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The Effectiveness and Sustainability of Fraud Prevention Policies in Improving the Quality of Hospital Services in Malang

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ABSTRACT

Loss of health funds in the health insurance program (JKN) due to poor quality and cost control policies. One of the quality and cost control policies that must be implemented and evaluated is the fraud prevention policy. The aim of this research is to evaluate the effectiveness and sustainability of fraud prevention policies in improving the quality of hospital services in Malang. The research method is qualitative with a realist evaluation (RE) approach, carried out in 3 (three) hospitals, anonymously, with respondents are hospital directors, deputy director/head of services and support, deputy director/head in finance, head of the anti-fraud team, head of the quality and cost control team, head of insurance. Data were obtained through interviews, with analysis using triangulation techniques through analysis of Minister of Health regulation number 16 of 2019. The result show that all hospital already has a Fraud Prevention Team as a technical requirement for extending cooperation with BPJS Health. The structure and function of the Team have not been translated into provisions containing descriptions of duties, responsibilities and authority. Hospitals also do not have policies, guidelines, standard operating procedures and work programs. The context-mechanism-outcome aspect of the fraud prevention policy in the JKN program in hospitals is not working.

Keywords: fraud prevention policies; hospital; national health insurance program realist evaluation;.

INTRODUCTION

The National Health Insurance (JKN) program has entered its tenth year and 8 (eight) JKN map targets have been set which will be studied and analyzed in 2019. In 2019, the Universal Health Coverage (UHC) target has been set in accordance with the JKN map. BPJS Health's efforts to improve the quality of health services are increasingly evident. The main target of the road map towards JKN in 2012-2019 shows that the 2019 target is 85% of participants stating they are satisfied with the services at BPJS and health facilities contracted by BPJS and 80% of health workers and facilities stating they are satisfied or receiving adequate payment from BPJS. Evidence of efforts to improve the quality of health services can be seen based on satisfaction figures from health facilities and JKN-KIS participants. Based on BPJS Health data, it was reported that the 2014 JKN-KIS participant satisfaction index was 81%. This figure exceeds the standard set at 75%. Meanwhile, the health facility satisfaction index is 75% with a standard of 65%. In 2019, the standard for JKN-KIS participant satisfaction and health facility satisfaction was 85% and 80%.

BPJS Health in increasing the effectiveness and efficiency of implementing the JKN program by developing the health service system, service quality control system, and health service payment system to increase the efficiency and effectiveness of health insurance in accordance with the mandate of the National Social Security System Law (SJSN) article 24 paragraph 3 [1]. One service quality control system

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is a service that does not have a risk of fraud in implementing the JKN program. Fraud in the JKN program is the loss of health funds due to poor quality services. In Indonesia, the potential for JKN Fraud in Advanced Referral Health Facilities (FKRTL) is 400 billion (KPK, 2015). In First Level Health Facilities (FKTP) the number of frauds reaches one trillion (BBC, 2018). Findings from the patient safety side, in cases of unnecessary cardiac catheterization in 750 patients which caused two patients to die (NHCAA, 2016). In Indonesia there is also no national quality framework in place that covers all dimensions of health service quality recommended by the World Health Organization (WHO) [4]. The policy concerns one of WHO's six quality dimensions, namely efficiency. The existing policy in carrying out the efficient dimension is the anti-fraud policy for health services.

Health policy in Indonesia in regulating fraud control is Minister of Health Regulation no. 36 of 2015 concerning anti-fraud in the Implementation of the Health Insurance Program in the National Social Security System. Having been revised into Minister of Health Regulation no. 16 of 2019. The findings of research by Fei et al., show that first, it is necessary to prevent medical fraud behavior in institutions, by effectively supervising the organization of medical administration, improving internal management and the role of supervision to prevent collusion in medical institutions. Second, focus on monitoring and reporting. Third, strengthening supervision and enforcing penalties for those who commit fraud and providing incentives for institutions that carry out good internal management [5]. Based on the problem, it is very important to carry out research on evaluating the effectiveness and sustainability of anti-fraud policies in improving the quality of hospital services in Malang.

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One of the main causes of inefficiency in health services is fraud (Gee, J., Button, M. 2011). Fraud based on Minister of Health Regulation Number 16 of 2019 is an act carried out intentionally to obtain financial benefits from the Health Insurance program in SJSN through fraudulent acts that are not in accordance with statutory provisions. Fraud actions can be carried out by health service providers, JKN/ KIS participants, BPJS Health, distributors of medicines and medical devices and other stakeholders. Fraud in health service providers, especially hospitals, can be committed by hospital leaders, claims officers, medical personnel and health workers. Fraud committed by hospitals is health insurance claims to BPJS Health by increasing the number of claims through upcoding, fragmentation, readmission and others. Fraud occurs because there is an element of intent, not complying with regulations, gaining profit, and causing harm to certain parties (Communication Bureau, 2018). It is estimated that around 10% of the costs incurred by the insurance industry and loss adjustments each year come from fraud claims (Fursov, I., Zaytsev, A., Khasyanov, R., Spindler, M., & Burnaev 2019). The potential for JKN Fraud in Advanced Referral Health Facilities (FKRTL) is 400 billion (KPK, 2015). In First Level Health Facilities (FKTP) the number of fraud reaches one trillion (BBC, 2018). Findings from the patient safety side, in cases of unnecessary cardiac catheterization in 750 patients which caused two patients to die (NHCAA, 2016).

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The National Health Insurance Program (JKN) has entered its tenth year. This program runs as an implementation of the mandate of the National Social Security System Law (SJSN)(Sekretaris Negara RI 2004) and the Social Security Administering Body Law (BPJS)(Indonesia 2011)Article 2 of the SJSN Law (2004) states that the National Social Security System is implemented based on humanitarian principles, benefit principles and social justice principles for all Indonesian people. Article 3 states that the National Social Security System aims to provide guarantees for the basic needs of a decent life for every participant and/or their family members. The BPJS Law (2011) in Article 2 states that BPJS organizes a national social security system based on the principles of: humanity; benefit; and social justice for all Indonesian people. Article 3: BPJS aims to realize the provision of guarantees for the fulfillment of the basic needs of a decent life for every participant and/or their family members. Unfortunately, from various mandates regarding the implementation of the JKN program, there is still minimal recommendation regarding the quality of health services. This is different from practice in Iran which shows that households prefer premium payments for health insurance, thus this is an opportunity for policy makers (health insurance) to increase premium packages and provide good benefits for health services (S.Nostratnejad, A. Rashidian, A. Akbari Sari 2017).

METHOD, DATA, AND ANALYSIS

The research method used is qualitative with a realistic evaluation (RE) approach. This means that the evaluation is carried out in the form of a context-mechanism-outcome (CMO) configuration. The RE approach explores more structured and stratified information on certain policies in the actual context based on the causes, conditions and context (Kazi, Mansoor. 2003). The RE approach does not just stop at the outcome of whether a program is successful or not, but goes further to explain in what context, by whom and the mechanisms by which a program can be successful or not (Greenhalgh et al. 2015). In research using the RE approach, there are 3 (three) stages, namely: (1) stage one: identifying program theory, namely theory about: how a program is expected to work, in what context, and to produce what output. Data to build an initial theoretical program can come from knowledge, experience, previous research and the program maker's assumptions about how the program should run (Better Evaluation 2020). Data is processed in the form of a Contexts–Mechanisms–Outcomes (CMO) configuration. CMO is a configuration of hypotheses regarding the causal relationships between different contexts, the various mechanisms that may arise, and the various outcomes produced. The following is the CMO hypothesis for evaluating the effectiveness and sustainability of anti-fraud policies in improving the quality of hospital services in Malang according to table 1.

Table 1. CMO hypothesis for evaluating the effectiveness and sustainability of anti-fraud policies in improving the quality of hospital services in Malang

No	Policy Components	Context (C)	Mechanism (M)	Outcome (O)
1	Establishment of an anti-fraud team	Organizational leaders have adequate understanding regarding fraud (Agrawal et al., 2013)	Organizational leaders have adequate understanding regarding fraud (Agrawal et al., 2013)	A JKN fraud prevention team was formed which can work optimally
2	The hospital anti-fraud team receives training or outreach regarding fraud prevention by local governments, especially the health department	Organizational leaders and employees acquire the knowledge necessary to participate and function effectively as members of the organization	Process socialization will gain knowledge of culture, values, organizational goals, new jobs, and role in the group, so employees can participate better in organizations (Haueter et al., 2003; Saks et al., 2007).	There is socialization about fraud prevention by local governments, especially the health department
3	Preparation of policies, guidelines and SOPs regarding anti-fraud	Organizational leaders have adequate understanding regarding fraud (Agrawal et al., 2013)	Leadership is committed to controlling fraud in the organization (Deloitte, 2019).	There are policies and guidelines for controlling JKN fraud
4	Development of anti-fraud culture	Leaders and staff provide examples of ethical and integrated behavior (Doody, 2010)	Employees are encouraged to always imitate the ethical behavior shown by their leaders (Filabi, 2018)	Implemented the development of a culture of JKN fraud prevention
5	Service Development Quality Control and Cost Control Oriented Health	Organizational leaders who create a work culture that supports accountability and compliance with standards	There are efforts to ensure that health services meet quality standards and requirements while still paying attention to service costs (Manghani, 2016; Business Dictionary, 2020)	Quality and cost control oriented health services are implemented

The second stage is to test the program theory. The program theory that has been built is then tested using qualitative research through interviews with program implementers with various context backgrounds. The diverse context consists of 5 elements in table 1, and stage three is to improve the program theory. At this stage the hypothesis is refined with a new CMO configuration that reflects findings in the field. The stages of RE implementation are outlined in Figure 1.

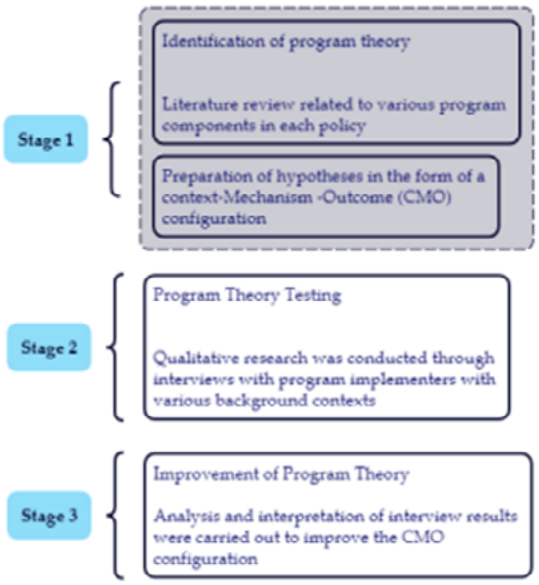

Figure 1. Stages of RE Implementation

This research was carried out at three hospitals, namely Hospitals head of insurance/casemix. The selection of research subjects used purposive sampling with certain considerations in accordance with the objectives of this qualitative research. Data collection was through interviews, data was collected using triangulation techniques through analysis of Minister of Health Regulation No. 16 of 2019. The research will be carried out in September-November 2020.

RESULTS AND DISCUSSION

Realist evaluation according is an evaluation based on the realist philosophy of science, namely discussing the questions of what works, for whom, under what circumstances, and how it is done (Ranmuthugala, Geetha, Cunningham, Frances C, Plumb, Jennifer J, Long, Janet; Georgiou, Andrew, Wesbrook, Johanna I, Braithwaite 2011). This approach is a way of evaluating policy implementation designed to capture aspects that occur in the field. In this approach, theories are framed as propositions about how a mechanism operates in a context to achieve certain outcomes (Pawson, R., Tilley 1997).

Realist evaluation is widely used in health research and other evaluation research. The assumption built in realist evaluation is that the program is an incarnation of theory. This means that every time a program is designed and implemented, it will always be influenced by one or more theories about what might cause change, even if these theories are not explicitly stated. Realist evaluation is very relevant for policy evaluation research because it aims to develop theory based on the importance of context in understanding why a program or policy is successful or unsuccessful. Thus, realist evaluation activities attempt to describe the relationship between mechanisms, context and results, not just limited to whether a program is successful or not. Thus, the results of this research will be more comprehensive in answering the research questions (Wong, G., Westhorp, G. Manzano, A., Greenhalgh, J., Jagosh, J., Greenhalgh 2016)

The realist evaluation approach requires that the theories underlying the program be expressed in clear hypotheses about how, for whom, to what extent, and in what context a program might work (cause change). The program evaluation carried out is aimed at testing and improving this hypothesis. The data collected in a realist evaluation that is used to achieve this goal includes the impact and process of program implementation, the context that may have an impact on outcomes, and certain mechanisms that may create change (Wong et al., 2016). Considering that the data required has a wide range, the methods used to collect this data can also vary. The data collection method chosen is expected to be adequate enough to capture intended and unintended outcomes as well as the C-M-O interactions that cause them. Apart from that, how data can be used to develop, support, refute or improve theory is also important to explain in the analysis plan (Wong et al., 2016). The following are the results of research at Hospitals.

One of the policies implemented in the JKN program is a policy related to anti-fraud. This policy is needed because fraud is one of the risks that can arise in health insurance programs. This policy was implemented in April 2015 and a revision of the policy was carried out on July 18 2019 regarding the prevention and handling of fraud as well as the imposition of administrative sanctions against fraud in the implementation of the Health Insurance program. Implementing anti-fraud policies evenly by all stakeholders can help control costs or funds managed by BPJS Health.

Based on table 2. shows that the results of research regarding the Evaluation of the Effectiveness and Sustainability of Anti-fraud Policies in Improving the Quality of Services at Hospitals fraud) in implementing the Health insurance program because the fraud prevention team was formed as a condition of Collaboration with BPJS Health, did not receive training or socialization by the city/district

Health Service, There are no policies, guidelines and SOPs regarding fraud prevention. There are no activity programs in developing a culture of fraud prevention. Fraud and there is no integration of the use of clinical service guidelines and clinical pathways with quality and cost control with accreditation standards.

Table 2. Matrix (CMO) of Realist Evaluation on the Implementation of Prevention Policy

No	Policy Components	Context (C)	Mechanism (M)	Outcome (O)
1	The formation of the Fraud Prevention Team	Hospitals have a fraud prevention team consisting of medical staff, financial personnel, and casemix personnel	The fraud prevention team serves merely as a technical requirement in collaboration with BPJS Health	The fraud prevention team has been established but fails to operate in accordance with Regulation of the Minister of Health No. 16 of 2019
2	Hospitals'fraud prevention teams receive training or socialization on fraud preventiona	Hospitals'fraud prevention teams do not receive training or socialization from the city health department but are briefed by BPJS Health Branch Malang on fraud prevention during invitations related to JKN/KIS participant services	The fraud prevention team does not understand its duties and functions because it has never received training or socialization by the city/district Health Service	The hospital fraud prevention team did not receive training or socialization by the city/ district Health Service
3	Preparation of policies, guidelines and SOPs regarding anti-fraud	The hospital fraud prevention team does not have policies, guidelines, SOPs and work programs	The hospital fraud prevention team uses regulations issued by the central government	There are no policies, guidelines and SOPs regarding fraud prevention
4	Developing a fraud prevention culture	There is no program of activities to develop a culture of fraud prevention	There is no program of activities to develop a culture of fraud prevention	There is no program of activities to develop a culture of fraud prevention
5	Service Development Quality Control and Cost Control Oriented Health	Has clinical service guidelines and clinical pathways and carries out utilization reviews	Clinical service guidelines and clinical pathways have not been implemented and only fulfill accreditation standards	There is no integration of the use of clinical services and clinical pathwa with quality and cost control with accreditation standards

Establishment of An Anti-Fraud Prevention Team At The Hospital

Hospitals X, Y and Z have an Anti-Fraud Team consisting of medical personnel, financial personnel and casemix personnel. The Anti-Fraud Team was formed as a requirement that hospitals must fulfill in collaborating with BPJS Health. The anti-fraud team at Hospitals X, Y and Z was not formed through a leadership meeting but only through direct appointment by the hospital leadership. So in practice the anti-fraud team does not carry out its duties and functions as an anti-fraud team because it does not know the job description, authority and responsibilities of the anti-fraud team. The duties and functions of the anti-fraud team are: (1) Carrying out early detection of fraud based on data on health service claims made by FKRTL and forwarding suspected fraud to internal supervisors; (2) Implementing socialization

of new policies, regulations and culture oriented towards quality control and cost control; (3) Encourage the implementation of good organizational governance and clinical governance; (4) Improving the capabilities of coders, as well as doctors and other officials related to claims; (5) Monitoring and evaluating anti-fraud implementation; and (6) Reporting on anti-fraud implementation. (2019 n.d.).

The fraud control process will run well if a supportive atmosphere is created. This atmosphere must be built by the leadership of the organization (tone of the top). A leadership style that has a sense of integrity will encourage all subordinates to behave and work with integrity (AHIMA Foundation n.d.). In preventing JKN fraud, integrity in hospitals must begin to be demonstrated at the hospital director level as the highest leader. Hospital directors must set an example of integrity so that the JKN fraud prevention system works. Leadership commitment to controlling fraud must also be proven in the form of policies.

Socialization Or Training of The Anti-Fraud Team By The Regional Government, Especially The District/City Health Service

The hospital anti-fraud team never received outreach or training by the regional government or district/city health service. This shows that the role of local government, represented by the Health Service, is not running well. Based on Presidential Regulation no. 82 of 2018 article 99 paragraph 2 letter c and paragraph concerning improving Health services through the provision of Health Facilities, fulfilling minimum service standards, and improving the quality of health services (Peraturan Presiden No.82 Tahun 2018 n.d.).

Efforts to control fraud are due to the lack of knowledge of various related parties regarding the problem of fraud in health services. This also happens to health facility leaders who lack understanding of fraud control strategies (Grant TM 2017). Lack of knowledge about emerging forms of fraud, no prevention system and no sanctions. This situation will have an impact on increasing fraud cases (L 2013). Providing education to various parties regarding fraud is an important stage in building a culture of compliance and integrity in the health system in general, and specifically in the context of national health insurance (P 2013).

The education and training programs provided include regulations/policies, understanding, sanctions, coding, reporting, detection techniques and JKN fraud investigation techniques (National Healthcare Anti-Fraud Association (NHCAA) 2007). Providing education and training needs to be balanced with evaluation to ensure that all parties have received good education. Education and training must also be carried out on an ongoing basis (8). Other studies also show that health workers really need to be given a good understanding of the importance of compliance with work standards and ethics (Price, M&Norris 2009) (Rowe, J&Kellam n.d.).

Preparation of Anti-Fraud Policies and Guidelines

The hospital does not have policies, guidelines and Standard Operational Procedures (SOP) regarding anti-fraud because the team does not understand the job description, so the fraud prevention team does not develop or create guidelines that are used to carry out their duties. This shows that the fraud prevention team does not implement the principles of Good Corporate Governance and Good Clinical Governance which include: (1) determining the authority and job descriptions of health and non-health workers: (2) determining and implementing SOPs. To determine SOPs for clinical services, refer to the National Guidelines for Medical Services (PNPK) and/or other guidelines stipulated by the Minister of Health: (3) establish internal procedures for submitting claims

Developing an Anti-Fraud Culture

The results of the analysis show that there is no activity program to develop an anti-fraud culture in hospitals. The absence of a culture occurs because the fraud prevention team does not know the duties and functions of the fraud prevention team. Based on Permnkes 16 of 2016, it is explained that the fraud prevention culture program that must be implemented is (1) Signing and implementing an integrity pact for all FKRTL employees including elements of FKRTL leadership; (2) Establish and implement a professional code of ethics and standards of behavior for FKRTL employees; (3) Carrying out anti-fraud culture education to all FKRTL employees and FKRTL participants; (4) Socialization of anti-fraud activities at FKRTL

Leaders in the health sector must create a work culture that supports accountability and compliance with standards. Leaders must emphasize the importance of compliance with national and regional regulations. This emphasis must be realized in the form of communication and examples of appropriate behavior.

Developing Health Services That Are Oriented Towards Quality Control And Cost Control

The research results show that the hospital has clinical service guidelines and clinical pathways and has a quality and cost control team. Clinical service guidelines and clinical pathways are not integrated in providing quality health services. This regulation has explained that service development is oriented towards quality control and cost control, including: (1) Establishment of a quality control and cost control team; (2) Strengthening the duties and functions of the quality control and cost control teams; (3) Accurate competence and authority of health workers; (4) Implementation of service standards, clinical service guidelines, and clinical pathways and other guidelines at FKRTL; (5) Carrying out clinical audits and utilization reviews (UR) periodically; (6) Determination of claims procedures including analysis of claims data; (7) Monitoring and evaluating the performance of the quality control and cost control teams; (8) Application of quality management concepts in health services; (9) Use of evidence-based information technology that is capable of monitoring and evaluating Health Insurance services at FKRTL in real time.

CONCLUSION AND SUGGESTIONS

Evaluation of anti-fraud policies in improving the quality of hospital services does not run effectively from all policy components, namely; The formation of the Fraud Prevention Team, Hospitals' fraud prevention teams receive training or socialization on fraud prevention, Preparation of policies, guidelines and SOPs regarding anti-fraud, Developing a fraud prevention culture, Service Development Quality Control and Cost Control Oriented Health. The hospital does not yet have policy documents, fraud prevention guidelines and SOPs. The development of a fraud prevention culture has not been implemented and has carried out one of the health service development activities that is oriented towards quality control and cost control in the form of clinical service guidelines and clinical pathways but is not integrated with health service costs.

Increasing the role of the Fraud Prevention Team in accordance with Minister of Health Regulation no. 16 of 2019, health services or local governments need to initiate training or outreach regarding fraud prevention. As a reference for implementation, policy documents, fraud prevention guidelines and fraud SOPs need to be prepared. Hospitals need to develop a fraud prevention culture and integrate the development of health services that are oriented towards quality control and cost control.

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