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Potential of Hospital Fraud in the Indonesia National Health Insurance Era (A Descriptive Phenomenological Research)

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Abstract

Results of the Public Research Anti Corruption Clearing House The Corruption Eradication Commission submitted on December 2, 2016 that until mid-2015 there was a potential of 175,774 hospital claims of fraud that had been detected with a value of Rp. 440 M. In 2016 found an indication of 1 million fictitious claims from the hospital with a value of Rp. 2 trillion. The potential for fraud in hospitals in the era of National Health Insurance (NHI) in Indonesia will have an impact on health financing inefficiencies and at the same time a threat to the sustainability of the NHI program which is expected to reach Universal Health Coverage in 2019. This phenomenological study aims to explore understanding and meaning of the concept of fraud for parties who has had the potential to commit fraud at the hospital. The research method used qualitative research with a Descriptive Phenomenology Research approach. The informants were officers who served patients in administrative and medical matters and the hospital management was selected by purposive sampling. The focus of the study was the experience felt by informants in running the NHI program and how knowledge and attitudes of informants towards the phenomenon of fraud in hospitals. The results achieved in this phenomenological research were in the form of a reflection of the implementation of NHI in hospitals, especially relating to the phenomenon of potential fraud reflected in the knowledge and attitudes of the hospital about fraud and a description of the occurrence of fraud in the hospital. This is the basis for researchers to formulate indicators of potential fraud that still needs to be tested in a larger population.

Keywords: *fraud, hospital, health insurance.*

Introduction

Healthcare fraud is intentional deception or misrepresentation that an individual knows, or should know, to be false, or does not believe to be true, and makes, knowing the deception could result in some unauthorized benefit to himself or some other person(s).

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(1) Reforming health care financing is an unavoidable consequence. Gradually the community will switch from out of pocket payments to premium payments paid monthly. Likewise for health service providers must start leaving the old payment mechanism (fee for services) to be claims based on Indonesia Case Based Group (INA-CBG).(2) The Social Security Organizing Body (BPJS) Health as the organizer of National Health Insurance (NHI) has a payment mechanism to health care providers namely capitation for primary outpatient health facilities and claims based on INA-CBG for Advanced Referral Health Facilities both inpatient and outpatient.(3)

The change in the payment system will potentially lead to fraud or fraud, where the diagnosis is regulated to obtain the largest CBG amount called upcoding

(increasing the code with a larger payment).[4] Acts like this are actually acts of corruption that are against the law. The Government of Indonesia has been concerning the prevention of fraud in the implementation of the Health Insurance Program in the National Social Security System has given attention and anticipation of fraud in the implementation of NHI.[5] Definition of fraud (Fraud) in the Implementation of the NHI Program according to the regulation is the action taken intentionally by participants, BPJS Health officers, health service providers, as well as providers of drugs and medical devices to obtain financial benefits from the health insurance program in the National Social Security System through cheat that is not in accordance with the provisions.

The problem of fraud in Indonesia that is of concern today is illustrated by an article posted by the Public Research Anti Corruption Clearing House of the Corruption Eradication Commission (KPK) on December 2, 2016 which stated that up to mid-2015 there were 175,774 claims of fraud. or FKRTL with a value of Rp. 440 M.[6] In 2016 found an indication of 1 million fictitious claims from the hospital with a value of Rp. 2 trillion. This fraud potential is only from a group of health service providers, not from other actors such as BPJS Health staff, patients, and suppliers of medical devices and drugs. The biggest form of fraud potential is done by upcoding which reaches 50%, then another 25% is done by unbundling, and then the third is by reading with a value reaching 6%. Also stated in the article that INA CBG rates that are considered low by clinicians and the high workload make them think of unnatural efforts to defend themselves (coping strategy) so as not to lose money.[6]

The potential for fraud is also a concern of the one district in east java which was stated directly by the Regent to fight it. This Regency has 3 regional hospitals, 1 provincial-owned hospital, 2 state-owned hospitals, and 6 private hospitals. Based on the results of interviews with the Head of Health BPJS Branch on November 13, 2017, information was obtained about the potential fraud reported in the form of potential claim fraud from hospitals detected through intelligence business in the form of applications developed to assist in the claim audit process. The menus provided include Defrada (data fraud detection). Through this application display, a warning system in the form of red flag is provided for claim transactions that are indicated as potentially fraud. This red flag is the basis for BPJS verifier officers to clarify and trace data to ascertain whether there is an element of error and intentions in filing claims that are indicated by fraud. This is what underlies the selection of the Jember Regency as a place of research.

Phenomenology study according to Packer is a reflective study of the essence (core) of the awareness experienced from the perspective of the first person, namely the perspective of people who experience an event or event directly.[7] The event referred to in this study is the potential for fraud in the implementation of the NHI program which has changed the health care and financing system in Indonesia. Phenomenological studies are widely used for policy implementation research so that it can describe the experience of implementing policies that determine the success or failure of a policy.

Method

The research method used qualitative research with a Descriptive Phenomenology Research approach because what is the object of research is the experience of informants in running the NHI program as an event or transition event of health care and financing policies. The informants were officers who served patients in administrative and medical matters and the hospital management who were willing to fill out informed consent and were selected by purposive sampling. The confidentiality of informants and institutions where research was conducted was the responsibility of the researcher.

The focus of the study was the experience felt by informants in carrying out the NHI program and how the knowledge and attitudes of informants towards the phenomenon of fraud in hospitals. Research transcripts are the basis for processing and analysis using the Desciptive Phenomenological Analysis (DPA) approach. According to Kahija that DPA moves from all the informants 'words in the transcript to the core meaning of all the informants' words.[8]

Results

The informants were chosen based on their involvement in the implementation of JKN policies and the phenomenon of potential fraud in hospitals. After conducting interviews with research informants, the results of the interviews are presented in the transcript. Research transcripts form the basis for processing and analyzing with the Desciptive Phenomenological Analysis (DPA) approach. The results will be divided

into the following sections.

Knowledge of Fraud

This study of knowledge aims to understand the most fundamental aspects of the phenomenon of fraud in hospitals. Knowledge about fraud will provide an overview of the extent to which this potential fraud is understood by hospital practitioners. Descriptions of knowledge are needed considering that the implementation of national health insurance in Indonesia has only begun in 2014. The potential for fraud as one of the problems that arise in the implementation of fraud is the concern of the government and health practitioners today.

The results showed that the informants have had enough knowledge about fraud that might occur in the hospital. This is indicated by the participation of informants in the dissemination of regulations on fraud in the NHI era held by hospitals, BPJS, as well as from professional organizations. The results of the interview indicated an expression of disagreement, especially from the clinician informants on the concept of fraud as outlined in government regulations. The informant mentioned "…the term "fraud version of BPJS" as a form of rejecting the concept of fraud as what informants understood and felt while providing services…"(Informant TR06, lines 8-9). Informants try to provide a rationalization of the potential for hospital fraud. Rationalization is an act that seeks justification by people who feel themselves trapped in a bad situation.

Situation Awareness

Implementation of national health insurance will have an impact on the situation in the hospital. The hospital is required to make changes and adjustments in order to carry out its functions in the new regulations. The potential for fraud as one of the negative consequences of implementing national health insurance must be fully realized by the hospital. Fraud actions, in addition to being contrary to moral values, also have the potential to act against the law. Hospitals need to identify points that have the potential to cause fraud so that planning, monitoring and evaluation activities can be carried out to prevent potential fraud.

The results of the interview indicated that there was an awareness of the informants about the risk of fraud, namely in the form of criminal sanctions. Therefore, informants are uncomfortable when their activities are often associated with potential hospital fraud. This discussion of fraud must be discussed in depth so that when the regulation on fraud sanctions is applied, it does not harm the parties who actually greatly contribute to the implementation of the NHI program.

Perception of Fraud

One of the themes that emerged in all informants was an increase in workload during the NHI era. This is a logical consequence of increasing public access to hospitals which is characterized by high visits, both outpatient and inpatient care. Along with the increase in workload, the main issue that should be considered by hospitals is the provision of fair rewards. Remuneration as an instrument for the distribution of rewards must be arranged as well as possible to avoid job dissatisfaction due to negative perceptions of the reward received. The emergence of attempts to commit fraud is possible because of the influence of dissatisfaction with NHI actors on the rewards received.

Potential fraud in health services during the NHI era has been aware by informants (risk awareness). But there was informant who argue "... maximizing claims is not fraud, but efforts to rationalize costs to meet medical needs ..." (Informant SPG01, lines 12-13). The theme of the potential for fraud in these hospitals deserves attention in an effort to succeed in NHI implementation. The potential for fraud in hospitals is the subject of the KPK's publication. So that matters relating to the causal factors, the mechanism of prevention and control, and the mechanism of action are the themes that arise from informants, especially from DPJP.

Discussion

The Government of the Republic of Indonesia seeks to fulfill the constitutional mandate for the implementation of National Health Insurance (NHI) which started on 1 January 2014 and established the achievement of Universal Health Coverage (UHC) in 2019. This means that all communities must obtain guarantees for their health needs (preventive, promotive, curative, and rehabilitative) with a health insurance mechanism.

One of the fundamental policies in the NHI program is the change in hospital payments from fee for services to claim INA CBGs as Minister of Health Regulation concerning the Indonesian Case Based Groups (INA-CBG's) guidelines NHI.[12] This has put pressure on the

policy implementers at the hospital level. Not to mention the problem with the difference between hospital rates and the value of INA CBGs given. This is considered to trigger the potential for fraud in hospitals as FKRTL.

Fraud in health services usually refers to false statements or false claims, complicated schemes, cover-up strategies, misrepresentations of value, misrepresentations of service.[1],[13] The subjective experience of individual implementing policies plays a very large role for the success of policy implementation.[14] There are three elements of implementing responses that can affect their abilities and desires to implement policies, namely: cognition (comprehension, understanding) about policies, kinds of responses to policies (acceptance, neutrality, rejection), and the intensity of those responses.[15]

Based on the conceptual framework of the policy implementation process, the attitude of acceptance or rejection of the implementing agent (disposition of implementers) will greatly affect the success or failure of the performance of public policy implementation.[16],[17] Disposition or attitude of the implementer will cause real obstacles to policy implementation if the existing personnel do not implement the policies desired by the policy holders.

Based on the phenomenological studies that have been carried out, the three elements triggering the occurrence of fraud appear in the experience of the informants. The pressure appears from the information conveyed by the informant in the form of dissatisfaction with the reward received compared to the perceived workload. Rationalization appears in an informational statement stating that maximizing a claim is not fraud. The third element, opportunity, is reflected in the experience of informants who stated that the hospital's antifraud team was not yet effective.[9],[10],[11]

Fraud prevention needs to be done both from the internal aspects of the hospital and external hospitals on health services covered by NHI, so that there is no dispute with BPJS and does not invite civil or criminal prosecution from legal apparatus. Thus, the substance of the policy and guidelines for preventing NHI fraud is an arrangement that wants to be applied along with the implementation procedures. These include the standards of behavior and discipline, monitoring and evaluation that ensure compliance with implementation, and the implementation of sanctions against violations.[18]

Conclusion

An increase in workload is an experience that arises in each informant's theme. Job dissatisfaction marked the implementation of NHI program at the hospital. The informant acknowledged that the potential for fraud was present, but not to be labeled with one particular profession or organization. Some concepts that are considered to be the triggers of fraud that need to be tested in a wider population, such as: increased workload, job satisfaction, acceptance or rejection of health service financing policies in NHI era (disposition of implementers), risk awareness of fraud behavior, and effectiveness of internal and external monitoring.

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Ethical Clearence: The ethical test for this research was conducted at the Health Research Ethics Commission (KEPK) at the Faculty of Dentistry, University of Jember in the form of the Ethic Committee Approval No. 348/UN.25.8/KEPK/DL/2019 issued on 6 February 2019.

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