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Optimization of Fraud Potential Prevention in Implementation of National Health Insurance at Puskesmas Abeli

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Kata Kunci

Fraud ; National Health Insurance ; Health Center

Abstrak

Fraud actions at institutions can catapult health costs. Globally, the potential loss due to fraud is estimated at 7,29% every year. Increasing the number of referrals in advanced health facilities FKTL is an indication of fraud behavior. In Southeast Sulawesi, the referral rate is high, reaching 17% with the maximum ideal standard for the average referral rate of first level health facilities(FKTP) to advanced health facilities(FKTL), not more than 5%. While in Kendari City in 2015, the referral rate from Puskesmas to Abunawas General Hospital was also still high at around 9.5% in 2015 and an increase of 15.3% in 2016. One of the puskesmas that provided referrals was Abeli Community Health Center. This study aims to analyze the potential for fraud prevention in the implementation of National health insurance(JKN) at Abeli Health Center. This study using observational analytic using one group pre test and post test design. Research was conducted at Abeli Health Center and technique used was cluster random sampling with 28 respondents. From the statatistic test results obtained, there were differences in knowledge before and after the intervention with a mean gap value of 0, 21429 with a lower limit of 0.05226 and an upper limit of 37631 and a p value<α (0.011 <0.05). The suggestion in this study is to the health centers and hospitals to increase more understanding of fraud in the implementation of the JKN program by having socialization.

Introduction

The National Health Insurance (JKN) is part of the National Social Security System (SJSN) which is implemented using a mandatory social health insurance mechanism based on Law Number 40 of 2004 concerning the SJSN with the aim of meeting the basic needs of decent public health. It is given to every person who has paid contributions or fees paid by the Government[1]. In the JKN era, puskesmas is a service facility first-level health (FKTP) who organizes efforts public health (UKM) and individual health efforts (UKP) and establish cooperation with BPJS Kesehatan to become level care health provider on the first level for JKN participants[2].

According to regulation of health ministry (Permenkes) number 36 of 2015 about fraud prevention in implementation of health insurance program in national health insurance (JKN) system defined that fraud in implementation of national health insurance (JKN). Actions are taken by the participants, BPJS Kesehatan officers, medicines and medical devices providers intentionally by obtaining financial benefits from the NHI program through fraudulent conduct that isn't in accordance with the provisions. While, Taufik [3] tated that fraud in health service is a deliberate action by providing facilities or benefits to individuals or institutions who have no right, so that it can harm others. Fraud action in institutions can increase the cost of health. Globally, the potential loss due to fraud is estimated at 7,29% every year. While according to Simanga Msane and Qhubeka Forensic service (Organization of Fraud Investigation), In South Africa, there are 500,000 – 1 million dollars of loss caused by fraud action of employees[4].

In United State of America, fraud potential could increase the health costs and caused loss potentials around 5-10% from the total of health service expense. In health services in Indonesia, fraud has existed for a long time, however, it has not been proven. It is feared, that fraud could increase the health costs and take the country into financial loss. According to the fraud incidents in United State of America, when BPJS cost in 2014 estimated as IDR 38.5 trillion rupiahs. It could be predicted that loss estimation will be 1.8 – 3.6 trillion rupiah[5].

In Indonesia, there have been fraud indications in health insurance service even though it has not been proven [6]. The implementation of national health insurance (JKN) has discovered irrelevance that caused disadvantage to BPJS. It was proven that at the beginning of 2015, from various sources stated that BPJS experience budget deficit around 2-5 trillion. One of the fraud actions was found in Advance Health Facilities (Fasilitas Kesehatan Tingkat Lanjut/FKTL) was unnecessary patient accommodation in the hospital[6]. Based on preliminary study results in the location of the research, there were complaints from the patients and their family related to patient's accommodation, the patients were recommended to stay at the hospital event it was unnecessary because the patient did not feel any symptoms of illness at all. Another case was over repeated blood sampling in the reason of laboratory examination.

The increase of advance health facilities (FKTL) of referrals the indication of fraud action. In Southeast Sulawesi, the hospital referral rate was 17 % categorized as high which measured from the maximum standard of FKTP to FKTL should not be more than 5%. While in Kendari at the beginning of 2015, referrals rate from community health center (puskesmas) to public hospital of Abunawas was still high. It reached 9.5% in 2015 and increased by 15.3% in 2016. The increase of referral numbers in FKTL illustrates the quality of referrals from FKTP, whereas the role of FKTP as a gatekeeper with the indicator primary doctors has the ability to diagnose 155 that reduce the number of referrals in FKTL. As the result, there was inefficiency and loss of BPJS. According to Trisnantoro (2015) stated that in the beginning of 2015, various sources informed that BPJS lacks around 2-5 trillion.

Methods

The method used in this study was a pre-experimental method by using one group pre-test and post-test design. The research was conducted in Puskesmas of Abeli. Population of the research was all the medical staff at Puskesmas of Abeli which were 48 staffs. The sampling technique used a cluster random sampling with the criteria that the subject was not on leave or stops working when collecting data with 28 respondents.

The data in this research was primary data which obtained by using instrument questionnaire contained structured questionsin order to obtain information from respondents. Method of data collection was described as follows: Scale Method. This method was used to obtain primary data, it was the data obtained directly fromsubject of the research through scale definition. Interview Method.This method was used to obtained supporting datato reinforce the result of research, it was the answer ofsubjectabout fraud potentials in implementation of national health insurance (JKN) Library Research.This method was done by analyzing or reviewing the books, literature, and previous related research to be references and several of them were citedto develop theoryin order to obtain secondary datawhich related to the research. Method of Socialization. This method was used to give detailed information about fraud potential prevention. Before socializing,pretest was given first. Then after socializing, post-test was given in order to identify the effectiveness of socialization method.

Instrument in this research was questionnaire. Instrument was designed and being adjusted to the objective of the research. Therefore, the questionnaire should have preliminary passed validity and reliability test to identify how far the respondents understand the questionnaire. Validity test used in this research was pearson product moment correlation. A variable would be valid if the variable score was significantly correlated with the total score. Correlation technique was evaluated by comparing value of r table with r-count. By using product moment correlation, valid criteria could be obtained if r-count > r-table. Otherwise, if r-count < r-table then the statement item must be discarded in this research instrument.

Results

Characteristic of Respondent

Based on the table 1, it showed that most of the staff who become respondents according to the gender being described as follows; 19 female respondents or 67.9% and 9 male respondents or 32.1%. Position distribution as staff are 21 respondents or 75% and position as head of programare 7 respondents or 25%, with the class grade under 3A are 8 respondents or 28.6% and linear to 3A are 20 respondents or 21.4%. While average work period of respondents average above 5 years are 25 respondents or 89.3% with highest education Diploma-III are 16 respondents or 57.1% and lower than Diploma-III are 12 respondents or 42.9%.

Table 1 Distribution of Respondents at Abeli Health Center

No	Characteristic of Respondents	N	%
1	**Gender**		
	Male	9	32,1
	Female	19	67,9
2	**Position**		
	Staff	21	75
	Head of Program	7	25
3	**Grade/Class**		
	< 3A	8	28,6
	≥ 3A	20	71,4
4	**Work Period**		
	< 5 tahun	3	10,7
	≥ 5 Tahun	25	89,3
5	**Last Education**		
	SPK	1	3,6
	D1	4	14,3
	D3	8	28,6
	S1	14	50
	S2	1	3,6

Source: Primary Data,Processed 2018

Bivariate Analysis

Table 2 Distribution of Respondents' Knowledge in Puskesmas Abeli

Knowledge	Mean	Gap	CI 95%		*P*
			Lower	Upper	
Before	1,5	0,21429	0,05226	37631	0,011
After	1,2857				

Source: Primary Data Processed, 2018

Based on the table above, it is shown that there are differences of increasing before and after intervention or treatment in the form of counseling about categories of frauds, there gap value mean 0. 21429 with the lower limit 0.05226 and upper limit 37631 andp value< α (0,011< 0,05) it means there are significant differences between pre and post treatment.

Discussion

The Social Security Organizing Agency, here in after abbreviated as BPJS, is a legal entity established to carry out social security programs[8]. One strategy for the sake of the achievement of UHC is by the existence of a Social Security System National (SJSN), in which there is a Health Insurance National (JKN) is held use the insurance mechanism compulsory social health or mandatory[9]. According to Law Number 40 of 2004 about the Social Security System National (SJSN). Which start to operate on January 1, 2014 until now BPJS Kesehatan has experienced many challenges in implementing the national health insurance program (JKN, one of which prevented fraud. According to the Head of the Legal Sub Division of the Directorate General of Health Efforts of the Ministry of Health, Andi Ardjuna Sakti, fraud allegedly could occur in the implementation of JKN. Can be cheated fraud is an action taken to seek profits improperly[10].

Fraud in health service has become dominant factor caused increasing of health service cost in United State of America. In Indonesia, even it has not been proven, however community health insurance (JKM) system currently resumed in national health insurance has indicated fraud. In health services, fraud is any form of manipulation and irregularity carried out by various parties in the health service to obtain their own benefits which exceed the benefits derived from standard operational procedures [11].

Fraud problems in Indonesia will lead to the worst geographical inequality in National Health Insurance. Health service facilities Indonesia concentrated in developed regions, so fraud will take up BPJS fund[12]. Some factors will also make fraud increase,they are: service provider perceptionagainstINA CBG magnitude which considered as low; IT in the hospital is not ready to obtain fraud data (fraud data that has been foundby PT. ASKES currently still far below 1%); eradicating of fraud still has no legal force: KPK has not considered in stage of investigation; the Financial Services Authority is still in observation phase; andmotivation of seeking "economic benefits" has been the basic human instinct.

In terms of fraud prevention, District/City health office included in institutions that work as the same as BPJS Kesehatan, professional organizations, and associations health facilities to establish a JKN fraud prevention system. According to Laksono Trisnantoro, a professor of Gajah Mada University (UGM),

DKK and Ministry of Health become a third party when there is a dispute between BPJS Health and health facilities and there is an alleged fraud so that there is a need for quality human resources to be able to identify the techniques of claim 97 and fraud, and detect actions fraud committed by the perpetrator[13].

According to the table above indicated knowledge enhancement after given intervention in the form of counseling about fraudwhich is indicated by the increasing of pre and post-test mean value. Gap positif value and p value< (a=0,05 it means that there has been increasing of the knowledge after given counseling about fraud. That could happen because of intensity and has been used to hear term of fraud through counseling and seminar. The value of pre and post-test increased which indicated by gap value,39286 andp value= ,000< 0,05 it means that competence of medical staff on understanding forms of fraud depends on the intensity of the dissemination information on fraud. Among the changes on knowledge they understand about forms of fraud, including the actions of health workers who always provide referrals to patients who are not appropriatewithp value= ,006 < 0,05. It means that all this time there are most ofmedical staffproviding referrals that are not in accordance with the proper rules and procedures.They also did not realize that their actions could be indicated as fraud.

The medical staff stated as well that it is very important to have routine counseling from relevant institutions especially from BPJS and public health office socialize it. They realize that fraud action can occur in their work environment due to knowledge about forms of fraud and can also be due to intentional factors for the benefit of a few people or groups. One of findings from health insurance agency BPJS is irrational claim[14]. Result of the research also indicated that claim giving which never given to the patientwithp value = 0,006 < 0,05 which means there is connection between pre and pos-test counseling about fraud. This also gives information and understanding to the medical staff that fraud is one of manipulations and irregularities which is usually done in government or institution that include health facilities that can implicate loss to the country (0,003 < 0,05). So that if there's no it will be detrimental to providers of health insurance services, especially the health insurance system. Some findings also show that the losses by the BPJS are one of the irrational claims made by medical staff.

From the aspect that causes someone to commit fraud, to economic condition swith p-value < α (0,012 < 0,05) means that there are difference point of view about fraud from financial aspect. Financial problem can trigger someone to commit fraud which break the image and disserve health service. The forms of fraud in health fasulities such as: irrational claims, specifically claim given by attaching specialist doctor whereas it can be done by doctor (p value <α = 0, 023 < 0,05); intended to gain profit, medical staff usually prolong the length of hospitalization that should be repatriated to get more claims(p value < α = 0, 001< 0,05); improper procedure referral processthat most of medical staffprovide referrals to patients both in terms of standards and referral levels (p value < α = 0, 002 < 0,05), whereas if it is based on procedures, there are health facilities which include that requires the competence of medical staff to be able to diagnose 155 diseases, so that patients who only suffer from fever or kind like that should be able to be treated at the first level of health facilities; including the recording of improper reporting, the main purpose of this is to increase claims for treatment days (p value < α = 0, 012< 0,05); another fraud indication ischanging service code to get claim from BPJS (p value < α = 0, 160< 0,05); In laboratory service, possibility for laboratory staff to commit fraud is providing laboratory testing services that do not actually require laboratory testing. (p value< α = 0, 012 < 0,05); In pharmacy department, it is more likely to commit fraud by collaborating with the PBF and getting compensation as compensation from its cooperation (p value< α = 0, 012< 0,05); all of fraud actions were committed by medical staff in health facilities were caused by economic factor, chance and opportunity, it means that the lower incentive/salary of staff more triggered they are to seek profits as much as possible added to chance and possibility to commit fraud (p value< α = 0, 001 < 0,05), by analyzing how easy possibility of fraud potential in health facilities then it is necessary to regulate anti-fraud policy (p value< α = 0, 000< 0,05) and there should be anti-fraud monitoring team (p value< α = 0, 012 < 0,05) to control fraud actions commited by medical staff in health facilities.

Financial condition can be the factor of someone to commit fraud which can break the image and disserve health service facilities. The forms of fraud in health facilities include: irrational claims, it is claim given by listing specialist doctor whereas it should be doctor, in order to gain profit, the officer or staff usually prolong the length of hospitalization that should be repatriated to get more claims (improper referral process, most of medical staff provide referrals to patients both in terms of standards and referral levels, whereas if it is based on procedures, there are health facilities which include with BPJS requires the competence of medical staff to be able to diagnose 155 diseases, so that patients who only suffer from fever or kind like that should be able to be treated at the first level of health facilities; including the recording of improper reporting, the main purpose of this is to increase claims for treatment days. Another fraud indication is changing service code to get claim from BPJS; In laboratory service, possibility for laboratory staff to commit fraud is providing laboratory testing services that do not actually require laboratory testing. In pharmacy department, it is more likely to commit fraud by collaborating with the PBF and getting compensation as compensation from its cooperation. All of fraud actions were committed by medical staff in health facilities that caused by economic factor, chance and opportunity, it means that

the lower incentive/salary of staff, more triggered they are to seek profits as much as possible added to chance and possibility to commit fraud. By analyzing how easy possibility of fraud potential in health facilities then it is necessary to regulate anti-fraud policyand. There should be anti-fraud monitoring teamto control fraud actions committed by medical staff in health facilities.

The potential of this Fraud needs to be prevented by internal supervision in the BPJS and Independent External Supervisors. The BPJS Law stipulates that the Financial Services Authority is an external supervisory institution. However, from various discussions with OJK leaders it was seen that this institution did not yet have the capacity for independent external supervision which entered into the clinical domain for fraud prevention[15].

Conclusion and Suggestion

The results of this study can be concluded that there are differences of fraud potential between before and after applying intervention through counseling related to competence or knowledge in implementation of health service in health facilitiesof National Health Insurance (JKN) at Puskesmas Abeli (0,011< 0,05).

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References

1. Thabrany, H., (2015) National Health Insurance, second print. PT. Raja Grafindo Persada
2. BPJS Health. Practical Guide Gate Keeper Concept Facility BPJS Health; 2015
3. Taufik, A., 2014. Fraud in health insurance. Medical Faculty, University of Indonesia. Jakarta
4. Djasri, H., 2015. Monitoring Mechanisms in Health Insurance: Literature Review. Yogyakarta
5. Trisnantoro, L., Hendrartini J & Riyarto, S (2009). Guidelines for operating the regional health insurance system financing system. Yogyakarta: PKMK UGM Faculty of Medicine
6. Trisnantoro, L., 2014. Introduction to the Seminar on the Role of the Head of the Health Office, Hospital Director in preventing fraud in the implementation of the National Health Insurance. Yogyakarta
7. Trisnantoro, L. 2015, Awareness All parties are needed to prevent fraud, BPJS Health Info Bulletin, XXIX Edition. Central Jakarta
8. Law Number 24 of 2011. Social Security Organizing Agency (BPJS)
9. Rizka zafirah, sutopo patria jati, syamsulhuda (2018). Analysis of Implementation of National Health Insurance Fraud Prevention Program in Semarang City Health Center. public health journal (e-journal) volume 6, number 4, august 2018 (issue: 2356-3346)
10. Utarini, A., (2011). How do you provide quality health services for everyone? Speech for inauguration of Professor of Gadjah Mada University. Yogyakarta.
11. Regulation of the Minister of Health Number. 36 of 2015. Prevention of Fraud Fraud in the Implementation of health insurance programs in the National Social Security System
12. Saeed, MA & Hamid TK (2012). The Role of Internal Audit unit in Fraud prevention in Government owned Hospitals in a Nigerian setting. International journal of bussiness and management. ISSN: 2278-487X Volume 2, issue 5
13. Trisnantoro L. Decentralization Health in Indonesia and Changes in Government Functions: 2001 - 2003 Is Is Trial Period. Yogyakarta : Gajah Mada Press; 2005
14. Abdullah, R & Mansor, N (2015). Fraud Triangle Theory and fraud diamond theory. Understanding the convergent and divergent for future research. International journal of academic research in accounting, finance and management science. Vol. 5 no.4, pp.38-45.
15. Center for Health Service Policy and Management, UGM Faculty of Medicine, Strategies for Preventing Fraud and Corruption in the National Health Insurance, http://keb Policykesehatanindoenesia.net/component/content/article/2232.html,2013 (accessed 10 April 2017).