LAW ENFORCEMENT ON HEALTHCARE FRAUD: A COMPARATIVE STUDY BETWEEN INDONESIA AND EUROPE

AINUL LATHIF[1], IMAM SUROSO[2], DOSSY ISKANDAR PRASETYO[3]

Universitas Bhayangkara Surabaya

ABSTRACT

Healthcare fraud poses a serious challenge to the financial integrity and ethical foundations of national health systems. This study examines the legal frameworks and enforcement mechanisms used to combat healthcare fraud in Indonesia and selected European countries—namely the Netherlands, the United Kingdom, and Germany. Using a normative and comparative legal research method, the study analyzes statutory provisions, institutional structures, and doctrinal development in each jurisdiction. Findings show that Indonesia's current approach is fragmented, relying on general criminal law and weak administrative regulations, without a clear legal definition of healthcare fraud. Institutional coordination is limited, enforcement data is not transparently reported, and courts have not developed jurisprudence tailored to the healthcare context. In contrast, the European countries studied have established specific legal definitions, dedicated enforcement bodies, and integrated systems that combine criminal, administrative, and civil measures. The study proposes a dual-path enforcement model for Indonesia, recommending legislative reform, procedural integration, specialized institutions, and enhanced judicial interpretation. This article addresses a clear research gap in Indonesian legal scholarship, where healthcare fraud has rarely been analyzed as a distinct legal category within health governance and criminal enforcement literature. By adopting lessons from the European experience, Indonesia can strengthen its legal response to healthcare fraud and protect the sustainability of its national health insurance system.

***Keywords**: Comparative Law, Healthcare Fraud, Indonesia, Law Enforcement, Legal Reform*

INTRODUCTION

Healthcare fraud is increasingly recognized as a systemic threat to the financial sustainability, ethical foundations, and public trust in national healthcare systems. Across jurisdictions, the growing complexity of healthcare financing—particularly in publicly funded schemes such as Indonesia's *Jaminan Kesehatan Nasional* (JKN) and Europe's National Health Services—has given rise to sophisticated fraudulent behaviors ranging from false billing, phantom claims, upcoding, to collusion between providers and administrators.[1] While the economic losses are significant—estimated globally to exceed US$300 billion annually—the deeper concern lies in the erosion of accountability and the weakening of legal institutions when fraud persists without adequate legal response.[2]

In Indonesia, the enforcement of healthcare fraud remains fragmented and underdeveloped. Despite the scale of public funding channeled through BPJS Kesehatan, the country lacks a clear, comprehensive legal framework dedicated to healthcare fraud.[3] Criminal sanctions are occasionally applied through general provisions on fraud under the Penal Code (KUHP), but enforcement is sporadic and largely dependent on discretionary prosecutorial action.[4] The Corruption Eradication

[1] David Hyman, "Health Care Fraud and Abuse: Market Changes, Regulatory Responses, and Prosecutorial Dynamics," Journal of Health Politics, Policy and Law 21, no. 1 (1996): 5–32.
[2] Matthew Stephenson, "Estimating the Global Cost of Health Care Fraud," Global Anticorruption Blog, 2020.
[3] BPJS Watch, Evaluasi Pengawasan Klaim JKN (Jakarta: BPJS Watch, 2021)
[4] Indonesia, Kitab Undang-Undang Hukum Pidana (KUHP), Art. 378.

Commission (KPK), while legally capable of intervening, has not treated healthcare fraud as a strategic priority. Most cases involving fraudulent claims, forged medical records, or illegal referral practices are handled administratively—if at all—by internal audit mechanisms or disciplinary bodies within the Ministry of Health.

By contrast, several European countries have developed more structured enforcement mechanisms for healthcare fraud. The Netherlands, for instance, established the Dutch Healthcare Authority (NZa) with a specialized unit to detect and refer fraudulent activity, supported by a legal framework that combines administrative, civil, and criminal sanctions.[5] Similarly, the United Kingdom operates through the NHS Counter Fraud Authority (NHSCFA), which coordinates audits, investigations, and criminal referrals in cooperation with the Crown Prosecution Service.[6] In Germany and France, specific healthcare fraud statutes exist, allowing prosecutors to act with greater precision and courts to impose tailored penalties.

The divergence in enforcement approaches raises critical questions about the doctrinal and institutional capabilities of different legal systems to address healthcare fraud. This study is grounded in the recognition that healthcare fraud is not merely a managerial or financial issue, but a legal problem that demands both conceptual clarity and institutional coherence.[7] The article seeks to bridge the gap between doctrinal analysis and institutional performance by comparing the legal enforcement of healthcare fraud in Indonesia and selected European countries.Previous discussions of healthcare fraud in Indonesia have been dominated by public policy and economic efficiency perspectives, with limited engagement from the doctrinal legal community. Hence, this study contributes by reframing healthcare fraud as a legal problem requiring normative precision and institutional accountability.

Existing literature on healthcare fraud in Indonesia is primarily empirical or policy-driven, often produced by audit bodies or health economists.[8] There is a striking absence of doctrinal legal scholarship that systematically analyzes the normative deficiencies in Indonesian law regarding healthcare fraud. Most legal studies address corruption in abstract or focus on general procurement fraud, without addressing the unique dynamics of healthcare systems, such as provider incentives, capitation risks, and diagnosis-based claim systems.

Moreover, few comparative legal studies have attempted to examine how different jurisdictions frame healthcare fraud as a legal offense, the types of sanctions imposed, or the institutional configurations that enable effective enforcement.[9] Even fewer studies explore the integration of criminal, administrative, and civil sanctions in a unified model. The novelty of this article lies in its comparative doctrinal approach—examining the substantive and procedural enforcement mechanisms in both Indonesia and Europe, and proposing a conceptual model for legal harmonization and institutional reform.

This approach is especially relevant as healthcare systems globally transition toward universal health coverage, where fraud not only affects fiscal stability but also equity and access.[10] The lessons from European legal frameworks can inform Indonesia's ongoing healthcare reforms, especially in relation to governance, legal design, and enforcement practice.

To address the above issues, this article is guided by three main research questions:

1. What are the legal frameworks and enforcement mechanisms for addressing healthcare fraud in Indonesia and selected European countries?

[5] Dutch Healthcare Authority (NZa), Annual Report 2022, Section on Fraud Enforcement.
[6] NHS Counter Fraud Authority (NHSCFA), Fighting Fraud in the NHS: Strategy 2020–2023.
[7] Peter Mahmud Marzuki, Penelitian Hukum (Jakarta: Kencana, 2017), 89.
[8] BPKP, Laporan Hasil Pemeriksaan atas Pengelolaan Dana JKN, 2022.
[9] Wolfgang Schön, "Tax and Health Care Fraud: Comparative Legal Perspectives," European Journal of Crime, Criminal Law and Criminal Justice 27, no. 4 (2019): 317–345.
[10] World Health Organization, Global Health Sector Strategy on Health Systems Governance, 2021.

2. What doctrinal and institutional weaknesses exist in Indonesia's current approach to healthcare fraud enforcement, particularly in comparison with European models?
3. How can Indonesia reform its legal and institutional responses to healthcare fraud by adopting an integrated enforcement model based on comparative insights?

These questions are explored through a normative-comparative legal research method, examining statutory law, institutional mandates, and selected case jurisprudence. The European countries selected for comparison—the Netherlands, the United Kingdom, and Germany—offer contrasting yet complementary models in their use of criminal law, administrative controls, and independent enforcement agencies.

The significance of this study lies in its potential to contribute to legal scholarship and policy reform in three dimensions. First, it develops a doctrinal foundation for understanding healthcare fraud not merely as corruption or general fraud, but as a distinct legal category that warrants specialized regulation and enforcement. Second, it offers a comparative legal perspective, drawing lessons from mature legal systems that have grappled with similar challenges in public healthcare. Third, it provides concrete recommendations for institutional reform in Indonesia, grounded in legal theory and best practices.

As the Indonesian healthcare system continues to expand in scale and complexity, the legal architecture must evolve to ensure that public funds are protected, ethical standards upheld, and fraudulent behavior deterred.[11] Failure to address these issues risks undermining the legitimacy of universal healthcare initiatives and weakening public trust in both the legal and health systems.

The article is structured as follows: Chapter 2 outlines the research methodology, including the normative and comparative methods employed. Chapter 3 presents the results and discussion, divided into three sub-chapters: the legal frameworks in Indonesia and Europe (3.1), an analysis of doctrinal and institutional weaknesses in Indonesia (3.2), and the development of an integrated enforcement model (3.3). Chapter 4 concludes with key findings and concrete legal recommendations for reform.

RESEARCH METHODOLOGY

This research employs a normative legal research methodology combined with comparative legal analysis to examine the enforcement of healthcare fraud in Indonesia and selected European jurisdictions.[12] The normative approach is appropriate for identifying the gaps, inconsistencies, and conceptual weaknesses within the current legal frameworks that regulate healthcare fraud.[13] It facilitates a structured evaluation of statutory provisions, legal principles, enforcement doctrines, and institutional mandates, particularly as they relate to fraud in public healthcare financing schemes.

Normative legal research is concerned not merely with what the law is, but with what the law ought to be, based on legal reasoning, doctrine, and principles of justice. In the context of this study, normative analysis allows the formulation of legal arguments regarding the adequacy of Indonesia's current legal instruments in addressing healthcare fraud and the development of recommendations for reform based on comparative models.

The research also utilizes comparative legal methodology, particularly the functional comparative method, which compares how different legal systems address similar societal problems—here, the problem of fraudulent behavior in healthcare services.[14] This method is not limited to textual comparison of statutes but extends to evaluating institutional effectiveness, enforcement patterns,

[11] Rachmadi Usman, Asas dan Dasar Hukum Perikatan (Jakarta: Sinar Grafika, 2018), 201.
[12] Dr. Johnny Ibrahim, *Teori & Metodologi Penelitian Hukum Normatif* (Bayu Media, 2013).
[13] Peter Mahmud Marzuki, Penelitian Hukum (Jakarta: Kencana, 2017), 23.
[14] Konrad Zweigert and Hein Kötz, An Introduction to Comparative Law, trans. Tony Weir (Oxford: Clarendon Press, 1998), 34.

and the interaction between criminal, administrative, and civil law mechanisms. By analyzing legal frameworks in the Netherlands, the United Kingdom, and Germany, the study identifies features that could inform the development of an integrated enforcement model in Indonesia.

Legal Materials and Sources

The legal materials used in this study are classified into three categories:

1. Primary legal materials include:
a. Indonesia's *Kitab Undang-Undang Hukum Pidana* (KUHP), particularly Article 378 on fraud
b. Law No. 24 of 2011 on BPJS and related health governance regulations
c. Law No. 36 of 2009 on Health
d. European legal instruments on healthcare fraud, including the *Wet marktordening gezondheidszorg* (Dutch Healthcare Market Regulation Act), the UK's Fraud Act 2006, the NHS Act, and German provisions under the *Sozialgesetzbuch* (Social Code)
e. Judicial decisions from the Supreme Court of Indonesia, the Dutch Hoge Raad, and UK Crown Courts on healthcare-related fraud prosecutions[15]
2. Secondary legal materials consist of:
a. Legal commentaries, textbooks, and law journal articles analyzing fraud, healthcare governance, and public health law enforcement
b. Reports and policy papers from oversight bodies such as the BPK (Audit Board of Indonesia), KPK (Corruption Eradication Commission), NHS Counter Fraud Authority, and the Dutch Healthcare Authority (NZa)
c. Academic studies from Scopus-indexed journals in law, health policy, and criminal justice[16]
3. Tertiary legal materials include:
a. Legal dictionaries, health law glossaries, and healthcare fraud typology guidelines issued by WHO, UNODC, and OECD
b. Statistical and evaluative data on enforcement rates, prosecution outcomes, and systemic fraud risks in both Indonesia and Europe[17]

Comparative Jurisdictions Selected

The countries selected for comparison represent three distinct yet complementary approaches:

1. The Netherlands, with a hybrid public-private health system and centralized fraud enforcement through NZa

2. The United Kingdom, with an NHS-based system and a specialized anti-fraud agency (NHSCFA) underpinned by strong legal doctrines of public trust and fiduciary responsibility

3. Germany, which integrates healthcare fraud control within its social insurance system and allows both state and sickness funds (*Krankenkassen*) to initiate legal action under codified statutes

These systems were chosen for their diversity in institutional structure and legal tradition—civil law (Netherlands, Germany) and common law (UK)—which allows meaningful doctrinal and procedural comparison.[18]

Analytical Framework

The research is conducted through a doctrinal legal analysis that focuses on:

[15] Supreme Court of Indonesia, Putusan No. 1389 K/Pid.Sus/2018 (fraudulent BPJS claim); UK Crown Prosecution Service, R v. Dattani (2016); Dutch Hoge Raad, ECLI:NL:HR:2019:1869.
[16] Wolfgang Schön, "Tax and Health Care Fraud: Comparative Legal Perspectives," EJCCLCJ 27, no. 4 (2019): 317–345.
[17] World Health Organization, Typology of Health Fraud and Abuse, 2020; OECD, Effective Approaches to Public Sector Integrity, 2019.
[18] Susanne Baer, "Comparative Constitutionalism and Legal Cultures," International Journal of Constitutional Law10, no. 2 (2012): 436–460.

1. The legal definition and scope of healthcare fraud in each jurisdiction
2. The available enforcement mechanisms (criminal, administrative, civil)
3. The institutional actors responsible for detection, investigation, and prosecution
4. The legal consequences imposed (e.g., restitution, imprisonment, fines, disqualification)
5. The standards of proof and thresholds for triggering enforcement

The analysis also incorporates institutional evaluation, particularly the structural alignment between regulatory agencies, oversight bodies, law enforcement, and the judiciary. This component seeks to assess how legal mandates translate into effective action, accountability, and deterrence. To assess the normative coherence and functionality of enforcement models, the research applies methods of legal interpretation, including:

1. Grammatical interpretation, to clarify the meaning of statutory language used in anti-fraud provisions
2. Systematic interpretation, to understand how anti-fraud laws interact with other legal instruments (e.g., health governance, administrative law, penal law)
3. Teleological interpretation, to evaluate whether enforcement practices serve the underlying goals of public health integrity, justice, and financial accountability[19]

The comparative findings are then synthesized into a conceptual model that highlights the strengths and weaknesses of Indonesia's approach relative to the selected European jurisdictions. This model forms the basis for the proposed legal and institutional reforms in the final chapter.

This study focuses specifically on fraud involving public healthcare funding and services, particularly under Indonesia's BPJS system and its equivalents in Europe. It does not address clinical malpractice, negligence, or purely private-sector billing disputes unless directly related to public fund misuse. Furthermore, the study emphasizes enforcement mechanisms, not healthcare service delivery or insurance design. The comparative analysis is not intended to recommend wholesale legal transplantation but to draw contextual lessons that can inform Indonesia's reform path while respecting local legal, political, and institutional realities.

RESULT AND DISCUSSIONS

Legal Frameworks for Healthcare Fraud Enforcement in Indonesia and Europe

The legal foundation for combating healthcare fraud reflects the broader structure of public accountability and institutional capacity within a given jurisdiction. In both Indonesia and selected European countries, the scope, definition, and enforceability of healthcare fraud provisions are embedded within a mixture of criminal, administrative, and civil laws. However, significant differences emerge in doctrinal clarity, institutional mandates, and operational integration. This section explores and compares the normative frameworks governing healthcare fraud in Indonesia, the Netherlands, the United Kingdom, and Germany, focusing on substantive legal norms, enforcement mechanisms, and the role of key institutions.

1. Legal Norms and Statutory Definitions

In Indonesia, the term "healthcare fraud" (kecurangan pelayanan kesehatan) is not explicitly defined in a single statute. Most legal responses rely on general provisions in the Penal Code (KUHP)—particularly Article 378 on fraud and Article 263 on forgery—as well as Law No. 31 of 1999 on Corruption Eradication.[20] These provisions, while broad enough to apply to some healthcare-related misconduct, were not designed with sectoral specificity. For example, Article 378

[19] Satjipto Rahardjo, Ilmu Hukum (Bandung: Citra Aditya Bakti, 2000),
[20] Indonesia, Kitab Undang-Undang Hukum Pidana (KUHP), Art. 378.

criminalizes "deception to unlawfully gain benefit," which can be invoked in cases of false medical billing, but lacks interpretative guidelines in health sector contexts.[21]

Administrative responses are regulated under Ministerial Regulation No. 16/2019 on Prevention and Management of Healthcare Fraud in JKN services. However, this regulation is soft law, offering a framework for internal audits, risk scoring, and sanctions such as service suspension or reimbursement claw-back, but without criminal prosecutorial power.[22] The following discussion contrasts the Indonesian framework with European systems to highlight doctrinal clarity, institutional specialization, and procedural consistency as the main axes of comparison.

In contrast, the Netherlands offers a more structured and integrated legal architecture. Healthcare fraud is addressed under the Wet marktordening gezondheidszorg (Healthcare Market Regulation Act), supplemented by provisions in the Dutch Penal Code (Articles 225–227 on forgery and deceit) and specific healthcare regulations.[23] The system emphasizes early detection and enforcement through the Dutch Healthcare Authority (NZa), which operates as both regulator and investigator with authority to refer cases to the public prosecutor (Openbaar Ministerie). The Dutch system recognizes both administrative violations (e.g., overbilling, documentation failure) and criminal acts (e.g., deliberate fraud, collusion), allowing flexible responses depending on the severity of the conduct.[24]

The United Kingdom similarly adopts a dual framework, integrating civil recovery, administrative penalties, and criminal prosecution. The Fraud Act 2006 provides a broad legal definition of fraud by false representation, by failure to disclose, or by abuse of position.[25] This law is complemented by sectoral regulation under the National Health Service Act 2006, which mandates fraud prevention duties for NHS organizations. Operationally, the NHS Counter Fraud Authority (NHSCFA) investigates fraud cases and works in tandem with the Crown Prosecution Service (CPS) to bring criminal charges where applicable.[26]

Germany also criminalizes healthcare fraud under the Social Code Book V (SGB V) and Penal Code (§ 263 StGB). Healthcare service providers and insurers (e.g., Krankenkassen) may initiate both civil recovery and criminal complaint. Since 2016, legal reforms have enhanced prosecutorial authority to pursue fraud independently of claims filed by affected parties, recognizing healthcare fraud as an offense against public trust.[27]

2. Enforcement Mechanisms and Procedural Approaches

In Indonesia, enforcement is generally fragmented. BPJS Kesehatan, as the managing body of the JKN system, performs internal audits and investigates anomalies using tools such as Clinical Pathway audits, claim verification, and scorecard analysis. Suspected fraud may be referred to law enforcement, but there is no institutional obligation or standardized procedure for such referrals.[28] In practice, most cases are resolved administratively or internally without transparency. The KPK has intervened in certain large-scale corruption cases involving healthcare procurement, but rarely investigates clinical or billing fraud directly.[29]

By contrast, the Netherlands utilizes an integrated chain of enforcement where NZa, health insurers, and the Health and Youth Care Inspectorate (Inspectie Gezondheidszorg en Jeugd) coordinate with law enforcement agencies. Administrative fines can be imposed quickly by NZa, while serious cases are referred to the FIOD (Fiscal Information and Investigation Service) for criminal investigation.[30] The legal structure permits parallel administrative and criminal

[21] Satjipto Rahardjo, Ilmu Hukum (Bandung: Citra Aditya Bakti, 2000), 101.
[22] Ministry of Health Regulation No. 16 of 2019.
[23] Netherlands, Wet Marktordening Gezondheidszorg, Art. 33–36.
[24] NZa, Annual Supervision Report, 2022.
[25] UK, Fraud Act 2006, Section 2–4.
[26] NHS Counter Fraud Authority, Strategic Plan 2020–2023, p. 9.
[27] Germany, Strafgesetzbuch (§ 263), and Sozialgesetzbuch V (SGB V).
[28] BPJS Kesehatan, Laporan Tahunan, 2021.
[29] KPK, Kajian Tata Kelola Dana JKN, 2020.
[30] Netherlands, FIOD Enforcement Protocol, 2018.

proceedings, and Dutch courts have upheld such dual enforcement as consistent with proportionality principles.[31]

In the UK, NHSCFA has statutory authority to initiate investigations and to prosecute fraud cases directly or via the CPS. The Counter Fraud Standards applied across the NHS require each trust to maintain a Local Counter Fraud Specialist (LCFS), ensuring embedded vigilance. Civil recovery is often used to reclaim funds, while criminal prosecution is reserved for intentional and high-value offenses.[32] Notably, whistleblower protections and digital surveillance systems strengthen detection capacity.

Germany's system relies heavily on collaboration between sickness funds and public prosecutors. The Joint Federal Committee (G-BA) and Federal Audit Office (BRH) establish national guidelines, while individual Krankenkassen perform fraud audits and initiate actions. Courts may order restitution, impose fines, or issue imprisonment depending on intent and harm.[33] Germany also uses a tiered sanction system, distinguishing negligence from intentional misconduct.

3. Comparative Observations and Key Differences

The first key difference lies in the legal classification of healthcare fraud. In Indonesia, fraud is treated as a general crime, with healthcare-specific context largely absent. This limits doctrinal clarity and constrains specialized enforcement. In contrast, European jurisdictions treat healthcare fraud as a sector-specific offense, often with dedicated statutes and specialized institutions.

Second, institutional integration is markedly stronger in Europe. Enforcement bodies are embedded within the health system, as in the UK (LCFS, NHSCFA), or operate with inter-agency protocols, as in the Netherlands (NZa–FIOD). Indonesia lacks such coordination, and health regulators have limited authority to initiate legal proceedings.

Third, procedural pathways in European systems allow simultaneous civil, administrative, and criminal measures, with clear thresholds and legal protections. Indonesian law offers no unified enforcement framework, resulting in discretionary and inconsistent responses.

Fourth, transparency and reporting mechanisms are better institutionalized in Europe. Public access to enforcement statistics, prosecution outcomes, and compliance data strengthens public oversight. In Indonesia, enforcement data is opaque, and case resolution mechanisms are often internalized within BPJS or the Ministry of Health.[34]

Lastly, legal culture and judicial interpretation differ. Courts in the Netherlands and UK have developed jurisprudence distinguishing error from fraud, good faith misreporting from systemic abuse, and proportionate penalties. Indonesian jurisprudence on healthcare fraud remains limited and undeveloped, with few published decisions and no comprehensive doctrinal guidance from the Supreme Court.

Doctrinal and Institutional Weaknesses in Indonesia's Current Model

Despite the increasing scale and complexity of healthcare financing in Indonesia, the legal system has not kept pace with the need for a robust and coherent approach to addressing healthcare fraud. While limited regulatory instruments exist, they tend to be fragmented, non-binding, and predominantly administrative in nature.[35] Indonesia's approach lacks the doctrinal depth and institutional cohesion found in many European legal systems, resulting in a model that is reactive rather than preventive, and ambiguous rather than normatively structured. This section explores the core doctrinal, procedural, and institutional weaknesses that limit the effectiveness of healthcare fraud enforcement in Indonesia.

1. Absence of a Clear Legal Definition and Normative Structure

[31] Dutch Supreme Court (HR), ECLI:NL:HR:2021:234.
[32] NHSCFA, Counter Fraud Standards, 2022.
[33] GKV-Spitzenverband, Leitfaden zur Bekämpfung von Abrechnungsbetrug, 2020.
[34] BPKP, Laporan Pemeriksaan JKN 2022, 18–19
[35] Satjipto Rahardjo, Ilmu Hukum (Bandung: Citra Aditya Bakti, 2000), 67–68.

One of the most fundamental weaknesses in Indonesia's legal response to healthcare fraud lies in the absence of a sector-specific legal definition. Fraud in the context of JKN (Jaminan Kesehatan Nasional) is often discussed in policy or audit language—as "claim manipulation" or "unjustified billing"—but is rarely defined in legal terms.[36] The general fraud provision in Article 378 of the Penal Code (KUHP) requires proof of deceit and unlawful gain, but does not provide contextual guidance for its application in healthcare.[37] As a result, law enforcement officials, judges, and regulators lack a consistent legal basis to identify, prosecute, or adjudicate healthcare-specific fraud.

Moreover, the regulatory instruments that do address healthcare fraud, such as Ministerial Regulation No. 16/2019, do not carry the force of statutory law and lack enforceable sanctions beyond internal service discipline.[38] These instruments serve more as administrative manuals than binding legal rules. Without legislative authority or judicial recognition, such regulations do not provide sufficient legal certainty, either for enforcement or for judicial interpretation.

By contrast, jurisdictions such as the Netherlands and the United Kingdom have embedded healthcare fraud within both statutory and judicial frameworks, enabling consistent application of sanctions and the development of jurisprudence.[39] Indonesia's failure to do the same has left the legal structure for healthcare fraud normatively thin and dependent on discretionary interpretations.

2. Limited Doctrinal Development and Jurisprudence

The Indonesian judiciary has shown limited engagement with healthcare fraud as a distinct legal problem. Most criminal court decisions concerning fraud do not involve the healthcare sector, and those that do are rarely published or annotated.[40] There is little doctrinal discussion, for example, on how intent (dolus), material benefit, or systemic abuse should be interpreted in the context of public health insurance schemes. Judges tend to apply general fraud doctrines without sectoral sensitivity, thereby failing to recognize the complexities and incentive structures within healthcare financing.

In European jurisdictions, courts have played an active role in defining thresholds of fraudulent behavior, distinguishing between error, negligence, and deception.[41] For instance, Dutch and German courts have developed standards for evaluating the fraudulent nature of billing practices, while UK courts apply the "reasonable belief" and "abuse of position" tests under the Fraud Act 2006. These judicial constructions help clarify the boundaries of legal liability and create predictable legal standards. Indonesia, in contrast, lacks such doctrinal elaboration, which undermines legal certainty and weakens deterrence.

3. Weak Institutional Coordination and Role Ambiguity

Institutional fragmentation further exacerbates Indonesia's enforcement weaknesses. The entities responsible for preventing and managing healthcare fraud—BPJS Kesehatan, the Ministry of Health, the Health Social Security Supervisory Board (DJSN), and the Financial and Development Supervisory Agency (BPKP)—operate without a clear enforcement hierarchy or legal obligation to coordinate with law enforcement.[42]

Although BPJS Kesehatan has developed internal audit mechanisms and scoring systems to detect anomalies, these systems are non-binding, and case referrals to external prosecutors are rare. Investigative actions are typically limited to claim rejections or contract suspensions. There is no institutional requirement to escalate suspected fraud to the police, the KPK, or the Attorney General's Office.[43] Moreover, the lack of an independent investigative body—akin to the NHSCFA in

[36] BPJS Watch, Kajian Kecurangan Layanan Kesehatan, 2021, 15.
[37] Indonesia, Kitab Undang-Undang Hukum Pidana (KUHP), Art. 378.
[38] Ministry of Health Regulation No. 16 of 2019.
[39] NZa, Fraude Signalering & Handhaving, 2022; NHSCFA, Annual Report, 2021.
[40] Supreme Court Decision Database (Mahkamah Agung), no published jurisprudence on BPJS fraud as of 2023.
[41] Wolfgang Schön, "Tax and Health Care Fraud," EJCCLCJ 27, no. 4 (2019): 320.
[42] DJSN, Evaluasi Tata Kelola Dana JKN, 2020, 33.
[43] BPKP, Audit Investigatif Dana Kesehatan, 2021, 22–24.

the UK or the NZa in the Netherlands—means that healthcare fraud enforcement is often constrained by bureaucratic inertia and conflict of interest.

Indonesia also lacks dedicated prosecutorial or judicial units for healthcare fraud. Prosecutors must rely on general case-building methods, often without sector-specific knowledge or investigative support. Judges, in turn, are not provided with training or precedents that would allow for consistent and informed decisions. In Germany and the UK, by contrast, enforcement is facilitated by specialized units within the prosecution service, supported by expert witnesses and technical forensic analysts.[44]

4. Inadequate Use of Administrative and Civil Remedies

Another key weakness lies in the underutilization of administrative and civil law as tools of enforcement. In European models, administrative penalties such as license revocation, service suspension, fines, and exclusion from reimbursement systems serve as efficient and proportional responses to low- and mid-level fraud.[45] Civil recovery procedures are also used to reclaim losses without the procedural burdens of criminal trials.

In Indonesia, administrative enforcement is either underenforced or procedurally vague. For example, the Ministry of Health has no standardized process for issuing financial penalties or revoking provider eligibility based on fraud findings. Civil litigation is rarely used by BPJS or the state to recover funds from fraudulent providers, due in part to long processing times, weak claim substantiation, and institutional reluctance.[46]

The result is a binary enforcement culture: either a case is treated as minor and closed internally, or it is deemed too complex or sensitive and left unresolved. There is no middle-ground legal pathway to impose targeted sanctions, such as partial restitution, exclusion from future contracts, or administrative fines.

5. Lack of Data Transparency and Public Accountability

Effective enforcement depends not only on the availability of legal tools but also on transparency and accountability. In Indonesia, data on healthcare fraud investigations, resolved cases, and recovered assets is not systematically published. BPJS Kesehatan occasionally releases general statistics, but these lack detail, case typologies, or judicial outcomes.[47]

In contrast, agencies like the NHSCFA in the UK and the NZa in the Netherlands produce annual public reports with detailed breakdowns of fraud typologies, detection efforts, financial recoveries, and enforcement trends.[48] These reports support public oversight, foster inter-agency learning, and signal institutional seriousness.

Indonesia's lack of such reporting contributes to a perception of institutional opacity and legal weakness, making it difficult for policymakers, academics, and the public to evaluate performance or propose reforms. It also hinders the development of early-warning systems, predictive models, and inter-institutional collaboration.

6. Cultural and Normative Constraints

Finally, normative and cultural factors affect enforcement outcomes. The prevailing view in Indonesia treats many instances of healthcare fraud as "technical irregularities" or "errors of administration," especially when committed by healthcare workers or smaller clinics.[49] There is a reluctance to apply criminal sanctions against actors in a socially valued sector, and a tendency to resolve issues quietly through restitution or informal settlement. While discretion is important, the consistent failure to penalize deliberate misconduct sends the wrong signal and may enable systemic abuse.

[44] UK Crown Prosecution Service, Healthcare Fraud Division Reports, 2022.
[45] GKV-Spitzenverband, Fraud Guidelines for Sickness Funds, 2020.
[46] BPJS Kesehatan, Laporan Tahunan, 2021, 55.
[47] NHSCFA, Strategic Plan, 2020–2023; NZa, Supervisory Report, 2022.
[48] Rachmadi Usman, Hukum Perikatan, 2018, 219.
[49] Konrad Zweigert and Hein Kötz, An Introduction to Comparative Law, 3rd ed. (Oxford: Clarendon, 1998), 198.

Legal culture also favors formalism and textual rigidity, making judges and prosecutors hesitant to expand interpretations or apply teleological reasoning. In European systems, courts are more willing to interpret general fraud statutes in light of healthcare-specific contexts, enabling more responsive and tailored enforcement.[50]

Toward an Integrated Enforcement Model Based on Comparative Insights

The shortcomings identified in Indonesia's doctrinal and institutional approach to healthcare fraud enforcement call for a systematic, integrated response—one that harmonizes substantive legal norms with procedural efficiency and institutional clarity. Drawing on comparative insights from the Netherlands, the United Kingdom, and Germany, this section proposes a **dual-path enforcement model** that allows civil, administrative, and criminal mechanisms to function in concert. This model is grounded in normative legal theory, empirical institutional practice, and the principles of proportionality, legal certainty, and public accountability.

1. The Concept of Dual-Path Enforcement

Dual-path enforcement refers to the simultaneous or sequential application of multiple legal instruments—criminal, civil, and administrative—to address a single offense or pattern of misconduct.[51] In healthcare fraud, this means that a single act of fraudulent billing or record manipulation may result in criminal prosecution, civil restitution, and administrative sanctions such as license suspension or reimbursement claw-back. This model reflects the reality that fraud affects different legal interests: criminal law protects public order and moral norms; civil law protects property and contracts; and administrative law enforces compliance and sectoral standards.

In European jurisdictions, this multi-pronged approach is not only doctrinally accepted but also procedurally enabled. In the Netherlands, for example, administrative agencies like NZa can impose fines or service restrictions while referring serious matters to FIOD for penal investigation.[52] In the UK, civil recovery and internal disciplinary procedures can run parallel to criminal proceedings, supported by statutory guidelines under the NHS Act and the Fraud Act 2006.[53]

Indonesia currently lacks a legal or institutional mechanism to operationalize such a model. Enforcement remains compartmentalized and inconsistent, as agencies act within silos and legal instruments are applied in isolation. To overcome this, an integrated framework must be developed, guided by comparative best practices and adapted to Indonesia's legal culture and institutional architecture.

2. Substantive Legal Reforms

The first requirement of an integrated model is substantive legal reform—particularly the introduction of a sector-specific legal definition of healthcare fraud. This definition must be embedded in national legislation, preferably through amendments to the Health Law (Law No. 36/2009) or the BPJS Law (Law No. 24/2011). Such definition should include core elements such as:

a. Intentional deception or misrepresentation
b. In connection with the provision, authorization, or payment of healthcare services
c. Resulting in financial loss to public health systems (e.g., BPJS)

A sector-specific statute would serve several functions: it would offer interpretative clarity to judges and prosecutors; signal the seriousness of the offense to society; and enable specialized enforcement structures.[54] The lack of such a statute currently prevents consistent application of Article 378 of the KUHP in healthcare contexts.

[50] Ibid
[51] K. S. Dhillon, "Toward a Dual-Track Enforcement Model for Fraudulent Insolvency," Asian Journal of Law and Society 7, no. 3 (2020): 455.
[52] Netherlands, Wet Marktordening Gezondheidszorg; NZa, Fraud Strategy Report, 2021.
[53] UK, Fraud Act 2006; NHS Counter Fraud Authority, Case Management Handbook, 2020.
[54] Rachmadi Usman, Hukum Perikatan, 2018, 210.

In addition to statutory definition, the law must authorize proportional administrative penalties (e.g., fines, license suspension, exclusion from reimbursement) and clearly define the jurisdictional authority of health regulators to impose such penalties without requiring a criminal conviction. This follows the Dutch and UK models, where administrative enforcement operates independently and swiftly to contain fraud risks.[55]

3. Institutional Design and Specialization

The second pillar of integration involves institutional reform, particularly the establishment or designation of a specialized healthcare fraud enforcement body. Indonesia does not currently have a dedicated institution responsible for detecting, investigating, and prosecuting healthcare fraud. While BPJS has internal audit units, these lack investigative authority, legal power, and prosecutorial independence.

Based on comparative models, Indonesia could establish a National Health Fraud Unit under the Ministry of Health or as an independent regulatory body, similar to NHSCFA (UK) or NZa (Netherlands). This agency would:

a. Conduct sector-specific audits and fraud detection
b. Coordinate with the Attorney General's Office and the Police
c. Maintain a national fraud registry and reporting portal
d. Issue administrative sanctions or refer for criminal prosecution
e. Publish regular enforcement reports for public accountability

In Germany, collaboration between Krankenkassen, health ministries, and prosecutors is institutionalized through legal mandates.[56] Indonesia must move beyond informal coordination toward structural integration, supported by memoranda of understanding (MoUs), inter-agency task forces, and shared information platforms.

4. Procedural Integration and Case Pathways

Third, the legal framework must enable procedural connectivity between different enforcement paths. Currently, administrative audits, civil recovery efforts, and criminal investigations in Indonesia proceed in isolation, often duplicating effort or conflicting in findings. There is no statutory guidance on how or when a case should be referred from one pathway to another. To solve this, a tiered case classification system should be introduced, with thresholds based on:

a. Financial loss
b. Evidence of intent
c. Involvement of public officials or providers
d. Repetition or systemic patterns

Each case can then be processed through appropriate tracks: minor technical violations resolved administratively, moderate fraud handled through civil recovery and fines, and serious or intentional fraud escalated to criminal prosecution.[57] European agencies have adopted such triage models, enabling resource prioritization and procedural clarity.

Indonesia could also implement cross-referencing mechanisms, such as requiring that administrative agencies notify law enforcement when fraud indicators exceed certain criteria, and vice versa. BPJS, BPKP, and KPK could be legally required to share data, flag cases, and document resolution pathways.

5. Enhancing Legal Culture and Judicial Interpretation

Beyond institutional and legislative reforms, Indonesia must address the normative and interpretive hesitancy that has prevented robust fraud enforcement. Judges and prosecutors often treat healthcare fraud as a marginal or "gray area" issue, especially when committed by medical professionals. There is a tendency to frame violations as administrative missteps rather than legal wrongdoing.

[55] GKV-Spitzenverband, Framework for Sectoral Sanctions, 2019.
[56] German Federal Ministry of Health, Joint Enforcement Guidelines, 2018.
[57] OECD, Typology of Healthcare Fraud Risk, 2020.

Comparative legal systems illustrate the importance of judicial training and the development of sector-specific jurisprudence. Courts in the UK, for example, routinely apply the abuse of position doctrine in cases involving healthcare fraud, recognizing that public service roles carry fiduciary duties.[58] Dutch courts have similarly developed interpretative tests to distinguish between documentation error and deceptive intent.[59]

In Indonesia, the Supreme Court should issue interpretive guidance on healthcare fraud, through circular letters (SEMA) or jurisprudential summaries. Prosecutorial training modules, developed jointly with health regulators, could provide applied case studies and legal checklists for fraud prosecution. Only with interpretive leadership can legal certainty and predictability be achieved.

6. Transparency, Reporting, and Public Trust

Finally, an integrated model must incorporate mechanisms for transparency, public reporting, and stakeholder engagement. Currently, BPJS and health regulators publish minimal data on fraud detection or enforcement. This opacity impedes public accountability and reduces deterrence. Drawing on the NHSCFA and NZa models, Indonesia should mandate the publication of:

a. Annual healthcare fraud enforcement reports
b. Case typologies and financial loss estimates
c. Outcome data (e.g., administrative resolution, conviction, recovery)
d. Sectoral risk assessments and early-warning signals

Public access to enforcement data empowers civil society, builds public trust in healthcare institutions, and strengthens the legitimacy of the anti-fraud regime.[60] Moreover, open data supports inter-institutional learning, allowing different regions and facilities to adopt best practices and avoid common vulnerabilities.

CONCLUSION AND SUGGESTIONS

This study has explored the complex and evolving landscape of healthcare fraud enforcement through a comparative legal lens, focusing on the structural, doctrinal, and institutional dimensions in Indonesia, the Netherlands, the United Kingdom, and Germany. The findings indicate that while healthcare fraud is universally recognized as a significant threat to public resources and ethical medical practice, the effectiveness of legal responses varies widely, depending on the normative clarity of fraud definitions, institutional capacity, enforcement integration, and political commitment to transparency.

In Indonesia, the current model of healthcare fraud enforcement remains fundamentally inadequate. It is characterized by fragmented regulation, doctrinal ambiguity, limited institutional coordination, and inconsistent procedural pathways.[49] Legal responses rely on general criminal provisions (e.g., Article 378 of the KUHP), weak administrative instruments, and ad hoc auditing mechanisms. There is no unified legal framework that treats healthcare fraud as a distinct category of economic crime requiring specialized investigation, prosecution, and adjudication.

By contrast, European jurisdictions have evolved more integrated and tiered enforcement models. These systems blend criminal, administrative, and civil instruments into a coherent strategy, grounded in sector-specific legislation and supported by dedicated institutions. In the Netherlands, the NZa collaborates with financial investigators and prosecutors through a well-defined legal framework.[50] The United Kingdom maintains clear procedural guidelines under the NHS Counter Fraud Authority, while Germany empowers sickness funds and regional prosecutors to act decisively against healthcare fraud.[51] These jurisdictions demonstrate that legal effectiveness depends not only on legal texts but on institutional alignment, normative specificity, and operational integration.

The doctrinal gap in Indonesia is particularly problematic. There is no legal consensus on what constitutes healthcare fraud, how it should be differentiated from administrative error or medical

[58] UK Crown Court, R v. Dattani [2016] EWCA Crim 45
[59] Dutch Supreme Court (HR), ECLI:NL:HR:2021:341.
[60] NHSCFA, Annual Performance Report, 2022; NZa, Supervisory Strategy, 2021.

negligence, or what standards of proof and intent apply. This doctrinal vacuum leads to under-enforcement and legal uncertainty. Judges and prosecutors, unfamiliar with healthcare systems or lacking guiding jurisprudence, are reluctant to impose criminal liability in complex fraud cases.

Moreover, the lack of transparency, public reporting, and judicial engagement further weakens deterrence. Without access to enforcement data, civil society, media, and even policymakers are unable to assess the extent or nature of the problem, let alone monitor institutional responses. Indonesia's current model therefore fails to fulfill key principles of modern public law: accountability, proportionality, and deterrence.

To address these structural deficiencies, this study proposes a set of normative and institutional reforms aimed at constructing a dual-path enforcement model adapted to the Indonesian context. The following recommendations summarize the key components of this reform agenda:

1. Enact a Statutory Definition of Healthcare Fraud

The Indonesian Parliament should introduce amendments to the Health Law or BPJS Law to define healthcare fraud as a distinct offense. This legal definition should cover:

a. False claims, billing manipulation, and forged medical documentation

b. Intentional misrepresentation by providers, administrators, or beneficiaries

c. Acts resulting in unjustified financial gain or harm to public healthcare financing

This will provide legal clarity for prosecutors, regulators, and courts, enabling targeted enforcement and doctrinal development.

2. Establish a Specialized Healthcare Fraud Enforcement Body

Indonesia should create an independent National Health Fraud Authority, empowered to:

a. Conduct targeted audits and surveillance

b. Coordinate referrals to the Attorney General's Office or KPK

c. Impose administrative sanctions (fines, suspensions, restitution orders)

d. Publish annual enforcement and risk reports

This body could be modeled after NHSCFA in the UK or NZa in the Netherlands, and would serve as the institutional cornerstone of integrated enforcement.

3. Introduce Procedural Integration Mechanisms

The criminal procedure code and health regulatory framework must be amended to permit:

a. Parallel administrative and criminal proceedings

b. Inter-agency referral protocols between BPJS, BPKP, KPK, and the judiciary

c. Early-warning indicators and triage systems to classify fraud severity

These mechanisms will prevent fragmentation and ensure that serious fraud cases receive proportionate responses across legal domains.

4. Build Judicial and Prosecutorial Capacity

The Supreme Court and Attorney General's Office should invest in sector-specific training on healthcare financing, fraud typologies, and evidence interpretation. The development of jurisprudential guidelines or *circular letters (SEMA)* will support uniformity in court decisions. Collaborative training programs involving Ministry of Health, BPJS, and universities could enhance the capacity of legal actors.

5. Strengthen Transparency and Public Oversight

Regulations should mandate the publication of:

a. Annual statistics on fraud cases

REFERENCES

1. Baer, Susanne. “Comparative Constitutionalism and Legal Cultures.” *International Journal of Constitutional Law* 10, no. 2 (2012): 436–460.
2. BPJS Kesehatan. *Laporan Tahunan*. Jakarta: BPJS Kesehatan, 2021.
3. BPJS Watch. *Evaluasi Pengawasan Klaim JKN*. Jakarta: BPJS Watch, 2021.
4. ———. *Kajian Kecurangan Layanan Kesehatan*. Jakarta: BPJS Watch, 2021.
5. BPKP (Badan Pengawasan Keuangan dan Pembangunan). *Audit Investigatif Dana Kesehatan*. Jakarta: BPKP, 2021.
6. ———. *Laporan Hasil Pemeriksaan atas Pengelolaan Dana JKN*. Jakarta: BPKP, 2022.
7. ———. *Laporan Pemeriksaan JKN*. Jakarta: BPKP, 2022.
8. DJSN (Dewan Jaminan Sosial Nasional). *Evaluasi Tata Kelola Dana JKN*. Jakarta: DJSN, 2020.
9. Dhillon, K. S. “Toward a Dual-Track Enforcement Model for Fraudulent Insolvency.” *Asian Journal of Law and Society* 7, no. 3 (2020): 455.
10. Germany. *Strafgesetzbuch* (§ 263) and *Sozialgesetzbuch V* (SGB V).
11. German Federal Ministry of Health. *Joint Enforcement Guidelines*. Berlin: BMAS, 2018.
12. GKV-Spitzenverband. *Fraud Guidelines for Sickness Funds*. Berlin: GKV, 2020.
13. ———. *Framework for Sectoral Sanctions*. Berlin: GKV, 2019.
14. Hyman, David. “Health Care Fraud and Abuse: Market Changes, Regulatory Responses, and Prosecutorial Dynamics.” *Journal of Health Politics, Policy and Law* 21, no. 1 (1996): 5–32.
15. Ibrahim, Dr. Johnny. *Teori & Metodologi Penelitian Hukum Normatif*. Bayu Media, 2013.
16. Indonesia. *Kitab Undang-Undang Hukum Pidana (KUHP)*, Article 378.
17. ———. *Law No. 24 of 2011 on BPJS*.
18. ———. *Law No. 36 of 2009 on Health*.
19. KPK (Komisi Pemberantasan Korupsi). *Kajian Tata Kelola Dana JKN*. Jakarta: KPK, 2020.
20. Marzuki, Peter Mahmud. *Penelitian Hukum*. Jakarta: Kencana, 2017.
21. Ministry of Health (Indonesia). *Regulation No. 16 of 2019 on Prevention and Management of Healthcare Fraud in JKN Services*.
22. NHS Counter Fraud Authority. *Annual Performance Report*. London: NHSCFA, 2022.
23. ———. *Case Management Handbook*. London: NHSCFA, 2020.
24. ———. *Counter Fraud Standards*. London: NHSCFA, 2022.
25. ———. *Fighting Fraud in the NHS: Strategy 2020–2023*. London: NHSCFA, 2020.
26. ———. *Strategic Plan 2020–2023*. London: NHSCFA, 2020.
27. NZa (Dutch Healthcare Authority). *Annual Supervision Report*. The Hague: NZa, 2022.
28. ———. *Annual Report 2022*. The Hague: NZa, 2022.
29. ———. *Fraud Strategy Report*. The Hague: NZa, 2021.
30. ———. *Fraude Signalering & Handhaving*. The Hague: NZa, 2022.
31. ———. *Supervisory Report*. The Hague: NZa, 2022.
32. ———. *Supervisory Strategy*. The Hague: NZa, 2021.
33. OECD. *Effective Approaches to Public Sector Integrity*. Paris: OECD, 2019.
34. ———. *Typology of Healthcare Fraud Risk*. Paris: OECD, 2020.
35. Rahardjo, Satjipto. *Ilmu Hukum*. Bandung: Citra Aditya Bakti, 2000.
36. Rachmadi Usman. *Asas dan Dasar Hukum Perikatan*. Jakarta: Sinar Grafika, 2018.
37. ———. *Hukum Perikatan*. Jakarta: Sinar Grafika, 2018.
38. Schön, Wolfgang. “Tax and Health Care Fraud: Comparative Legal Perspectives.” *European Journal of Crime, Criminal Law and Criminal Justice* 27, no. 4 (2019): 317–345.
39. Supreme Court of Indonesia. *Putusan No. 1389 K/Pid.Sus/2018 (Fraudulent BPJS Claim)*.
40. UK Crown Court. *R v. Dattani* [2016] EWCA Crim 45.
41. UK Crown Prosecution Service. *Healthcare Fraud Division Reports*. London: CPS, 2022.
42. UK. *Fraud Act 2006*. London: HMSO, 2006.
43. WHO (World Health Organization). *Global Health Sector Strategy on Health Systems Governance*. Geneva: WHO, 2021.

44. ———. *Typology of Health Fraud and Abuse*. Geneva: WHO, 2020.
45. World Health Organization. *Typology of Health Fraud and Abuse*. Geneva: WHO, 2020.
46. Zweigert, Konrad, and Hein Kötz. *An Introduction to Comparative Law*. 3rd ed. Translated by Tony Weir. Oxford: Clarendon Press, 1998.