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Prevention of fraud in the implementation of the National Health Insurance (NHI) program (Case study: Abunawas Hospital Kendari City, 2023) Southeast Sulawesi Province, Indonesia, 2023

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Abstract

Background: The World Health Organization (WHO) estimates that 7.29% of health funds are lost due to services proven to be fraudulent throughout the world. The National Health Care Anti-Fraud Association (NHCAA) estimates that health costs resulting from fraud are in the tens of billions of dollars. Fraudulent health insurance claims are carried out through service providers, insurance customers and insurance companies. The potential for fraud at the Abunawas Hospital, Kendari City, comes from the Patient Information and Complaints Providing (PICP) officer of the Kendari branch of BPJS, who stated that patients often complain that when they want to be admitted to the hospital, their class room is full, so patients are required to move up to class 1 level above, there is Also collecting fees from Social security administration agency patients purely related to procedures or medicines. This is suspected to be administrative manipulation on the part of the hospital. Based on this, potential fraud committed by hospitals risks harming state finances.

Method: The type of research used is qualitative research, namely for see and describe how fraud is prevented in the JKN era at the Abunawas Regional Hospital, Kendari City. This research uses an explorative/exploratory approach. Determining informants was carried out using purposive sampling technique. The key informants in this research include the director of the Kendari City Regional Hospital while the regular informants are the INA CBGs Coder and the Social security administration agency verification officer. The data collection method was carried out using interviews. Data analysis used includes: data reduction, data presentation as well as drawing conclusions and verification.

Result: The research results showed that the implementation of Minister of Health Regulation no. 16 of 2019 concerning Guidelines for preventing and handling fraud and the imposition of administrative sanctions against fraud in the implementation of the Health Insurance program at the Kendari City Regional Hospital involving elements of the Financial Audit Agency, Internal Supervisory Unit, Public Accounts Commission and Hospital Director as proxies budget users at the Kendari City Regional Hospital. Complaints or reports of alleged NHI fraud must at least consist of: the identity of the complainant, the name and address of the agency suspected of committing NHI fraud, and the reason for the complaint. If there is a dispute regarding determining whether there is NHI fraud or not, the Provincial Health Service or Health/City Service can forward the complaint to the NHI fraud prevention team appointed by the Minister of Health.

Conclusion: Implementation of fraud prevention in NHI is carried out by the Minister, Head of the Provincial Health Service and Head of the Regency/City Health Service and Kendari City Regional Hospital in accordance with their respective authorities. Forms of guidance and supervision at the Kendari City Hospital include advocacy, outreach and technical guidance, training and increasing human resource capacity as well as monitoring and evaluation. Implementation of Minister of Health Regulation no. 16 of 2019 concerning Guidelines for preventing and handling

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fraud and the imposition of administrative sanctions against fraud in the implementation of the Health Insurance program at the Kendari City Regional Hospital involving elements of the Financial Audit Agency, Internal Supervisory Unit, Public Accounts Commission and Hospital Director as proxies budget users at the Kendari City Regional Hospital. So the hospital management collaborated with BPJS to form an anti-fraud investigation team in accordance with Minister of Health Regulation no. 16 of 2019 concerning guidelines and policies for preventing fraud and collaboration between integrity assessment surveys and public accounting firms in preventing fraud at Regional Hospital Kendari City.

Keywords: Prevention; Fraud; Implementation; National Health Insurance

1. Introduction

Health is a human right and one element of prosperity that must be realized in accordance with the ideals of the Indonesian nation as intended in Pancasila and the Preamble to the 1945 Constitution of the Republic of Indonesia. In Law number 36 of 2009 concerning health, it is stated that everyone has the right in obtaining safe, quality and affordable health services [1]. Apart from that, health development must basically be carried out on the principle of protection. Social security administration agency is a legal entity formed to administer social security programs and consists of Social security administration agency Health and Social security administration agency Employment. Social security administration agency 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 [2]. In its implementation, there is the potential for fraud which can cause hospital losses.

The World Health Organization (WHO) estimates that 7.29% of health funds are lost due to services proven to be fraudulent throughout the world [3]. Health expenditure is much higher than economic growth. The aspect that most influences this expenditure is fraud in health services globally. The National Health Care Anti-Fraud Association (NHCAA) estimates that health costs resulting from fraud are in the tens of billions of dollars [4].

In health services in Indonesia, fraud has existed for a long time, but has not yet been proven. It is feared that this could increase health costs which are detrimental to the country. Based on the number of fraud incidents in America, predictions in Indonesia are that the Social security administration agency premium in 2014 is estimated at Rp. 38.5 trillion, so the estimated loss due to fraud is IDR 1.8 – 3.6 trillion [5].

Fraudulent health insurance claims are carried out through service providers, insurance customers and insurance companies. Fraud in health insurance claims has become a significant problem its growth is rampant and affects the delivery of services global health. In addition to the financial losses incurred, patients who truly need medical care suffer because service providers are not paid on time due to delays in claims in medical examinations [6].

Types of fraud committed by health service providers in advanced health facilities, namely: manipulating diagnoses and/or procedures, plagiarizing claims from other patients (cloning), false claims (phantom billing), inflating bills for medicines and/or medical devices (inflated bills), splitting of service episodes in accordance with medical indications but not in accordance with statutory provisions, splitting of service episodes that are not in accordance with medical indications (services unbundling or fragmentation), pseudo-referrals, repeated bills or claims (repeat billing), extending the length of stay, manipulating treatment classes (room charge manipulation), billing for actions that were not carried out, carrying out treatment actions that are not in accordance with medical indications, repeated admissions (readmissions), collecting fees from Participants do not comply with the provisions of laws and regulations, give and/or receive bribes and/or rewards related to Health Insurance, and falsify Health Worker Practice Permits and Health Facility Operational Permits [7].

The Corruption Eradication Committee stated that this type of health insurance fraud often occurs in hospitals, such as the most frequent incidents being upcoding in Advanced Outpatient Care amounting to 230,909 cases, Advanced Inpatient Care amounting to 297,376 cases with a total of 528,285 upcoding cases or 49 .77%. The second most frequent cases were service Unbunding or Fragmentation at Advanced Outpatient Care with 259,649 cases and at Advanced Inpatient Care with 5,923 cases with a total of 265,572 cases or 25.02%. Ranked third with readmission cases in Advanced Outpatient Care amounting to 57,876 cases, in Advanced Inpatient Care 6,104 cases with a total of 63,980 cases or 6.03%. Apart from these three largest fraud cases, there are many other fraud cases committed at the hospital level [8].

A preliminary survey regarding the potential for fraud at the Abunawas Hospital in Kendari City was sourced from the BPJS Kendari Branch Patient Information and Complaints Providing (PICP) officer, who stated that patients often complained that when they wanted to be admitted to the hospital, their class room was full, so patients were required to move up to class 1. At the level above, there is also a collection of fees from pure Social security administration agency patients related to procedures or medicines. Other information was also mentioned by the Social security administration agency claims verifier that, there were several hospitals that claimed outpatient visits with the same diagnosis, which were suspected of deliberately breaking up the visit episodes but not according to the rules. Another form of fraud was mentioned, the hospital manipulated the diagnosis but was not accompanied by medical support or indications, information about other potential fraud was that there was one private hospital that claimed the patient's bill for a surgical procedure but on average it was not planned or was an emergency. This is suspected to be administrative manipulation on the part of the hospital.

Based on this, potential fraud committed by hospitals risks harming state finances. Apart from that, the amount of funding mismatch for Social security administration agency Health contributions and claims experienced a JKN deficit in 2014-2018 reaching 11.6 trillion. [9]. Minister of Health Regulation No. 16 of 2019 concerning prevention and handling of fraud as well as the imposition of administrative sanctions against fraud in the implementation of health insurance programs. This Minister of Health Regulation is an update of the previous anti-fraud regulation, namely Minister of Health Regulation No. 36 of 2015[7].

2. Method

The type of research used is qualitative research, namely to see and describe how fraud is prevented in the NHI era at the Abunawas Regional Hospital, Kendari City. This research uses an explorative/exploratory approach. Determining informants was carried out using a purposive sampling technique, namely looking at those who best understand and know the information needed, namely based on considerations of employees with a minimum of 1 year of service and those who have a high position in the workplace. Data collection was carried out by interviews. Data analysis includes: data reduction, data presentation, drawing conclusions and verification.

3. Result and Discussion

3.1. Fraud prevention policies and guidelines at Abunawas Regional Hospital, Kendari City

In 2016 Social security administration agency Health issued Social security administration agency Health regulation number. 7 of 2016 concerning fraud prevention systems in the implementation of health insurance programs in this regulation there are preventive, detection and handling measures. In 2019, the government issued Minister of Health Regulation Number. 16 of 2019 concerning prevention and handling of fraud and the imposition of administrative sanctions against fraud in the implementation of health insurance programs [7]

Based on the results of interviews with Key Informants, it is stated as follows:

"For the Kendari City Hospital, out of the 66 assessment points carried out by the Kendari City Hospital, it has met 53 assessment points so it is good enough to implement the Minister of Health Regulation No. 36 of 2015 (Minister of Health Regulation 16, 2019. (Informant SP, 47 years)

"At the moment we don't have a special fraud prevention team, but we do have an internal monitoring unit (SPI) specifically to prevent fraud in hospitals." (Informant RM, 34 years old)

Based on the results of the interview above, it can be concluded that the implementation of the Minister of Health Regulation regarding NHI fraud has been implemented well, but the Regional Hospital Kendari City must improve health services for the community. Then it relates to the administrative sanctions applied in enforcing Minister of Health Regulation no. 36 of 2015 concerning fraud as stated by the following informant:

" So far no one has been found to have committed any fraud violations, so we are still at zero. Usually, if there is a BPK violation, an audit goes straight to the hospital. Then SPI carries out monitoring and evaluation every quarter." (Informant RM, 34 years old"

"At the time of the BPK's annual inspection, if there are any findings, the BPK will instruct for a return, or other sanctions from the BPK which will be directed at the hospital." (BK informant, 46 years old)

"We here, apart from having BPK audits, we also have KAP (Public Accounting Commission) which directly supervises hospital finances." (DRS informant, 53 years old)

Based on the results of the interview above, it can be concluded that in implementing Minister of Health Regulation no. 16 of 2019 concerning prevention and handling of fraud and the imposition of administrative sanctions against fraud in the implementation of the Health Insurance program at the Kendari City Regional Hospital by involving elements of the Financial Audit Agency, Internal Supervisory Unit, Public Accounts Commission and Hospital Director as authorized users. budget at the Kendari City Regional Hospital.

Based on the results of the interview, the implementation of the Minister of Health Regulation regarding NHI fraud has been carried out well, but the Kendari City Regional Hospital must improve health services for the community. Then it relates to the administrative sanctions applied in enforcing Minister of Health Regulation no. 36 of 2015 concerning fraud.

Fraud in Social security administration agency needs to be prevented so as not to cause losses. This is as mandated in Article 7 of Minister of Health Regulation no. 36 of 2015 that in implementing the Health Insurance Program in the National Social Security System, Social security administration agency of Health, District/City Health Services, and advanced health facilities in collaboration with Social security administration agency, must build a NHI Fraud prevention system. Thus, hospitals as advanced health facilities that collaborate with Social security administration agency must build a NHI fraud prevention system.

In line with research conducted by Tatik (2016) which states that it is quite important in preventing NHI fraud at Menggala District Hospital that providing services must be in accordance with the Minimum Service Standards as regulated in Minister of Health Decree No. 129 of 2008 concerning Medical Service Standards in Hospitals, Clinical Service Guidelines and clinical pathways [10]

Minister of Health Regulation No. 36 of 2015 regulates guidance and supervision in the context of preventing fraud in JKN carried out by the Minister, Head of the Provincial Health Service and Head of Regency/City Health Service in accordance with their respective authorities. The form of guidance and supervision takes the form of advocacy, outreach and technical guidance, training and increasing human resource capacity as well as monitoring and evaluation. Furthermore, Minister of Health Regulation 36 of 2015 regulates sanctions for perpetrators of fraud. Administrative sanctions that can be imposed on the perpetrator include a verbal warning, written warning and/or an order to return losses to the injured party. In principle, these administrative sanctions do not eliminate the penalties that can be imposed on perpetrators of cheating or fraud as regulated in Article 378 of the Criminal Code. This means that the application of administrative sanctions must be synergistic with criminal sanctions. Therefore, in the future it is necessary to create special regulations that regulate fraud, this could take the form of an Anti-Fraud Law in Health Services.

3.2. Prevention of Fraud in the Implementation of the Health Insurance Program (Study at Abunawas Hospital Kendari City)

According to the provisions of Article 7 of Minister of Health Regulation Number 36 of 2015, in implementing the Health Insurance Program in the National Social Security System, Badan penyelenggara jaminan sosial Health, District/City Health Services, and fasilitas kesehatan tingka lanjut in collaboration with BPJS, must build a NHI Fraud prevention system.

Based on the results of interviews with Key Informants, it is stated as follows:.

"Writing appropriate diagnosis codes, namely not changing diagnosis and/or procedure codes to codes that have higher rates than they should." (Informant RM, 34 years old)

This is the same as the expressions of other informants. The following are excerpts from the interview:

"For example, we take precautions because we feel that the costs listed in the INA-CBGs package are low, so the hospital looks for other ways to make a profit. "Paying Social Security Administrator Health claims to hospitals as per the INA-CBGs tariff package which has no upper limit also triggers fraud." (informant: DRS, 53 years old)

Minister of Health Regulation No. 36 of 2015 regulates guidance and supervision in the context of preventing fraud in NHI carried out by the Minister, Head of the Provincial Health Service and Head of Regency/City Health Service in

accordance with their respective authorities. The form of guidance and supervision takes the form of advocacy, outreach and technical guidance, training and increasing human resource capacity as well as monitoring and evaluation. Furthermore, Minister of Health Regulation 36 of 2015 regulates sanctions for perpetrators of fraud. Administrative sanctions that can be imposed on the perpetrator include a verbal warning, written warning and/or an order to return losses to the injured party. In principle, these administrative sanctions do not eliminate the penalties that can be imposed on perpetrators of cheating or fraud as regulated in Article 378 of the Criminal Code. This means that the application of administrative sanctions must be synergistic with criminal sanctions. Therefore, in the future it is necessary to create special regulations that regulate fraud, this could take the form of an Anti-Fraud Law in Health Services.

Based on the results of research conducted at Kendari City Hospital, fraud in BPJS needs to be prevented so as not to cause losses. This is as mandated in Article 7 of Minister of Health Regulation no. 36 of 2015 that in implementing the Health Insurance Program in the National Social Security System, Social Security Administrator Health, District/City Health Services, and advanced health facilities in collaboration with Social Security Administrator, must build a NHI Fraud prevention system. Thus, hospitals as advanced health facilities that collaborate with Social Security Administrator must build a NHI fraud prevention system.

In principle, NHI participants have the potential to commit fraud. Fraud committed by participants, as specified in Article 3 of Minister of Health Regulation Number 36 of 2015, can be in the form of:

- making false statements regarding eligibility (falsifying membership status) to obtain health services;
- taking advantage of his right to unnecessary services by falsifying health conditions;
- providing gratification to service providers so that they are willing to provide services that are not appropriate/not covered;
- manipulating income so as not to have to pay too large contributions;
- collaborating with service providers to submit false claims;
- obtain prescribed drugs and/or medical devices for resale; and/or
- commit other acts of JKN fraud other than letters a to f.

Minister of Health Regulation No. 36 of 2015 orders each relevant party to build a fraud prevention system. For Social Security Administrator Health, Minister of Health Regulation 36 of 2015 orders the preparation of policies and guidelines for NHI fraud prevention, the development of a culture of NHI fraud prevention as part of good organizational governance and the formation of a NHI fraud prevention team at Social Security Administrator of Health. advanced health facilities must establish a similar system as mandated by Minister of Health Regulation 36 of 2015. The role of the community is also needed to prevent fraud in the NHI program, because anyone who knows about fraud in the NHI program can make a complaint. To do this, the complainant submits it in writing to the head of the health facility, Regency/City and/or Provincial health service. Complaints must be accompanied by the complainant's identity data, then the name and address of the agency suspected of committing fraud and the reason for the complaint.

Minister of Health Regulation No. 36 of 2015 regulates guidance and supervision in the context of preventing fraud in JKN carried out by the Minister, Head of the Provincial Health Service and Head of Regency/City Health Service in accordance with their respective authorities. The form of guidance and supervision takes the form of advocacy, outreach and technical guidance, training and increasing human resource capacity as well as monitoring and evaluation. Furthermore, Minister of Health Regulation 36 of 2015 regulates sanctions for perpetrators of fraud. Administrative sanctions that can be imposed on the perpetrator include a verbal warning, written warning and/or an order to return losses to the injured party. In principle, these administrative sanctions do not eliminate the penalties that can be imposed on perpetrators of cheating or fraud as regulated in Article 378 of the Criminal Code. This means that the application of administrative sanctions must be synergistic with criminal sanctions. Therefore, in the future it is necessary to create special regulations that regulate fraud, this could take the form of an Anti-Fraud Law in Health Services.

3.3. Obstacles faced in preventing fraud in the implementation of the National Health Insurance Program by Social Security Administrator Health at Abunawas Hospital Kendari City

Based on the results of interviews with informants, it is stated as follows:

"With the existence of SPI and routine checks carried out by SPI, no one dares to commit fraud, the only problem is usually that coordination between SPI and KAP departments is less effective." (Informant RM, 34 years old)

This was also stated by other informants as follows:

"As the expenditure treasurer, the problem is that the data that is requested from the units routinely verifies data between receipts and expenditures on the financial activities carried out." (BK informant, 46 years old)

To make it easier to report suspected fraud, a good system is needed. Minister of Health Regulation Number 36 of 2015 concerning Prevention of Fraud in the national health insurance program, in the national social security system, states that reporting suspected fraud must at least include the identity of the reporter consisting of the name and address of the agency suspected of committing NHI fraud. The results of in-depth interviews with the informant hospital said the following:

"...the experts who designed it collaborated with other parties, such as the architect's department, the hospital consulted with the hospital regarding the floor plan..." (MK informant, 40 years old)

"...Every year the hospital always improves itself, this is still at the stage of providing the best patients, if there is a problem we solve the problem." (BK informant, 46 years old)

All forms of service for BPJS participants have been stated in the NHI Technical Guidelines to prevent fraud. The results of the researcher's interview regarding the form of service for Social Security Administrator participant informants explained as follows:

"The first procedure is to use Social Security Administrator for outpatient care. Prepare a valid Social Security Administrator Health card and Resident Identity Card with the same identity as in the Social Security Administrator Health database. After bringing the two cards, go to the Level I Health Facility according to the information on the card regarding which location is the Level I Health Facility. When you arrive at the Level I Health Facility, register at the counter so that the data is recorded. "Furthermore, the health examination process can be carried out according to procedures by a Level I Health Facility doctor. If the patient's health condition can be treated at a Level I Health Facility, the doctor will write a prescription and you can redeem it at the Level I Health Facility Pharmacy." (informant MK, 40 years old)

"...if the patient's health condition does not allow it, the follow-up action that the doctor will take is to provide a referral to the hospital so that the patient can receive services from a specialist doctor..." (Informant RM, 34 years old)

Based on the results of research that has been carried out, the obstacle currently faced in preventing fraud in the implementation of national health insurance at the Abunawas Hospital, Kendari City, is that supervision carried out by SPI and KAP is carried out intensively to minimize incidents of fraud committed by both service providers. Social Security Administrator health participants and selected drug and pharmaceutical service providers.

In line with research conducted by Achmad Saleh Abdullah (2018) who analyzed "Factors Causing Fraud Incidents Caused by Upcoding Health Service Costs to Social Security Administrator Health Ambon Branch". The results of research conducted at Ambon City Hospital are that there is potential for upcoding that occurs in hospital health service claims in Ambon City where the factors causing potential upcoding that occur include, internal verification of the hospital and feedback from BPJS Health has not yet occurred. functions well as a supervisor of fraudulent activities[11].

For complaints about alleged NHI fraud, they must include at least: the identity of the complainant, the name and address of the agency suspected of committing NHI fraud, and the reason for the complaint (Article 25 paragraph (3) Minister of Health Regulation No. 36 of 2015). If there is a complaint about NHI fraud, the head of the health facility, District/City Health Service and/or Provincial Health Service must follow up on the complaint by conducting an investigation. The investigation was carried out involving BPJS Health, the NHI Fraud prevention team at advanced health facilities.

3.4. Identification of Fraud Prevention in the Implementation of the National Health Insurance Program (Study at Abunawas Hospital Kendari City)

Some excerpts from interviews with informants in identifying fraud prevention are as follows:

"We always carry out routine monitoring and evaluation every month, quarter and 6 months so as to minimize the occurrence of fraud in budget user implementation units." (Informant RM, 34 years old)

"The identification that we often carry out is in collaboration with SPI, KAP and the internal financial commission by carrying out routine monitoring and evaluation."

Based on the results of the interview above, it can be concluded that identifying the prevention of fraud incidents at the Kendari City Hospital by carrying out monitoring and evaluation in collaboration with the internal supervisory unit, the public accountability commission and the financial treasurer at the Kendari City Regional Hospital to prevent fraud incidents in health service providers, Participants and Social Security Administrator of Health.

Identify Forms of Prevention:

- Form a team at the Kendari City Regional Hospital to unite opinions and/or look for written guidelines or regulations to find the best solution so that it does not disrupt the service process at the Kendari City Regional Hospital and it is hoped that claims can be paid.
- If they cannot find a common ground, the hospital will report it in writing to the Kendari City Cost Control Quality Control Team. Next, the Social Security Administrator reported it to the Kendari City Medical Advisory Council.

The most classic form of fraud identified by Social Security Administrator officers is collaboration with participants and/or health facilities to submit false claims and manipulate benefits that should not be guaranteed so that they can be guaranteed. This condition was also revealed based on the results of interviews with Kendari City Regional Hospital staff that it was possible for participants to collaborate with Social Security Administrator officers.

Acts of NHI fraud committed at advanced health facilities according to Article 5 of Minister of Health Regulation Number 36 of 2015 include:

- Writing excessive diagnosis codes/upcoding, namely changing diagnosis and/or procedure codes into codes that have higher rates than they should.
- Plagiarizing claims from other patients/cloning, namely claims made by copying existing claims from other patients.
- False claims/phantom billing are claims for services that were never provided.
- Inflated bills for medicines and medical equipment/inflated bills, namely claims for the cost of medicines and/or medical devices that are greater than the actual costs.
- Breaking down service episodes/services unbundling or fragmentation, namely claims for two or more diagnoses and/or procedures which should be part of one service package in the same episode or billing for several procedures separately which should be billed together in the form of a service package, to obtain a claim value greater in a single episode of patient care.
- Pseudo-referrals/self-referrals are claims for service costs resulting from referrals to the same doctor at other health facilities except for facility reasons.
- Repeat billing is a claim that is repeated in the same case.
- Extending the length of stay is a claim for greater health service costs due to changes in the length of inpatient treatment.
- Manipulating the class of care/type of room charge is a claim for health service costs that is greater than the actual cost of the class of care.
- Canceling actions that must be carried out/cancelled services, is a claim for a diagnosis and/or action that was not carried out.
- Carrying out actions that are not necessary/no medical value, is a claim for actions that are not based on medical needs or indications.
- Deviations from service standards/standards of care are claims for diagnoses and/or actions that are not in accordance with service standards.
- Carrying out unnecessary treatment is a claim for unnecessary treatment.
- Increasing the length of time you use a ventilator is a bigger claim due to the increase in the time you use a ventilator that is not in accordance with your needs.
- Not carrying out a proper visit/phantom visit is a claim of a fake patient visit.
- Not carrying out procedures that are supposed to be/phantom procedures, is a claim for actions that were never carried out.
- Repeated admissions/readmissions are claims for the diagnosis and/or treatment of one episode that are treated or claimed more than once as if there were more than one episode.

4. Conclusion

Implementation of fraud prevention in NHI is carried out by the Minister, Head of the Provincial Health Service and Head of the Regency/City Health Service and Kendari City Regional Hospital in accordance with their respective authorities. Forms of guidance and supervision at the Kendari City Hospital include advocacy, outreach and technical guidance, training and increasing human resource capacity as well as monitoring and evaluation. Implementation of Minister of Health Regulation no. 16 of 2019 concerning Guidelines for preventing and handling fraud and the imposition of administrative sanctions against fraud in the implementation of the Health Insurance program at the Kendari City Regional Hospital involving elements of the Financial Audit Agency, Internal Supervisory Unit, Public Accounts Commission and Hospital Director as proxies budget users at the Kendari City Regional Hospital. So the hospital management collaborated with social security administrative agency to form an anti-fraud investigation team in accordance with Minister of Health Regulation no. 16 of 2019 concerning guidelines and policies for preventing fraud and collaboration between SPI and KAP in preventing fraud at the Kendari City Regional Hospital.

Compliance with ethical standards

Disclosure of conflict of interest

No conflict of interest to be disclosed.

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