



HEALTH FINANCING PLANNING IN HOSPITAL

Michelle Angelika S, Handar Subhandi Bakhtiar

Faculty of Health Law, Pembangunan Nasional Veteran Jakarta University, Jakarta, Indonesia

Email: michelleangelika111@gmail.com / handar_subhandi@yahoo.com

Corresponding Author:

Michelle Angelika S, MD

Faculty of Health Law, Pembangunan Nasional Veteran Jakarta University, Jakarta, Indonesia

Jl. Rs. Fatmawati, Pondok Labu, Jakarta Selatan, DKI Jakarta, 12450

Email: michelleangelika111@gmail.com

HP: (+62) 821-1155-9784

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ABSTRACT

Health financing is a factor that significantly affects the health quality of a country. Problems arising from health financing include a lack of funds and an increase in funds. This paper used a literature review as the method. The purpose of this scientific paper was to increase awareness about health financing in hospitals. Thus, this paper is expected to be useful in building financing plans to optimize health services. From various research articles, it can be concluded that the importance of health financing is used as a reference for targets that hospital activities in the future must achieve. The need for synchronization between one policy and another, starting from planning documents to budgeting. There is a strong relationship between the hospital institutional status and health financing pattern.

Keywords: health financing, planning, hospital

INTRODUCTION

Indonesia is a country that has a large population. The health of every citizen is one of the main elements in every person's life. This is because a person's health is very supportive of their daily activities. Health development in the nation's life has

a very large investment value, especially in human resources. By creating a healthy environment and maintaining the health of a nation's population well, the country will have more optimal human resources in development.(Putri, Paud and Medan, 2017)

Humans are starting to realize the possibility of overcoming any risks that might occur due to their daily activities. No one expects a risk to happen to him, even the lowest risk. It has become a human characteristic always to want profit and not want to lose. If the risk occurs, then the risk will be detrimental to the party affected by the risk. Humans certainly don't want to be exposed to risks, let alone bear those risks. The risk management in question includes being able to be transferred to another party who is willing to meet certain conditions.

The party willing to bear the risk is often referred to as the Insurer in the form of an Insurance Institution. The existence of insurance or coverage institutions in society is in line with the development and needs of the community. In the activities of modern society, insurance institutions have a fairly important position, namely as financial institutions in addition to banks, which are usually referred to as non-bank financial institutions.(Sari, SKM, MSE, 2018)

According to Law No. 44 of 2009, a hospital is a health service institution that provides complete individual health services that provide inpatient, outpatient and emergency care services. Public Hospital has a mission to provide quality and affordable health services to the community to improve the community's health status. The process of health services cannot be separated from health financing. Health costs are the number of funds

provided to organize and or utilize various health efforts needed by individuals, families, groups and communities.(Republik Indonesia, 2009)

Health problems cannot be adequately solved without adequate financial support. Health financing is a factor that significantly affects the health quality of a country. Problems arising from health financing include a lack of funds and an increase in funds. Lack of funds occurs due to inefficiency in financing management and the wrong allocation of funds. Meanwhile, what is meant by increased costs is the trend of increasing medical technology as a diagnosis base (evidence bases) which causes cost consequences, as well as the trend of supply-induced demand, which is currently widespread. In addition, the dominance of financing with a fee for service mechanism and the lack of allocating resources and services themselves (poor management of resources and services)(Ministry of Health RI, 2009). Therefore, it is necessary to examine related to the health financing system at hospitals in order to know how the implementation of health financing in hospitals in Indonesia.

METHODOLOGY

This research method reviewed problems based on normative jurisdiction. It was carried out through peeling and guiding conclusions from various explanations contained in several secondary data sources; all of them are relevant to the problems

to be discussed. This study used three approaches, namely: the statute approach, conceptual approach, and case approach (Ibrahim, 2006).

DISCUSSION

The Concept of Planning

Planning is a structured way of arranging activities or activities needed to prevent problems encountered to achieve the goals that have been set. Planning can also be defined as a way of achieving goals and possible with existing resources to be more efficient by paying attention to the socio-cultural, physical and biological environment (Ascobat Ghani, 2019)

WHO defines planning as a thorough, careful interpretation and effort to develop regular health services carried out on the basis of utilizing all modern science and experience.

The Concept of Health Financing

The process of health services cannot be separated from health financing. Health costs are the number of funds that must be provided to organize and utilize various health efforts needed by individuals, families, groups and communities. Based on this definition, health costs can be viewed from two points of view, namely:(Endra Budi Setyawan, 2017)

1. Health Service Provider is the number of funds that must be provided to be able to carry out

health efforts. When viewed from the point of view of service providers, health costs are the main problem for the government and/or the private sector, namely those who will carry out health efforts. The amount of funds for health service providers refers to all investment costs and all operational costs.

2. Health consumer is the number of funds that must be provided to be able to take advantage of the service. In this case, health costs are the main problem for service users, but within certain limits, the government also participates, namely in order to ensure the fulfilment of health service needs for people who need it. The amount of funds for service users refers more to the amount of money that must be spent (out of pocket) to be able to take advantage of a health effort.

Strong, stable and sustainable health financing plays a very important role in the implementation of health services to achieve various important goals of health development in a country, including equitable access to health services and access (equitable access to health care) and quality services (assured quality). Therefore, health policy reforms in a country should focus on health financing policies to ensure the implementation of adequacy, equity, efficiency, and effectiveness of health financing itself (Ascobat Ghani, 2019)

According to the Ministry of Health of the Republic of Indonesia (2004), health services have

several characteristics that do not allow each individual to bear the cost of health services when needed:

- 1) The need for health services appears sporadically and is unpredictable, so it is not easy to ensure that each individual has enough money when they need health services.
- 2) The cost of health services under certain conditions is also very expensive. For example, services in hospitals and advanced health services (surgeries and other special actions), emergency conditions, and long-term illness that the general public cannot afford.
- 3) The poor are more difficult to access health services and need more health services because they are vulnerable to various health problems due to poor nutrition and housing conditions.
- 4) If the individual suffers from the illness, it can affect the ability to function, including work, thereby reducing finances.

The World Health Organization (WHO) focuses on a health financing strategy that contains the main issues, challenges, main objectives of the policy and program of action in the following areas:

- 1) Increasing public investment and spending in the health sector.
- 2) Striving to achieve universal participation and strengthen health care for the poor.

- 3) The development of pre-effort financing schemes, including social health insurance.
- 4) Exploring national and international support.
- 5) Strengthening the regulatory framework and functional interventions.
- 6) The development of health financing policies based on scientific data and facts.
- 7) Monitoring and evaluation.

The implementation of a health financing strategy in a country is directed to several main things, namely; sustainability of priority health program financing, reduction of health financing in individual cash (out-of-pocket funding), eliminating cost barriers to obtain health services, equity in access to services, increasing efficiency and effectiveness of resource allocation (resources) and quality of service that is adequate and acceptable to service users. The sources of funding for health costs differ in several countries. In general, they come from: Government budgets; Community budgets; Cost assistance from within and outside the country, and the combination between government and community budgets.

Several things cause the high health costs, including a) inflation rate; b) demand rate; c) advances in science and technology; d) changes in disease patterns; e) changes in the pattern of health services; f) changes in the pattern of doctor-patient relationships; g) misuse of health insurance.

Health Financing System

The big question is what kind of health policy model should be implemented in Indonesia and what kind of financing system is suitable for the lives of our community. Several models of health care financing systems run by several countries, based on the source of financing:(Endra Budi Setyawan, 2017)

Direct Payments by Patients has the main characteristic. The direct payment model is that each individual directly bears the cost of health services according to the level of use. In general, this system will encourage more careful use of health services and competition between health service providers to attract consumers or a free market.

User payments. In this model, patients directly pay the cost of both government and private health services. The difference with the informal model is that the government and providers have formally regulated the amount and mechanism of payment and groups that are excluded.

Saving based. This model has the characteristic of 'risk spreading' for individuals, but there is no risk pooling between individuals. It means that the individual will bear direct health costs according to the level of use, but the individual gets assistance in managing the collection of funds (saving) and their use when they need health services.

Informal. The main characteristic of this model is that individuals make payments to formal health providers such as doctors, midwives, and other health providers such as elderly and traditional medicine; it is not carried out formally, or the amount, type and mechanism of payment are not regulated. The fees usually arise from an agreement or are primarily held by the provider and can also be in the form of payment in kind. This model usually appears in developing countries where they do not yet have a health care system and financing that can cover all groups of people and types of services.

Insurance Based System is financing with an insurance approach that has the main difference: the individual does not bear the direct costs of health services. The concept of insurance has two special characteristics: the transfer of the risk of illness to one individual in one group and sharing losses fairly. In simple terms, it can be described that a group of individuals has a risk of illness that has taken into account the type, frequency and amount of costs.

Health Insurance

Insurance is a condition to ensure that someone who is sick will get the services they need without considering his economic situation. Some parties guarantee or bear the costs of treatment or care. The party who guarantees is called the Insurer.

Insurance is the answer to the uncertainty of the occurrence of illness and the need for health

services. To ensure that the need for health services can be adequately financed, a person or small group of people transfers risk to another party called an insurer or an insurance agency.(Thabrany, 2001)

According to article 246 of the Commercial Code (KUHD), insurance is an agreement in which the Insurer loses himself to the insured by receiving a premium to compensate for the loss due to loss or not obtaining an expected profit can be suffered due to an unknown event. In terms of insurance, six basic principles must be met, namely

- 1) Insurable interest is the right to insure, which arises from a financial relationship, between the insured and the insured and is legally recognized;
- 2) Utmost good faith is an act to wholly and accurately disclose all material facts about something to be insured, whether requested or not. It means that the Insurer must honestly explain clearly everything about the extent of the terms or conditions of the insurance, and the insured must also provide clear and correct information on the object of the interest insured;
- 3) Proximate cause is an active and efficient cause that causes a chain of events and gives rise to an effect without the intervention of someone starting and actively from a new and independent source;
- 4) Indemnity is a mechanism whereby the Insurer provides financial compensation to place the insured in the financial position they have shortly

before the loss occurs (KUHD article 252.253 and emphasized in article 278);

- 5) Subrogation is the transfer of claims from the insured to the Insurer after the claim is paid;
- 6) Contribution is the right of the Insurer to invite other insurers who share the same, but not necessarily the same obligation to the insured to participate in providing the indemnity.

Generally, the insurance model encourages the emergence of moral hazard, including a) On the insured (patient) side, there is a tendency to maximize health services because all costs will be covered by insurance, and a tendency not to take preventive action; b) On the provider side, there is a tendency to provide excessive therapy to maximize income. Thus, some insurance schemes are arranged in such a way as to reduce the occurrence of moral hazard, for example, by setting limits on service packages, setting the amount of contribution according to the level of risk insured.

Health Financing in Hospital

The case-mix system was first developed in Indonesia in 2006 using INA-DRG (Indonesia Diagnosis Related Group) as the name. The implementation of payments with INA-DRG began on September 1, 2008, at 15 vertical hospitals. On January 1, 2009, it was expanded to all hospitals that collaborated for the Community-Based Health Insurance (CBHI) program.(Purwadi, 2019)

On September 31, 2010, the nomenclature was changed from INA-DRG (Indonesia Diagnosis Related Group) to INA-CBG (Indonesia Case-Based Group) in line with the change in grouper from 3M Grouper to UNU (United Nation University) Grouper. Thus, from October 2010 to December 2013, payments to Advanced Health Service (PPK) Providers in public health insurance (CBHI) used INA-CBG.

The INA-CBGs (Indonesia Case Base Group) system is a system in which the amount of claim payments by Healthcare and Social Security Agency (BPJS) to advanced level referral health facilities is a codification system of final diagnoses and actions or procedures that become service outputs referring to the International Code of Diseases Ten (ICD 10) and the International Code of Diseases Nine (ICD 9), Clinical Modification (CM) compiled by the World Health Organization (WHO). Based on the Regulation of the Minister of Health Number 27 of 2014 concerning Technical Instructions for the Indonesian Case Base Groups (INA-CBGs) System, it is stated that the INA CBGs are one of the patient data entry tools used to group rates based on data derived from medical resumes. To use the INA – CBGs application, hospitals must have a hospital registration code issued by the Directorate General of Health Efforts. Then, activation is carried out for each hospital according to the hospital class and regionalization.

Since implementing the case-mix system in Indonesia, there have been three changes in the number of rates, namely the INA-DRG rates in 2008, the INA-CBG rates in 2013 and the INA-CBG rates in 2014. The INA-CBG rates has 1,077 rates groups consisting of 789 group codes/ inpatient group and 288 code groups/outpatient groups, using a coding system with ICD-10 for diagnosis and ICD-9-CM for procedures/actions. The grouping of diagnostic codes and procedures is carried out using the UNU grouper (UNU Grouper). UNU-Grouper is a case-mix Grouper developed by United Nations University (UNU).

The INA-CBGs rates used in the National Health Insurance (JKN) program as of January 1, 2014, is enforced based on the Regulation of the Minister of Health, with the following principles:

The rates are grouped for seven hospital clusters: Class A Hospital Rates; Class B Hospital Rates; Class B Education Hospital Rates; Class C Hospital Rates; Class D Hospital Rates; National Referral Special Hospital Rates; National Referral General Hospital Rates. The rates grouping is based on adjustments after looking at the Hospital Base Rates (HBR) of the hospital obtained from the calculation of the total cost of hospital expenses. If there is more than one hospital in one group, then the Mean Base Rate is used.

Regionalization, the rates are divided into five regions based on the Consumer Price Index

(CPI) and has been mutually agreed upon between the Healthcare and Social Security Agency (BPJS) and the Association of Advanced Health Facilities.

There is an additional payment (Top-Up) in the INA-CBGs version 4.0 system for certain cases included in the special case-mix main group (CMG), including Special Procedures; Special Drugs; Special Investigations; Special Prosthesis; Special Groups Subacute and Chronic.

Top up on special CMG is not given for all cases or conditions but only in some instances and conditions. Especially in some cases or conditions where the ratio between the INA-CBGs rates that have been made is quite different from the hospital rates. A more detailed explanation of Top Up can be seen in point D.

There is no difference in rates between public and private hospitals, adjusted for the class determination owned for all hospital services based on the class assignment decree issued by the Indonesian Ministry of Health.

The INA-CBGs rates are package rates that include all components of hospital resources used in both medical and non-medical services. For hospitals that do not have class assignments, the INA-CBGs rates used are equivalent to Class D Hospital rates according to their respective regionalizations.

The calculation of INA CBGs rates is based on cost data and hospital coding data. Costing data are obtained from selected hospitals (sample

hospitals), representation of hospital class, type of hospital and hospital ownership (private and government hospitals), covering all cost data incurred by hospitals, excluding drugs whose sources of financing are from government programs (HIV, TB, and others). The coding data is obtained from the coding data of the PPK Community-Based Health Insurance (CBHI) hospital. To prepare JKN rates, data on the cost of 137 government and private hospitals and 6 million coding data (cases) are used.

Presidential Regulation Number 12 of 2013 concerning Health Insurance, as amended by Presidential Regulation Number 111 of 2013, mandates that rates be reviewed at least every 2 (two) years. The efforts to review rates are intended to encourage rates to reflect more and more the actual costs of services provided by hospitals. In addition, to improve the sustainability of the applicable rates system, be able to support the necessary medical needs and be able to give rewards to hospitals that offer services with good outcomes. For this reason, the involvement of hospitals in collecting complete and accurate coding and costing data is very much needed in the process of updating rates. (Republik Indonesia, 2013)

For example, a study conducted by Lasyera, Yeni Busuddin (2018) aimed to plan the business strategy of the Arosuka General Public Hospital. This study was carried out with a descriptive research design and a policy study with a qualitative

method. The results of this study indicated that there was a high relationship between spending on marketing and increasing sales, the market share of competitors decreases while the total industry sales increased, and the existing market was not saturated with the company's products and services. It means that the hospital must do careful planning and adequate budgeting for these promotional activities. Thus, the study results are the first step in making the Arosuka Regional General Hospital Business Strategic Planning.(Lasyera, Yeni and Busuddin, 2018)

Conclusion

Health insurance is the right choice for health financing because of the increasingly uncontrolled increase in service costs and the inability of public health to access services. Considering the economic condition of the state and society and the limited resources available, it is necessary to develop health insurance options with an efficient, effective and quality approach to reach the wider community. For this reason, it is time to develop national health insurance with managed care as its operational form. With wider insurance coverage, a wider service network (hospital) is needed. The demand for good quality services for the implementation of health insurance and the provision of health services will increase; continuous improvement efforts are the responsibility of health service providers and the

implementation of insurance. We recommend that you follow the health insurance program from an early age. This is to anticipate the rejection of health insurance participation because the risk borne in old age is enormous, in contrast to when you are young.

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