak monitoring systems. Research also shows that although there are administrative sanctions, law enforcement against fraud perpetrators is still not very effective. Fraud in healthcare negatively impacts not only finances but also the quality of services received by patients. The gaps in research, such as the lack of empirical studies measuring the direct impact of policies and the insufficient use of technology in detecting fraud, add to the complexity of this issue. Therefore, a more holistic approach is needed, including better collaboration among stakeholders, strengthening regulations, and utilizing information technology, to enhance the effectiveness of policies and prevent fraud in the National Health Insurance (JKN).

SUGGESTION

The necessity for more in-depth empirical research to measure the direct impact of policies on the reduction of fraud, as well as the collection and analysis of data from the experiences and perceptions of stakeholders, particularly healthcare workers and patients. Additionally, it is recommended to conduct longitudinal analyses to monitor changes in fraud practices over time, as well as to explore the utilization of information technology and data management systems as tools to enhance the detection and prevention of fraud in the healthcare system.

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