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Fraud in Bpjs According To Ethics And Health Law No. 17 Of 2023

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Abstract: ***Background:*** *Fraud in the National Health Insurance (JKN) program managed by BPJS Kesehatan poses a serious challenge to maintaining the sustainability of healthcare services in Indonesia. This study aims to analyze the forms of fraud, their impact on the healthcare system, and prevention strategies based on ethical and regulatory perspectives, specifically Health Law No. 17 of 2023 and Minister of Health Regulation No. 16 of 2019.*

Methodology: *This study uses a normative legal approach with a descriptive-qualitative analysis method. Data were obtained through a literature review of applicable regulations, academic literature, and document analysis related to fraud in BPJS health. Primary legal sources include Health Law No. 17 of 2023 and various related regulations, while secondary sources consist of journal articles and research reports. The analysis was conducted by identifying fraud patterns, evaluating the effectiveness of supervision and administrative sanctions, and reviewing the role of technology in fraud mitigation.*

Results: *Research shows that BPJS health fraud occurs due to weak supervision, minimal participant literacy regarding rights and obligations, and gaps in the claims and verification system. Implementing an information technology-based anti-fraud system, participant education, and increased oversight are strategic steps to minimize fraud. With a multidisciplinary approach, it is hoped that the JKN system can function optimally, ensure transparency, and increase the accountability of healthcare providers*

Keywords: *Fraud, BPJS Health, National Health Insurance, Medical Ethics*

Abstract : **Latar Belakang:** Fraud dalam program Jaminan Kesehatan Nasional (JKN) yang dikelola oleh BPJS Kesehatan menjadi tantangan serius dalam menjaga keberlanjutan layanan kesehatan di Indonesia. Penelitian ini bertujuan untuk menganalisis bentuk fraud, dampaknya terhadap sistem kesehatan, serta strategi pencegahan berdasarkan perspektif etika dan regulasi, khususnya Undang-Undang Kesehatan No. 17 Tahun 2023 dan Peraturan Menteri Kesehatan No. 16 Tahun 2019.

Metodologi: Penelitian ini menggunakan pendekatan hukum normatif dengan metode analisis deskriptif-kualitatif. Data diperoleh melalui studi pustaka terhadap regulasi yang berlaku, literatur akademik, serta analisis dokumen terkait fraud dalam BPJS Kesehatan. Sumber hukum primer meliputi Undang-Undang Kesehatan No. 17 Tahun 2023 dan berbagai regulasi terkait, sedangkan sumber sekunder terdiri dari artikel jurnal dan laporan penelitian. Analisis dilakukan dengan mengidentifikasi pola fraud, mengevaluasi efektivitas pengawasan dan sanksi administratif, serta meninjau peran teknologi dalam mitigasi kecurangan.

Hasil : Penelitian menunjukkan bahwa fraud BPJS Kesehatan terjadi akibat lemahnya pengawasan, minimnya literasi peserta terkait hak dan kewajiban, serta adanya celah dalam sistem klaim dan verifikasi. Implementasi sistem anti-fraud berbasis teknologi informasi, edukasi peserta, dan peningkatan pengawasan menjadi langkah strategis dalam meminimalisir kecurangan. Dengan pendekatan multidisiplin, diharapkan sistem JKN dapat berfungsi optimal, memastikan transparansi, serta meningkatkan akuntabilitas penyelenggara layanan kesehatan.

Keywords: Fraud, BPJS Kesehatan, Jaminan Kesehatan Nasional, Etika medis

I. INTRODUCTION

Fraud is problem main in system service health in Indonesia, particularly in the National Health Insurance (JKN) program run by BPJS health. With the system economical payments , BPJS Health is organization in charge give service health to all over Indonesian society , whatever condition his finances .

However, due to the complexity of the system and the large number of claims handled, fraud often occurs, negatively impacting the government and the public. Participants, medical personnel, and healthcare providers are just a few groups that may be involved in fraud in this situation. The purpose of this article is to identify and evaluate cases of fraud in BPJS health from an ethical perspective and from a compliance perspective with the provisions of Health Law No. 17 of 2023.

II. PROBLEM

Fraud within BPJS health can occur in various forms, such as false claims, inappropriate use of healthcare facilities, or misuse of participant data for personal gain. This not only harms the state through wasted funds but also threatens the quality and sustainability of healthcare services for the public. One of the key issues arising in this situation is how to manage and stop fraud while still considering existing legal regulations, particularly those outlined in Health Law No. 17 of 2023, and ethical standards in healthcare delivery. Although BPJS health has implemented various prevention and control efforts, fraud remains an issue that requires significant attention.

Formulation of the Problem

1. How does fraud impact the sustainability of the National Health Insurance program?
2. What efforts has BPJS health made to prevent and handle fraud?
3. What is the role of supervision and sanctions in preventing STHM fraud in BPJS health?

III. DISCUSSION

Fraud within the BPJS health (Social Security Agency for Health) involves various aspects that require in-depth analysis. From an ethical perspective, fraud contradicts the basic principles of healthcare, such as fairness, transparency, and responsibility. Medical ethics require medical professionals and BPJS administrators to act with integrity and professionalism, so any action that harms others or the state can be categorized as an

ethical violation. In addition to violating social standards, the use of fraud by BPJS contradicts the organization's mission to provide equitable healthcare services to all. Indonesia.

The rights and responsibilities of JKN providers and participants are clearly outlined in Health Law Number 17 of 2023. Several articles of this law regulate the protection of participants' personal data, oversight of health services, and sanctions for misuse of the JKN program. These documents offer a strong legal basis for addressing BPJS fraud. Strict oversight and the imposition of severe penalties are believed to serve as a deterrent against fraudsters and prevent further abuse. Fraud prevention efforts can also be carried out through a more integrated information technology system, which can facilitate early detection of fraud committed by participants or health service providers.

Furthermore, public involvement in monitoring and reporting fraud is also a crucial step in addressing this issue. BPJS health (Social Security Agency for Health) needs to educate participants about their rights and obligations and increase transparency in the management of JKN funds. A secure and easily accessible reporting system can be one way to strengthen fraud prevention.

Regulation of the Minister of Health Number 16 of 2019.

In the implementation of the National Health Insurance (JKN) program, Minister of Health Regulation Number 16 of 2019 specifically regulates the prevention and handling of fraud and the application of administrative sanctions against it.

As the JKN program expands in scope, the potential for fraud increases. In addition to harming JKN customers, fraud in this program can also harm the state budget and lower healthcare standards. Therefore, strict regulations are needed to prevent and decisively address fraud in all its manifestations.

What is covered in the Minister of Health Regulation Number 16 of 2019?

The following topics are generally covered in these regulations:

- Definition of fraud: Explains in detail what is included in the category of fraud in the JKN program.
- Types of fraud: Identifying the different types of fraud that may occur, such as false claims, data misuse, and so on.
- Fraud prevention: Regulating preventive measures that must be taken by JKN program organizers, health facilities, and other related parties.
- Fraud handling: Explains the procedures for handling fraud cases, from reporting, investigation, to imposing sanctions.
- Administrative sanctions: Establishes various types of administrative sanctions that can be given to parties proven to have committed fraud.

Main Purpose of This Regulation:

- Preventing fraud: The JKN program is expected to prevent fraud by establishing clear regulations.
- Take strict action against fraudsters: Strict penalties will be imposed in accordance with relevant regulations for caught fraudsters.
- Ensuring the sustainability of the JKN program: The JKN program is expected to function effectively and sustainably by avoiding fraud and taking firm action against it.

Who Does This Rule Affect?

This regulation must be complied with by all parties implementing the JKN program, including:

- JKN Participants: JKN participants who commit fraud, such as falsifying information or making excessive claims.
- BPJS Kesehatan: As the organizer of the JKN program, BPJS Kesehatan is tasked with stopping and firmly combating fraud in all forms.
- Health care facilities: Health care facilities that collaborate with BPJS Kesehatan are required to implement fraud prevention measures.
- Drug and medical device providers: This rule also applies to drug and medical device providers who collaborate with BPJS Kesehatan.

WHY DOES THE KPK PRIORITIZE THE JKN PROGRAM AND THE HEALTH SECTOR?

- Many people's lives are at stake and more and more health budgets are involved.
- According to healthcare fraud data, there may be a 5% to 10% chance of irregularities in healthcare services.

Types of Healthcare Fraud

- The following is a summary based on PMK No. 16 of 2019:
    1. Participant.
    2. BPJS Health.
    3. Health center or service provider.
    4. Supplier of health supplies and medicines.
    5. As well as other interested parties

Causes of fraud

There are several fraud theories, including the Fraud Scale Theory, Diamond Fraud Theory, Triangle Fraud Theory, and Hexagon Fraud Theory. However, the author cites the Triangle Fraud Theory, where according to the concept of the fraud triangle or Cressey's Theory by Donald R. Cressey in 1953 with the publication entitled "Other's

People's Money: A Study in the Social Psychology of Embezzelent", the causes of fraud are:

• Pressure

• Opportunity

• Rationalization

ADMINISTRATIVE SANCTIONS RECOMMENDED BY THE FRAUD PREVENTION TEAM (SE MINISTER OF HEALTH No. HK.02.01/MENKES/1567/2024)

1. Warning in words.
2. Written warning.
3. An order to compensate the party harmed by fraud.
4. Additional administrative sanctions; or.
5. Sanctions range from revocation of permits to revocation of permits for health facilities or health service providers within the health facility environment.

Responsibilities of the FKRTL JKN Fraud Prevention Team (Article 20):

- Improve programming skills.
- Expanding the capacity of doctors and other staff regarding claims.
- Better administration of initiatives to identify fraud early (claims data analysis, investigations, and reporting of findings).
- Dissemination of new policies, rules and culture that focus on KMB (Quality Control, Cost Control).

ANTI-FRAUD SYSTEM IN THE JKN PROGRAM (MINISTRY OF HEALTH REGULATION NO. 19/2016)

1. PREVENTION: preparation of policies/guidelines, Fraud prevention culture, formation of Fraud Prevention Team and Quality Control Cost Control.
2. DETECTION: utilization of data analysis results and utilization of information systems.
3. HANDLING: Joint external action against fraud.

POWER TO IMPLEMENT SANCTIONS

Administration (through the Head of the Provincial/City/District Health Service and the Minister)

1. Issue a verbal warning.
2. Give a written warning.
3. Return the loss to the injured party.
4. Administrative sanctions.

5. Revocation of SIO/SIP.

Preventing fraud in BPJS health requires more systematic and comprehensive efforts, involving increased oversight, technology utilization, and strict law enforcement. With better policy implementation, broader education, and solid collaboration between all parties, it is hoped that the JKN system will function optimally, provide maximum benefits to participants, and maintain the sustainability and integrity of the national health insurance program.

IV. CONCLUSION

Fraud in BPJS health is a serious issue and requires attention from all parties involved, including the government, healthcare providers, and participants themselves. Based on ethical research and the requirements of Health Law No. 17 of 2023, fraud undermines the fundamental principles of healthcare services, including public funds. Therefore, that, is necessary effort extensive for prevent and address fraud, including supervision strict, use technology, and improve knowledge and involvement society. Every participant must act honorable and obedient condition relevant laws for create system service transparent and fair health .

The government's efforts to maintain the integrity of the JKN program are reflected in the Minister of Health Regulation Number 16 of 2019. This regulation is expected to improve the implementation of the JKN program and maximize benefits for each participant.

Would you like to know more specifically about a particular part of this regulation? For example, you could ask about:

- Types of administrative sanctions given: What sanctions can be given to perpetrators of fraud?
- Fraud reporting procedures: How to report a fraud case?
- The role of BPJS health in preventing fraud: What does BPJS health do to prevent fraud?

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