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QUALITATIVE STUDY OF FRAUD IN HEALTH SERVICES AND LEGAL FRAMEWORK IN INDONESIA: A LITERATURE REVIEW

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Abstract

Health sector fraud is a significant global challenge that undermines health systems by exploiting financial gains through methods like upcoding and false insurance claims. Despite legal updates, healthcare fraud remains a persistent issue. This study systematically examines fraud detection techniques and the legal framework, providing insights to guide policymakers in developing effective prevention strategies in Indonesia. This research employs a doctrinal research methodology with a literature review approach. Using secondary data from Scopus, PubMed, ScienceDirect, and Google Scholar, this study investigates the patterns, causes, and effects of fraud in the Indonesian healthcare system. This paper reviews nine selected articles and compares them with updated Indonesian legal instruments, mainly Law No. 17 of 2023 on Healthcare and Law No. 1 of 2023 on Criminal Code. The findings demonstrate that although legislative reforms have introduced stricter provisions, their implementation remains inconsistent due to lack of oversight and technology. This study proposes integrative strategies, such as digital audit systems, strengthening legislation, and public reporting mechanisms, to improve fraud prevention. It contributes to the debate by identifying gaps in enforcement and proposing regulatory and technological solutions to strengthen the transparency and integrity of the Indonesian healthcare system.

Keywords: *Fraud; Healthcare Services; Legal Framework.*

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1. Introduction

Fraud in healthcare has become a global problem, posing significant challenges to healthcare systems, especially in developing countries such as Indonesia. The complexity and scale of healthcare systems create opportunities for exploitation. Fraud in healthcare facilities is characterized by dishonest practices by healthcare providers, patients, or even insurance companies, aimed at obtaining unlawful financial or personal gain. This not only results in financial losses for governments and insurance companies, but also affects the quality of healthcare delivery, patient outcomes, and the level of public trust in the healthcare system.

Based on data from the Report to The Nations 2024 issued by the Association of Certified Fraud Examiners, there were at least 1921 fraud cases in 138 countries with fraud cases in health services as many as six percent (117 cases) of the total cases. According to the ACFE, fraud cases themselves are divided into three causes including Corruption (64.4%), Misuse of State Assets or Wealth (29.9%), and Financial Report Fraud (6.7%). According to the survey results, 67.4 percent of Financial Report Fraud cases were found to be less than 10 million per case. This reflects examples of fraud cases that occur in health services such as upcoding services and inappropriate BPJS claims.[1]

According to ACFE data from year to year, fraud cases worldwide in 2016 there were 144 cases in healthcare from a total of 2410 cases, while in 2024 there were 117 cases in healthcare from a total of 1921 cases. Although the data showed an increase in the number of cases in 2018, which was 2690, the graph from 2016 to 2024 showed a downward trend.[2] However, fraud cases that occur in Indonesia are still very high according to surveys conducted by several agencies and organizations. According to the 2023 KPK Report, there were three cases of phantom billing from six inspected hospitals with a total loss of IDR 35 billion (around USD 2.15 million) related to JKN. In addition, of the 4,341 claims submitted by the hospital, only 1,072 claims (around 24%) were supported by medical record data, indicating more claims were inappropriate.[3]

Fraud in healthcare can take many forms, including billing for services not rendered, falsifying patient records, upcoding (charging for services that are more expensive than those provided), and providing unnecessary medical care. Some examples of healthcare fraud that have occurred include submitting claims to companies or government programs (such as BPJS Kesehatan) for care or services that were not actually provided. This is one of the most common and frequent forms of fraud that causes significant losses to insurance companies and patients. In addition, in some cases, providers perform medical procedures (such as tests, treatments, surgeries) that are not needed by the patient just to gain financial gain. This type of fraud not only causes financial loss but also puts patients at risk of harm due to unnecessary procedures. Fraud cases can also be carried out by patients or recipients of healthcare services, for example by carrying out bribery practices in order to get the results they want (such as sick leave letters, laboratory test results, or other personal interests). These activities not only burden the health care system financially, but also erode public trust, compromise patient safety, and create inefficiencies in health care delivery.[4]

In Indonesia, cases of fraud in healthcare services have become increasingly problematic with the development of national health insurance programs such as BPJS Kesehatan (Social Security Administering Agency), a national health insurance program designed to provide affordable healthcare for millions of citizens. The financial incentives associated with these programs have, in some cases, led to exploitative practices, where healthcare providers, either intentionally or due to systemic weaknesses, engage in fraudulent activities. This results in huge state losses, estimated to reach billions of rupiah annually. Moreover, these fraudulent acts have direct and indirect impacts on patient care, where health outcomes are potentially compromised by unnecessary or falsified care. Several cases of fraud in healthcare have been reported in recent years, exposing systemic vulnerabilities.[5]

One of the most significant cases in 2018 involved several public hospitals that were found to have overbilled BPJS Kesehatan. The hospitals in question billed for more expensive procedures, such as surgeries and higher-level diagnostic tests, while only providing basic or

[1] ACFE, "Survei Fraud Indonesia 2019" (Jakarta, May 2020), https://acfe-indonesia.or.id/wp-content/uploads/2021/02/SURVEI-FRAUD-INDONESIA-2019.pdf.

[2] ACFE, "Report to the Nations on Occupational Fraud and Abuse," 2016, https://www.acfe.com/fraud-resources/report-to-the-nations-archive; ACFE, "Report to the Nations 2018 Global Study on Occupational Fraud and Abuse," 2018, https://www.acfe.com/fraud-resources/report-to-the-nations-archive; ACFE, "Report to the Nations 2020 Global Study on Occupational Fraud and Abuse," 2020, https://legacy.acfe.com/report-to-the-nations/2020/; ACFE, "Occupational Fraud 2022: A Report to the Nations," 2022, https://acfepublic.s3.us-west-2.amazonaws.com/2022+Report+to+the+Nations.pdf; ACFE, "Occupational Fraud 2024: A Report to the Nations," 2024, https://legacy.acfe.com/report-to-the-nations/2024/.

[3] KPK, "Laporan Tahunan KPK 2023" Link .... ? (Jakarta, 2023).

[4] Siti Kustinah, "Investigating Fraud and Corrupt Practices in Indonesia," *Journal of Governance* 7, no. 1 (April 20, 2022), https://doi.org/10.31506/jog.v7i1.14520.

[5] Ridwan et al., "Fraud Prevention System with Whistleblowing System in Health Services: A Systematic Review," *Jurnal Jaminan Kesehatan Nasional* 4, no. 1 (June 30, 2024): 13–25, https://doi.org/10.53756/JJKN.V4I1.182.

routine care. An investigation by the Ministry of Health found substantial discrepancies in billing records that resulted in financial losses for the BPJS system.[6]

These cases underscore systemic weaknesses in monitoring, enforcement, and auditing within Indonesia's health care system. While significant efforts have been made to address fraud, some health care providers persist in exploiting loopholes, exacerbating the financial strain on the national health budget and jeopardizing the quality of patient care.

The novelty of this article lies in its comprehensive analysis of emerging fraud patterns in Indonesia's health care system, which have not been adequately explored in previous studies. Unlike prior research that focuses primarily on general policy shortcomings, this study provides specific insights into how fraudulent practices evolve in response to regulatory changes. Additionally, the authors propose a unique framework for integrating advanced auditing technologies with community-based monitoring systems, offering practical solutions to mitigate fraud while ensuring equitable access to quality health care.

To address this issue, the Indonesian government enacted Law No. 17 of 2023 on Health, which provides a comprehensive legal framework to regulate and oversee the health care sector. Among its various provisions, the law includes explicit steps in defining legal obligations, penalties or consequences, and the institutional framework needed to combat fraud and corruption in health services.

In addition, Law No. 17 of 2023 discusses the penalties and legal consequences for health service providers who are found guilty of fraudulent activities. The law also authorizes supervisory institutions, such as the Ministry of Health and BPJS, to audit and investigate potential fraud cases, in order to ensure accountability in the public and private health service sectors.

In addition to these legal mechanisms, the law also encourages the development of digital health records and billing systems to minimize human error and manipulation, thereby reducing the opportunity for fraudulent activities. For example, the use of electronic health records (EHR) and automated billing systems.

Despite these provisions, challenges remain in the full implementation and enforcement of the law. Limited resources, inconsistent oversight, and the complexity of health care delivery have created loopholes that continue to be exploited by some providers. This study aims to explore these issues by conducting a literature review of health care fraud cases in Indonesia. It will also examine the effectiveness of Law No. 17 of 2023 in addressing these challenges and propose recommendations to strengthen regulatory enforcement and increase transparency in health care practices.

Through a qualitative analysis of existing fraud cases and an evaluation of the legal framework, this study seeks to address a critical research problem: the lack of understanding regarding the root causes of fraud in the Indonesian healthcare system and the challenges in enforcing legal provisions to mitigate it. By bridging the gap between theory and practice, the study aims to uncover the underlying causes of fraud and evaluate the effectiveness of Law No. 17 of 2023 in addressing these issues. The findings will not only enhance our understanding of how fraud occurs but also provide practical insights to strengthen enforcement efforts, ultimately protecting patients, service providers, and the integrity of the healthcare system.

2. Method

This article adopts a doctrinal research method, utilizing a literature review as the research approach. Data were gathered from internationally reputable journals and various databases, including Scopus, PubMed, ScienceDirect, and Google Scholar, as secondary data sources. The sociological method examines the real-world implications of legal frameworks, while the normative method analyzes the legal principles and rules related to fraud in the healthcare system. The literature review serves as a tool to synthesize and critically evaluate existing studies to support the analysis. The keywords used are "Fraud " AND "Health care" AND "Fraud

[6] Rizki Nurul Fatimah, Misnaniarti, and Risma Adlia Syakurah, "Potential Fraud in The Implementation of National Health Insurance in The Health Sector: Systematic Review," *JMMR (Jurnal Medicoeticolegal Dan Manajemen Rumah Sakit)* 10, no. 3 (2021): 255–70, https://doi.org/10.18196/JMMR.V10I3.10825.

Detection". Furthermore, the study title, abstract, and access of the study were examined. Studies or articles that did not meet the inclusion criteria were excluded from the research data. Full access articles from the included publications were reviewed to verify their eligibility.

This research article uses a qualitative cross-study type of research that applies a normative method and content analysis by combining sources from research articles and the legal framework applicable in Indonesia. The inclusion criteria for this study include studies written in English and accessible for review. The articles must be from internationally reputable journals, such as those indexed in Scopus or Web of Science/Thomson Reuters, or from nationally reputable journals such as Sinta. The focus of the articles is to identify fraud incidents in healthcare facilities. The exclusion criteria for this study are articles published within the last 10 years (since this literature review was conducted), abstract-only articles (non-full text), and literature studies, systematic reviews, or meta-analyses. This literature review conducted data extraction using the Prisma flowchart. All included articles underwent eligibility and quality control checks before being reviewed for fraud cases in health services.

3. Results and Discussion

A total of 861 articles were obtained using four databases, including Scopus, PubMed, Sciencedirect, and Google Scholar secondary data. After further identification and elimination of exclusion criteria, 9 articles were selected for further study in this literature review.

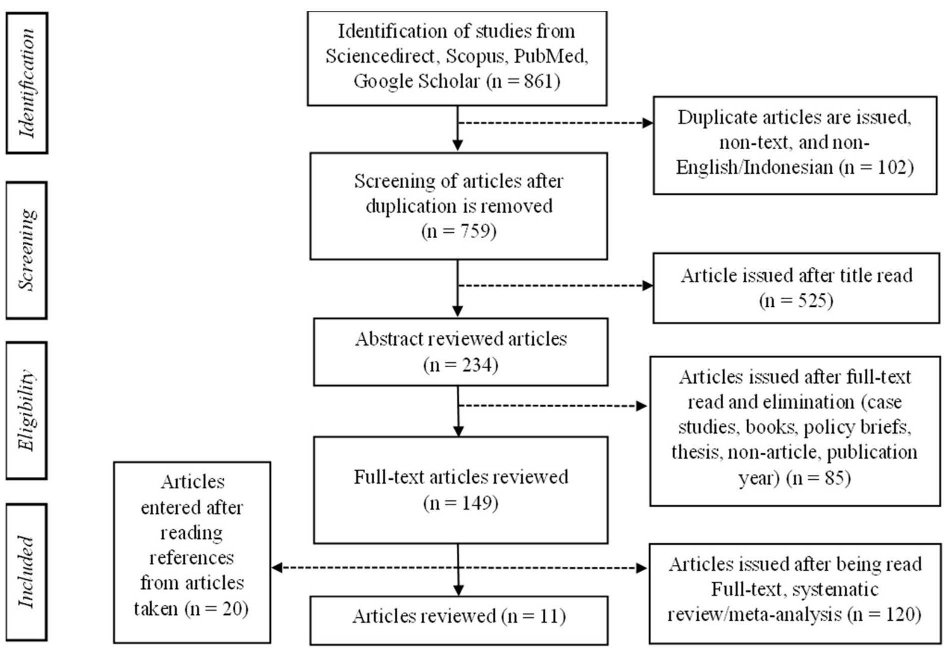

Figure 1. Prisma flow chart

Based on the results of a literature study that included 11 selected publications[7], numerous research have been conducted to investigate and identify fraud issues in healthcare services,

[7] Solehuddin Solehuddin, Ladito Risang Bagaskoro, and Ria Casmi Arrsa, "Fraud Prevention Strategy Framework Related to Government Inventory Towards Good Governance," *Mendapo: Journal of Administrative Law* 4, no. 2 (June 1, 2023): 106–33, https://doi.org/10.22437/MENDAPO.V4I2.24782; Tatik Sri et al., "PENCEGAHAN KECURANGAN (FRAUD) DALAM PELAKSANAAN PROGRAM JAMINAN KESEHATAN PADA SISTEM JAMINAN SOSIAL KESEHATAN (SJSN) (Studi Di Rumah Sakit Umum Daerah Menggala Tulang Bawang)," *Fiat Justisia: Jurnal Ilmu Hukum* 10, no. 4 (May 29, 2016): 715–32, https://doi.org/10.25041/FIATJUSTISIA.V10NO4.808; Hossein Joudaki et al., "Improving Fraud and Abuse Detection in General Physician Claims: A Data Mining Study," *International*

particularly those related to health insurance and medical service claims. The Attributed Heterogeneous Information Networks (AHIN) model successfully detects intricate fraud patterns by looking at interactions between patients, service providers, and other connected entities. These studies also showcase novel approaches to fraud detection. However, because of the intricacy of the algorithm used, the primary difficulty is putting this model into practice on a large data scale.

Furthermore, it has been demonstrated that outlier detection techniques can identify fraud patterns that traditional methods are unable to identify. Additionally, they are quite successful at identifying questionable claims in vast amounts of data, such Medicaid dental claims. Other studies that stress the importance of data mining, unsupervised learning, and sequence mining techniques to identify data upcoding and fraudulent transactions specifically highlight the need for an automated and comprehensive system to reduce financial losses resulting from fraud in the healthcare industry.

Examples of cutting-edge technologies that have been tested to identify fraudulent activity on health crowdfunding websites, doctor-pharmacist collaboration, and false claims in the Medicare and SJSN systems include neural networks, graph attention networks, and hybrid models. As a result, these AI-based techniques can increase the effectiveness of monitoring and the precision of detection; nevertheless, in reality, there are still barriers to their widespread use and advancement.However, as mandated by Law No. 17 of 2023 concerning Health and Law No. 1 of 2023 concerning the Criminal Code, fraud prevention necessitates not only technology but also strengthening governance, internal audits, data monitoring, and strict enforcement of regulations and legal sanctions, as highlighted by multiple studies. Since the primary weaknesses for fraud are inadequate oversight, data integrity, and stakeholder coordination, prevention measures need to be thorough and integrated.

Overall, the literature highlights that efforts to prevent fraud in health services necessitate a multidisciplinary strategy that incorporates technological innovation, bolstering internal control systems, and a clear and strict legal framework. This holds true for both technology and government. This is important to ensure the sustainability, efficacy, and public trust in Indonesia's healthcare system, as well as to close several gaps that still allow fraud to occur in the future.

3.1. Fraud in Health Services

3.1.1. Fraud

Fraud is defined as an intentional deception intended to gain personal and unlawful advantage over another person or organization. Fraud involves misrepresenting information or concealing facts with the intent to deceive another party. Fraud can result in financial loss for the

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Journal of Health Policy and Management 5, no. 3 (2016): 165–72, https://doi.org/10.15171/ijhpm.2015.196; Jiangtao Lu et al., "Health Insurance Fraud Detection by Using an Attributed Heterogeneous Information Network with a Hierarchical Attention Mechanism," *BMC Medical Informatics and Decision Making* 23, no. 1 (December 1, 2023), https://doi.org/10.1186/s12911-023-02152-0; Guido van Capelleveen et al., "Outlier Detection in Healthcare Fraud: A Case Study in the Medicaid Dental Domain," *International Journal of Accounting Information Systems* 21 (June 1, 2016): 18–31, https://doi.org/10.1016/j.accinf.2016.04.001; R. Bauder, T.M. Khoshgoftaar, and N. Seliya, "A Survey on the State of Healthcare Upcoding Fraud Analysis and Detection," *Health Services and Outcomes Research Methodology* 17, no. 1 (2017): 31–55, https://doi.org/10.1007/s10742-016-0154-8; J.M. Johnson and T.M. Khoshgoftaar, "Medicare Fraud Detection Using Neural Networks," *Journal of Big Data* 6, no. 1 (2019), https://doi.org/10.1186/s40537-019-0225-0; M.E. Haque and M.E. Tozal, "Identifying Health Insurance Claim Frauds Using Mixture of Clinical Concepts," *IEEE Transactions on Services Computing* 15, no. 4 (2022): 2356–67, https://doi.org/10.1109/TSC.2021.3051165; I. Matloob et al., "A Sequence Mining-Based Novel Architecture for Detecting Fraudulent Transactions in Healthcare Systems," *IEEE Access* 10 (2022): 48447–63, https://doi.org/10.1109/ACCESS.2022.3170888; J. Choi, J. Kim, and H. Lee, "Hybrid Fraud Detection Model: Detecting Fraudulent Information in the Healthcare Crowdfunding," *KSII Transactions on Internet and Information Systems* 16, no. 3 (2022): 1006–27, https://doi.org/10.3837/tiis.2022.03.014; S. Mardani and H. Moradi, "Using Graph Attention Networks in Healthcare Provider Fraud Detection," *IEEE Access*, 2024, https://doi.org/10.1109/ACCESS.2024.3425892.

victim and unjust enrichment for the perpetrator.[8] According to the Association of Certified Fraud Examiners (ACFE), fraud encompasses a range of prohibited behaviors including theft, embezzlement, forgery, and false pretenses. The intent behind fraud distinguishes it from other unethical practices; fraud is not simply an error or omission, but a deliberate act carried out to mislead others for personal gain. Fraud can manifest itself in a variety of sectors including finance, insurance, commerce, and healthcare, each with its own unique characteristics and consequences.[9]

The potential for fraud can arise if there are opportunity factors, pressure factors, rationalization factors, arrogance factors, and ability factors according to the Pentagonal Fraud theory. This Pentagonal Fraud theory is built on the traditional Triangle Fraud theory by adding two new aspects, competence and arrogance. The pressure aspect is an external force that drives someone to commit fraud, such as financial pressure.[10] The opportunity aspect is a situation that allows fraud to occur, including poor internal control measures. The rationalization aspect is a method of justification used to excuse fraudulent acts, such as blaming the previous audit. The competence aspect is an individual's ability to commit fraud, sometimes related to changes in leadership in a company. And the arrogance aspect is a mindset that makes people believe that they are beyond responsibility, which causes them to ignore the rules.[11]

Fraud is classified as civil or criminal. Civil fraud causes financial loss without criminal charges, like falsifying income on a loan. Criminal fraud breaks the law and can lead to prosecution and imprisonment. Financial fraud includes embezzlement (misusing entrusted funds) and securities fraud (misleading investors), both causing major financial and reputational harm. Identity theft happens when criminals steal personal data (e.g., Social Security numbers, credit cards) to open accounts or secure loans fraudulently. The FTC reports that millions of Americans face identity theft yearly, with cybercriminals exploiting personal data for illegal financial gain.[12]

Insurance fraud can be committed by individuals, organizations, or even healthcare and insurance staff. It happens when someone provides false information to get undeserved benefits, like fake medical claims or inflated damages. The National Insurance Crime Bureau reports that fraud costs consumers billions yearly. Hospitals, clinics, or their staff may manipulate claims for financial gain, while insurance members may exploit the system. Fraud varies by role, making it complex. Healthcare fraud is especially concerning as it raises costs and affects patient care, including billing for unprovided services, upcoding, and false claims to programs like Medicare and Medicaid.[13]

3.1.2. Impact of Fraud

The impact of fraud is significant across sectors. In the United States alone, it is estimated that healthcare fraud costs the system approximately $455 billion (IDR 4 quadrillion) annually. This represents a significant portion of total healthcare spending, which is approximately $7.35 trillion (IDR 114 quadrillion) worldwide. The impact extends beyond financial losses; it can

8 Andi Yaumil Bay R. Thaifur et al., "How to Detect Healthcare Fraud? 'A Systematic Review,'" *Gaceta Sanitaria* 35 (January 1, 2021): S441–49, https://doi.org/10.1016/j.gaceta.2021.07.022.

9 Yuriy Timofeyev and Mihajlo Jakovljevic, "Editorial: Fraud and Corruption in Healthcare," *Frontiers in Public Health* 10 (June 1, 2022): 921254, https://doi.org/10.3389/FPUBH.2022.921254.

10 Fera Tjahjani et al., "Fraud Pentagon Theory: Indication Toward Fraudulent Financial Reporting on Non-Banking Sector," *Business and Accounting Research (IJEBAR) Peer Reviewed-International Journal* 6 (2022), https://doi.org/https://doi.org/10.29040/ijebar.v6i3.6026.

11 Dewi Masitah, "Analysis of the Effect of Fraud Pentagon on Financial Statement Fraud Using M-Score and F-Score," *Indonesian Journal of Innovation Studies* 25, no. 4 (June 14, 2024), https://doi.org/10.21070/ijins.v25i4.1142.

12 Natalis Christian and Piere Ricardo, "Kajian Impact of Fraud: Nasional Dan Internasional," *Jurnal Ilmiah Manajemen, Ekonomi, & Akuntansi (MEA)* 6, no. 2 (May 15, 2022): 102–17, https://doi.org/10.31955/MEA.V6I2.1978.

13 Johnson and Khoshgoftaar, "Medicare Fraud Detection Using Neural Networks."

undermine trust in institutions, lead to increased regulatory scrutiny, and result in legal consequences for those involved in fraudulent activities.[14]

Fraud has serious social effects. When organizations commit fraud, they promote corruption and weaken public trust in both government and private institutions. This loss of trust can harm communities and economic stability over time. In Indonesia, fraud causes major financial losses. Individuals may suffer personal financial damage, lower credit scores, and difficulty getting loans or mortgages. Businesses face financial losses, reputational harm, and lost customer trust. A Flagright report warns that increasing online and cyber fraud, driven by financial digitalization, threatens Indonesia's financial sector. [15]

Financial fraud in Indonesia is committed by individuals, organized crime groups, and international cybercriminals. Many exploit digital platforms and public ignorance of security risks. Individual fraudsters take advantage of weak security systems through phishing, identity theft, or fake investments. Organized crime syndicates run large-scale scams like money laundering, fake businesses, and illegal online trading. Cybercriminals pose a major threat, using hacking, ransomware, and phishing to steal sensitive data, causing financial losses. Identifying these perpetrators is essential to developing effective fraud prevention strategies.[16]

Widespread fraud weakens trust in financial institutions and slows economic growth. The Indonesian Financial Services Authority (OJK) warns that financial crime deters foreign investment and stifles innovation. The true cost of economic crime is likely much higher due to underreporting and low fraud awareness. In Indonesia's healthcare sector, fraud occurs in hospitals and advanced facilities, involving management or medical personnel through phantom billing, fee mark-ups, fictitious claims, and misuse of capitation funds and insurance claims.[17]

Fraud has a significant impact beyond financial losses, creating distrust among consumers and businesses. When people lose confidence in financial institutions and government agencies due to widespread fraud, economic participation declines. This is especially concerning in Indonesia, where trust in institutions is already weak. A survey shows that 39% of companies face corruption and bribery as common issues. Corruption in public and private sectors also lowers employee and civil servant morale. Research shows that when corruption becomes part of an organization's culture, unethical behavior is tolerated or expected, making fraud harder to prevent.[18]

Indonesia struggles to combat healthcare fraud due to weak regulations, affecting care quality, finances, and public trust. False medical claims are a major issue, with providers overcharging, billing for unprovided services, or misreporting care to BPJS Kesehatan, wasting public funds. Misuse of medical supplies and drugs also occurs, inflating costs and limiting access for the poor. Weak oversight worsens the problem, as poor transparency and lack of public-private collaboration hinder enforcement. Cultural factors contribute, with some justifying fraud due to system failures, while rapid healthcare growth outpaces regulation. Stronger oversight, transparency, and accountability are needed, requiring collaboration between the government, private sector, and civil society to improve fraud prevention.[19]

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14 R.A. Bauder and T.M. Khoshgoftaar, "The Effects of Varying Class Distribution on Learner Behavior for Medicare Fraud Detection with Imbalanced Big Data," *Health Information Science and Systems* 6, no. 1 (2018), https://doi.org/10.1007/s13755-018-0051-3.

15 Putri Galuh Inggi and Anhari Achadi, "Evaluation of Fraud Prevention Policies in the National Health Insurance System in Indonesia: Narrative Literature Review," *Media Publikasi Promosi Kesehatan Indonesia (MPPKI)* 7, no. 10 (October 5, 2024): 2449–57, https://doi.org/10.56338/mppki.v7i10.6164.

16 Syafrawati Syafrawati et al., "Incidence and Root Cause of Upcoding in The Implementation of Social Health Insurance in Rural Province Hospital in Indonesia," *Asia Pacific Fraud Journal* 5, no. 1 (June 20, 2020): 56, https://doi.org/10.21532/apfjournal.v5i1.135.

17 Else Nur Fitriana and Indrawati Yuhertiana, "Analysis of Fraud in the Indonesian Public Sector through Three Behavioral Lenses," *National Conference on Accounting and Fraud Auditing* 2, no. 2 (2020), https://doi.org/doi.org/10.31326/.v2i2.783.

18 Dara Pustika Sukma, Adi Sulistiyono, and Widodo Tresno Novianto, "Fraud in Healthcare Service," *SHS Web of Conferences* 54 (2018): 03015, https://doi.org/10.1051/shsconf/20185403015.

19 Inggi and Achadi, "Evaluation of Fraud Prevention Policies in the National Health Insurance System in Indonesia: Narrative Literature Review."

3.2. Legal Framework in Indonesia

3.2.1. Law Number 17 of 2023 concerning Health

This legal framework regulates health by setting limits on the terms used in its regulation. This law came into effect on August 8, 2023 with a legal basis including the 1945 Constitution of the Republic of Indonesia, Article 3, 4, 5, 9, 29, 177-178, and Article 350-351 of Law No. 17 of 2023. This law provides legal certainty and consequences for violators of the law such as fraud or other fraud in the health sector.[20]

Manipulating medical records is a common form of fraud, where patient data is altered to show more expensive or invasive treatments than actually performed. This violates Article 29 of Law No. 17 of 2023, which stresses the need for accurate and uniform medical records, as well as professionalism in healthcare. For example, in a Jakarta hospital, a doctor and administrative staff falsified records to claim certain surgeries were performed when they were not. This led BPJS Kesehatan to overpay significantly. A 2023 Indonesian Health Ministry report states that such fraud harms the financial stability of health insurance and reduces public trust in healthcare. This case highlights the rise of healthcare fraud in Indonesia, where providers manipulate records, bill for unperformed services, or inflate costs. The impact goes beyond financial losses, damaging the credibility and trust in the health system.[21]

To prevent fraud, Article 3 of Law No. 17 of 2023 stresses the need for effective and efficient health resource management. Transparent and accountable health fund management is also essential to reduce financial fraud. Article 4 states that fraud in health services violates human rights, including the right to safe, quality, and affordable healthcare. Patients often suffer from fraud, such as false claims, which compromise service quality. Article 5 requires healthcare providers to deliver quality services, a duty often breached through fraud like medical record manipulation. Article 6 reinforces the importance of accountability and transparency in healthcare, which fraud, such as data manipulation or false claims, directly undermines, further eroding public trust.[22]

Law No. 17 of 2023 also regulates the responsibilities of healthcare providers regarding the Health Information System (Articles 350–351) and Data and Information Protection (Articles 177 and 351). Providers must ensure patient data security and maintain a reliable health information system. Poor system management can lead to fraud, such as data manipulation for inflated claims. For example, hospital staff at a private hospital exploited weaknesses in the system to submit excessive claims, far exceeding actual costs. Similarly, Article 178 mandates healthcare facilities to uphold service quality and report patient safety issues. However, some facilities commit fraud by falsifying or concealing reports. A clinic, for instance, was caught hiding malpractice cases and altering medical records to avoid financial and legal consequences. Such actions damage public trust and threaten the integrity of the healthcare system.[23]

The sanctions in this law are strict, imposing heavy penalties on health facilities that fail to meet service quality and patient safety standards. These penalties include fines, license suspension, or even permanent revocation to ensure accountability, patient welfare, and public trust. Law No. 17 of 2023 provides a strong legal framework to prevent and address healthcare fraud while regulating other health sector issues. However, effective enforcement requires consistent implementation, strict supervision, and collaboration among the government, healthcare providers, medical personnel, patients, and all related parties.[24]

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20 Republik Indonesia, “Undang-Undang (UU) Nomor 17 Tahun 2023 Tentang Kesehatan,” Pub. L. No. 17 (2023), https://peraturan.bpk.go.id/details/258028/uu-no-17-tahun-2023.
21 Republik Indonesia.
22 Republik Indonesia.
23 Republik Indonesia.
24 Republik Indonesia.

3.2.2. Law No. 1 of 2023 on the Criminal Code

Health care fraud cases in Indonesia are a serious problem that requires strong legal intervention because they harm many parties and endanger the integrity of the health care system as a whole. Various types of fraud-related crimes are regulated in Law Number 1 of 2023 concerning the Criminal Code (KUHP), including those that occur in the health care industry.

Article 492 states that “any person who intentionally benefits himself or another person unlawfully, by using a false name or fraud, can be subject to a maximum imprisonment of four years.” An example of a case related to this article involves submitting a false claim to BPJS Kesehatan or other insurance companies, where medical personnel can bill for services that were never provided. In this situation, medical personnel committing fraud, such as phantom billing (submitting a bill for services that were never provided) or upcoding (increasing the diagnosis code to receive a larger reimbursement), can be charged under this article.

Fraud involving goods or services is covered in Article 493, which states that fraud in this area can lead to up to five years in prison. This applies to healthcare providers who falsely claim to use expensive medicines or medical devices. Article 395 regulates medical certificate forgery, stating that doctors who issue false health or death certificates can face up to four years in prison. If a falsified certificate is used to place or keep someone in a mental hospital, the penalty increases to eight years. This law targets fraud in medical records, especially for insurance claims.[25]

In addition, Article 396 also relates to falsification of medical certificates. This article indicates that patients who apply for a false medical certificate can be subject to legal sanctBellions. Patients who falsify a medical certificate to obtain permission to be absent from work or mislead officials can be subject to legal sanctions of imprisonment for a maximum of three years and six months.[26]

3.3. Fraud Prevention Strategy by Legal Framework and Technological Development

Health fraud occurs when healthcare workers seek illegal financial gains, such as inflating insurance claims, overusing services, or falsifying patient data. The issue becomes more complex when institutions pressure their staff to commit fraud for profit. While such cases in Indonesia are not widely exposed, unethical practices have been reported. These actions harm public health and strain government budgets, highlighting the need for stricter regulations and oversight. To combat fraud, strategies include whistleblowing systems that allow employees to report misconduct while ensuring confidentiality and protection. Digitalizing healthcare can also enhance accountability and transparency. Technology-based audits, digital patient records, and automated claim processing help detect fraud early and improve oversight. An integrated and transparent system is key to reducing fraud effectively.[27]

In addition, regulatory frameworks play a critical role in combating fraud. Legal frameworks such as laws serve as critical tools to address healthcare fraud by sanctioning individuals or entities that submit false claims or upcode for reimbursement. The effectiveness of these measures relies heavily on collaboration between stakeholders—including government agencies, healthcare providers, insurers, and law enforcement—to create a comprehensive approach to combating fraud.[28]

Fraud prevention is a key part of Indonesia's health service regulations. Law No. 17 of 2023 on Health stresses the need for integrity and provides a legal basis to prosecute violations. Fraud

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25 Republik Indonesia, “Undang-Undang (UU) Nomor 1 Tahun 2023 Tentang Kitab Undang-Undang Hukum Pidana,” Pub. L. No. 1 (2023), https://peraturan.bpk.go.id/Details/234935/uu-no-1-tahun-2023.

26 Republik Indonesia.

27 Masitah, “Analysis of the Effect of Fraud Pentagon on Financial Statement Fraud Using M-Score and F-Score.”

28 A.J. Mary and S.P.A. Claret, “Imbalanced Classification Problems: Systematic Study and Challenges in Healthcare Insurance Fraud Detection,” in *Proceedings of the 5th International Conference on Trends in Electronics and Informatics, ICOEI 2021*, 2021, 1049–55, https://doi.org/10.1109/ICOEI51242.2021.9452828.

cases involving digital and consumer issues are also governed by other regulations. However, enforcement faces challenges. Weak monitoring and lack of transparency in claims make fraud detection difficult. To address this, the government must strengthen regulations and oversight. Stricter penalties, such as heavy fines or criminal charges, are needed to deter fraud. Reducing fraud requires not just regulations but also strong enforcement. Law enforcers need clear authority and adequate resources. Collaboration between the Ministry of Health, BPJS, and law enforcement must improve to ensure violations are properly addressed. [29]

4. Conclusion

This qualitative study highlights that fraud remains a persistent issue in health services, involving health service providers, medical personnel, and patients. These fraudulent activities result in financial losses and degrade the quality of health services provided to the community. Indonesian Law No. 17 of 2023 addresses fraud through several articles (3, 4, 5, 6, 177, 178, 350, and 351), offering a comprehensive legal framework. However, the lack of consistent and firm enforcement has allowed fraud to persist. To effectively combat this issue, it is essential to address the gaps in the legal system and adapt it to contemporary challenges. For these measures to have a deterrent effect, they must be enforced rigorously and consistently. The future development of safe and clean health services hinges on the establishment of a stricter legal framework, enhanced law enforcement, and the integration of digital technology and transparency within the healthcare system.

Further research is needed to evaluate the effectiveness of law enforcement and regulations in addressing fraud in health services. Future studies should explore how law enforcement, courts, and health authorities manage fraud cases, and identify the challenges they face in implementing these laws effectively. Without a clear research problem to guide these conclusions, it is difficult to ascertain the full scope and implications of the current legal framework's limitations.

It is important to conduct further research in analyzing the effectiveness of law enforcement or regulation on fraud cases in health services. Related studies can examine how law enforcement officers, courts, and health authorities handle fraud cases, as well as the obstacles faced in implementing related laws.

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