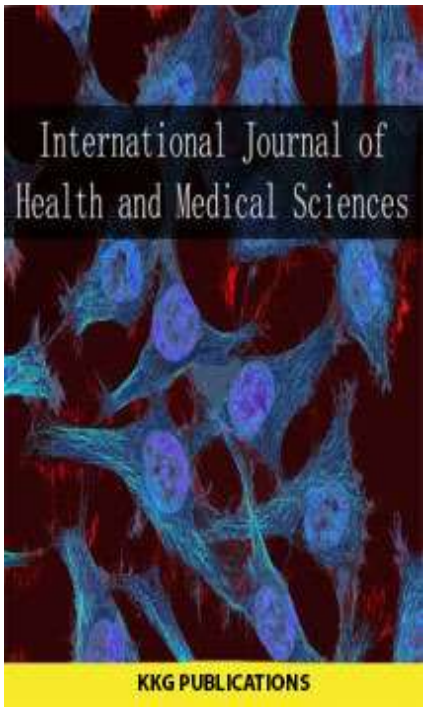

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ANALYSIS ON NATIONAL HEALTH INSURANCE FINANCING AT JENEPONTO REGENCY, INDONESIA

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Abstract. The health service funding by the Social Security Organizing Board (SSOB) is generally carried out by the pre-paid method for PHC and the post-paid method for the hospital. Meanwhile, the Health Service Providers (HSP) undergo difficulty in the budgeting of the National Health Insurance (NHI), primarily the claim disbursement in the form of the claim disbursement felt too complicated, claim file problem, subsequent claim magnitude, tariff incongruity proposed by the hospital with the INA CBGs tariff or being paid by the Health SSOB, disease diagnosis coding peculiarity, or the delay of the claim payment by Health SSOB. Therefore, the good management claim must and is important to be conducted by the Health SSOB. The research aimed at investigating the implementation of the National Health Insurance (NHI) financing at Jeneponto Regency. The research used the qualitative approach. The research was conducted in the hospital, PHC, SSOB, private clinic, and patients at Jeneponto Regency in 2014. The research informants included the hospital head, PHC head, SSOB head, clinic doctors, and patients. The research result indicates that the NHI financing still has problems in terms of the vagueness of the health service's real value and the hospital's inability in assessing the adequacy level of the NHI fund in line with the necessity, lack of comprehension of the hospital management concerning the NHI fund utilization. The hospital still complains of the delay in the claim verification result conveyance. The claim payment is carried out repeatedly, the claim disbursement procedure difficulty, the level of SSOB budget disbursement easiness to the PHC is not evenly distributed, there are still PHC'S which get the NHI fund payment once in four months, and the SSOB side does not pay the NHI fund because of the incongruity between the participant's card and family card so that PHC undergoes the loss because of this. The research concludes that generally, the NHI fund has been carried out properly, however, there are still problems in terms of fund adequacy, fund management comprehension, fund disbursement delay, the delay of the claim verification result, the PHC claim procedure difficulty of one payment in four months, and some other problems. Suggestion: it is necessary to provide the sufficient fund addition, punctual claim verification, fund management training, and claim simplification.

INTRODUCTION

The Law 1945 states that "every citizen has the right to have access to health care and the state is responsible for providing health care for all citizen". In Article 19 paragraph (1) of Law No. 40 of 2004 on National Social Security System (SJSN), is written "national health insurance is administered by the principle of social insurance and equity". Social health insurance with compulsory membership can raise funds from the public as a source of health financing, reducing direct payment system (out of pocket) and can improve the pre-effort system (pre-paid system) so that the universal health insurance coverage (universal coverage) can be implemented.

National health insurance was implemented since January, 1st, 2014 . The objective was to provide health care benefits and meet

the basic health need of the participant. During the implementation, the program experienced a transformation of the health financing system as the mandate of the Law 40/2004 on National Social Security System (SJSN). According to Presidential Decree No. 12/2013, health insurance was an insurance for participants to get a health protection so that the participant could obtain health care benefit and to meet basic health need provided to every person who had paid the premi of the insurance or was paid by the government. In 2019, BPJS on health have the target to cover 250 million people, the entire population of Indonesia will be covered by this health insurance program.

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During its implementation, JKN had a lot of things that need to be Improved both in terms of membership, services and financing. The obstacles during the implementation of JKN because JKN was lack of smart planning, either lack of at financing system or socialization factor, so that there were still many problems occurred from registration of the participants, and the financing system. JKN payment system with INA-CBGs had also produced a lot of problems in which the tariff was set without the involvement of health professional organization, so that the price paid by the patient was relatively low if compared with the services provided by the health personnel. As the consequences, many health personnel provided low quality of health services that ultimately led to much protest from the hospital and also from a professional organization.

BPJS administered health services financing by using pre-paid method to health center and post-paid method to the hospital. PPK had currently experienced many difficulties in financing the JKN, especially on the reimbursement of claim was difficult and complicated, the problem with the claim file, the problem with of the second claim, the price discrepancy between the tariff proposed by the hospital with the tariff set by INA CBGs or BPJS on Health, unfamiliar coding of disease diagnosis, or late payment of claim by BPJS on Health. Therefore, there should be good management by BPJS on health in handling the claim.

The result of the survey by student of FKM UI 2014 showed that there were several phenomena that required special attention from BPJS as the implementator of the program, such as; 1. The system of for health care provider or hospital referral used the INA CBGs. One of the Private Hospitals in Depok had lost 5% of their income because the tariff set by INA CBGs was lower than the standard tariff from the hospital. 2. Not all health centers had the facilities and infrastructure such as the availability of emergency room, laboratories, and other supporting polyclinics to handle 155 diseases set by JKN. Of course, this required the policy of the BPJS so that the health center could still refer the case of severe illness to the hospital.

Based on that finding, the government should anticipate the possibility of unintended problem that would be emerged, and to immediately address these issues in a holistic manner from planning to implementation, so that the systemic problem could be fixed and the organization could run well. Another important factor that need to get attention was the readiness of health staff in supporting the implementation of JKN. Since the launch of JKN, system and form of health services provided would undergo a variety of changes that need to be prepared, there was a need to improve the quality of health staff and other structure and infrastructure.

Objective

The objective of this study was to analyze the implementation of National Health Insurance, Financing in Jeneponto regency from Provider, and BPJS.

RESEARCH METHOD

Research Design

This study used qualitative approach. This approach concerned with the decomposition of the observed phenomenon and the context surrounding the meaning of a reality. A qualitative approach took place in a natural setting, the researcher was the main instrument. The data collection was in the form of descriptive data. It was more concern with the process rather than the result, and it used inductive data analysis [1].

Research Location

The research was conducted at the Hospital, Health Center, BPJS office in Jeneponto regency.

The Subject of the Research

The selection of informant was conducted by using purposive sampling technique, i.e. by selecting the informant with the criteria: understood the problem deeply, a reliable source of data, and be able to express his/her opinion accurately.

Data Collection

Literature-review, the method was used to collect secondary data, especially the basic concept or theories related to the object of study. Field study. The researcher observes directly to the object of study to collect primary data. The data collection used a set of instrument, such as observation, interview. The data collection used triangulation, i.e. in-depth interview, observation and document review.

Data Analysis

The data analysis used qualitative analysis to analyze the problem. The qualitative analysis technique analyzed the problem descriptively i.e. the study that emphasized the analysis of inference process on the dynamic between the observed phenomenon by using logic and argumentative by using the formal way of thinking [2].

Data Presentation

Data presentation would be in narrative form with some explanations.

THE RESULTS AND DISCUSSION

Types of Health Insurance from the Government

The results of the study showed that health care financing came from the fund of JKN and Jamkesda. Another finding i.e., the problem of calculating the real value of health services and the inability of the hospital in assessing the adequacy of JKN fund. Lack of understanding of the hospital management on the use of JKN fund. The hospital complained the slow progress of claim verification, double payment of the claim, the difficulty of the claim reimbursement procedure, the budget reimbursement of

BPJS was not evenly distributed to the health center, health centers still got a payment of JKN fund once for four months and BPJS didn't pay the fund of JKN because the card of the member was different with the card of the family so that the health center wouldn't get the fund for this case.

From qualitative data, it showed that in Jeneponto there were other types of health financing other than BPJS, the source was also coming from local government Province/City/Regency. We could identify this type of financing based on the statement of healt centre staff, who stated that the health center provided the health services, but the cost of providing these services was charged to the budget of Jamkesda because BPJS didn't want to pay such services.

"... Budget besides JKN is Jamkesda ..." (DGS)

Jamkesda was a type of health insurance that had been existed before JKN. Jamkesda was provided by the local governments (province, city and regency) to their people who use health services and the payement was paid by Jamkesda, both for low income community (poor) and for the high income community (rich).

The result of the study of [3] showed that if there was a lack of funding for health care for the poor families, then the local government that got a support from the stakeholder would allocate the fund from the local government budget.

Health financing program with a cross-subsidy mechanism got a support from the stakeholders as an alternative way to ensure the sustainability of health care for poor families in Buton. The obstacles in health financing in poor families in Buton was the readiness of human resources and the infrastructure as well as the limitation of local government funding.

The result of the study of [4] showed that the Health Insurance of Bali Mandara was one program that aimed to provide health care financing fully subsidized by the provincial government and district/city in Bali for people who didn't have health insurance.

The JKBM policy forced the Tabanan Regency to liquidate the Askes Mandiri Program while Jembrana decided not to take part in the JKBM program. In the midst of conflict, the development of JKBM could potentially expand to achieve universal coverage, improve the fairness in health financing and maintaining the principle of non-profit in its implementation. JKBM also had some weaknesses, such as the lack of attention to the principle of social solidarity and mutual cooperation. The role of the community in health financing that was started to be built by JKJ and Askes Mandiri was ignored. In addition to the weakness, JKBM also less adoption in the district health insurance who had first introduced so that it could potentially disadvantage some group of people from the aspect of portability and benefit coordination.

The result of the study by [5] showed that the health services provided for Jamkesda patient in Penajam Paser Utara was generally good, though there were still weakness on the services. The effort that was made to improve health services for Jamkesda patient at the hospital Penajam Paser Utara, as follow: Developing health care quality program by improving the human resources (HR) and optimizing the structure and infrastructure, the effort to improve human resource development i.e.,: asking the commitment of the employees by implementing the reward and punishment system, improve the quality and quantity of employees (medical and non-medical). The obstacles factors that inhibited the improvement of patient care for Jamkesda participant at the Penajam Paser Utara hospital such as: weak coordination between the unit/room due to different goal and different perspective, the internet technology had not yet connected to all the units in the hospital. There was a need to have more budget from the local government on the financing and regulation.

The existence of Jamkesda had positive and negative influence on the success of BPJS program to achieve Universal Health Coverage. This was due to people who were not the participantof BPJS could be served using Jamkesda fund. Thus, it is assumed that if the financing scheme is not integrated with Jamkesda BPJS, it will affect the level of the coverage BPJS.

On the other hand, if Jamkesda didn't integrate at BPJS, then it would influence the coverage rate of BPJS. However, the presence of Jamkesda could help the poor who didn't have JAMKESMAS card. As all we know, people didn't have JAMKESMAS card would automatically become the participant of BPJS, as a participant who received the premi (PBI). However, not all poor people had received JAMKESMAS card. With this Jamkesda financing scheme, the poor who didn't get JAMKESMAS card and unable to pay the premi of BPJS, then they could still receive health services using Jamkesda fund. It is important to remember that this year there would be no more participant who received the premi (PBI) from the government.

However, keep in mind that Jamkesda only provided the insurance to the residence in the City/Regency and The health services that could be accessed limited only to the area of the City/Regency. If people need to have further treatment to other health services outside the area of the City/Regency then they had to pay for themselves because Jamkesda would not pay it. This was certainly the advantages of BPJS, because the participant of BPJS could be served at all level of health services , from First Level Health Facility (FKTP) and FKTL (Advanced Health Facility) in Indonesia, especially if there was a cooperation between health provider with BPJS.

Pemanfaatan Dana BPJS Oleh Faskes

The Utilization of BPJS Fund by Health Facilities

JKN program managed by BPJS was still a new program for all health facilities and health facilities was required to be able to manage and utilize the capitation of fund and the claim fund that they received. So of course, the staff at health facilities should understand the use and the allocation of BPJS budget, which then would determine the competence and the capacity development at

the health facilities in providing health care services to meet the expectation of the community.

The problem in the hospital because they can't calculate the real cost of the health care in the hospital and the inability of the hospital in assessing the adequacy of BPJS fund (from the claim) with the need of the hospital budget. Then, it was also found a lack of understanding of the hospital management on the use of BPJS fund submitted to the hospital.

"There are funds provided by BPJS and we receive these funds previously from Jamkesmas transferred to JKN. The adequacy of the funding can not be assessed because we can't calculate the real cost of the health care in the hospital, but we are trying to use these funds in accordance with the minimum standard of the service so that if funds are not sufficient we wish there will be an extra budget. "(DAA)

If you read the interview excerpt above, it could be seen that there was a lack of understanding of determining the real cost of health care in the hospital, which could lead to uncertainty whether the fund would be enough or not to finance the JKN participant. The respondent expression to have additional budget showed a lack of understanding of the hospital management on the use of BPJS fund transferred to the hospital.

A similar situation was also expressed by the head of the section of mobilization of the fund at the hospital, as follow:

"No Special fund from BPJS, financing our activities is taken from our hospital budget. All operational costs are paid by the hospital, but for medical supplies are still covered by the local government. The funding received from BPJS is based on the submission of claims that have been verified by a third party and internal BPJS hospital ". (SRI)

The above statement also showed a lack of understanding of the hospital staff about the use of BPJS budget in the hospital. Because in fact, the operational fund for BPJS participant should be allocated from BPJS claim, not from other sources of the budget in the hospital.

The study of [6] indicated that the understanding of the content of the agreement in the MoU by all the relevant sections could prevent the occurrence of an error in the delivery of services and could avoid the rejection of claims by health insurance.

The Process of Claim and Payment Process

The payment of health care costs of BPJS to the hospital as provider based on the claims submitted to BPJS. Thus, the faster or slower payment of claims depended on the completeness of the process of filing a claim to BPJS.

Field findings showed that the hospital was still complaining about the slow delivery of the results of the verification of claims by BPJS:

"... the obstacles during this JKN era is the slow payment so that sometimes there is a miss/error. Sometimes the information we collect is not fast ... for example any constraints outside of the package cost ..... sometimes we get the information from the branch of BPJS that makes us confused. For Example: the delay of verification by BPJS, it also creates a problems for us "(WKR)

The slow verification of the hospital would delay the process of adding the necessary document which led to the late payment of claim to the hospital. In addition, the hospital staff also complained on the claim payment were not paid all at once. As revealed by the informant: "the constraint of BPJS payment is because the payment is not paid all at once, but only partial payment" (STR)

The study by [7] based on the analysis and discussion of the evaluation of internal control over payment of health insurance claims in PT. AJ Bringin Life Prosperity, stated that the Company had operated with good management. Some of their weaknesses and strengths in the company's internal control activities including; shortage of human resources at division claims, make a survey report with the old claims, the delay in the payment of claims, and the supporting archive documents for the payment of claims was put in two places.

In addition to the things mentioned above, the hospital also complained about the difficulty of the BPJS procedure to withdraw the fund from the district local government budget. So even though the payment of BPJS was paid every month, they were not able to immediately use these funds.

"The payment of BPJS is paid every month but sometimes we find some difficulties to draw it because there should be permitted from BPKD because the report must come first, but it is rather complicated since we first make a correspondence to the availability of new fund, then we can handle it"(RRJ))

The hospitals in Indonesia were categorized as a Public Service Board (BLUD) and non Public Service Board (non-BLUD). For hospitals with Public Service Board status (BLUD) , the budget from the claim would be transferred directly to the account of the hospital and did not require the approval by the local finance manager to draw it. However, not so for the hospitals with non Public Service Board (non-BLUD), BPJS funds would be transferred to the account of the local government and the reimbursement process similar to the process of taking APBD budget . This led to the slow utilization of BPJS fund in the hospital.

In contrast to the hospital, the feedback from health center staff about the process of filing and payment of claims from BPJS were varied:

"Because of slow payment, the BPJS told us that the fund has been transferred into the district health office account, but, the reimbursement is so slow, they told us it is still in the process "(KTJ)

"in the past, the payment model is transferred into the district health office account but now it is transferred into the health center account, but it is still remain the same because there must be a process/a letter from district health office for the reimbursement "(KTJ).

"they told us that the payment would be every month after JKN,

but in fact, it's just the same with jamkesmas, every four-month" (KTJ)

From the above interview, it could be seen that there was a variation of reimbursement of BPJS budget to the health center in South Sulawesi province. Capitation payment for outpatient and inpatient claims were transferred directly to the health center account, however the reimbursement still required the approval of district health office. Similarly, the delivery time of BPJS fund, the delivery of BPJS fund was carried out on 15th every month to health centers in the urban areas, while for health centers in the district, the payment was made only once for four-month.

The health center also got the disadvantage because they had to serve the patient and sometimes the cost for treating the patient were not paid by BPJS because there was a difference between the data card of BPJS with the Family card.

"Things that make us disadvantage is because we have served the patient, and sometimes the cost of treating the patient were not paid by BPJS because there was a difference between the the data card of BPJS with the Family card, ooh...sometimes we don't know, when we ask for the claim, then there is mismatch between the card of BPJS and the family card,....we then will not get the reimbursement. So, my advice is if the Jamkesmas patient have been treated then, there should be reimbursed, because if it is not the same with an identity card, then we will not get the payment, then we have treated them, we got a disadvantage because there are still many claims that have not been paid "(BTJ)

The study of [8] stated that the bottleneck occurred during the process of claims and, the effort of PT. Askes Indonesia to overcome these constraints were (1) The obstacles that occured during the process of claim could be explained, i.e. PT. Askes Semarang had struggled to provide social insurance to the participants of the Health Insurance, but in this case, the participant had to know their rights and obligations, They should follow the existing regulations therefore participant had to comply with the requirement and procedure established by PT. Askes Indonesia. (2) Efforts made by PT. Askes (Persero) Indonessia to overcome these obstacles were: (a) It was expected that the participant of health insurance paid more attention to everything related to his treatment or the treatment for his family member, so there was no longer the case of civ payment that would be disadvantaged the participant himself; (b) to give instruction to the entire Regional Office and Branch Office in Indonesia, to carry out the Administration Service of Social Health Insurance according to the guidelines referred to the first dictum in an orderly and responsibly; (c) To the leaders at all level of management and the Regional Office and Branch Office, to socialize the guidelines to all employee on their unit and to monitor its implementation.

CONCLUSION

In general, the JKN financing had been well-implemented, but there were still some problems in terms of the adequacy of funding, understanding the management of fund, the delay in the reimbursement of fund, the slow verification of claims, the difficulty of the procedure of health center's claim, it was paid once for four-month, and so forth.

RECOMMENDATIONS

The need for adding sufficient fund, claim verification and the reimbursement of fund are on time, the need for training of fund management and there should be simplification of claims.

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— This article does not have any appendix. —