Analysis of BPJS Based National Health Insurance Program Financing For Sectio Caesarea Birth In Indonesia

Yulidar Ewi[1], Siska Hermawati[2], Erlina Puspitaloka Mahadewi[3]*

[1,2] Master of Public Health, Faculty of Public Health, Universitas Respati Indonesia
[3] Universitas Esa Unggul, Jakarta Indonesia
*Corresponding Authors:
Email: erlina.puspitaloka@esaunggul.ac.id

Received : 23 November	Revised : 19 January	Accepted : 08 February

Abstract.
The study focused on the purpose of finding out about caesarean section delivery is the last alternative to save the mother and fetus when normal delivery is not possible. The increase in caesarean sections worldwide has become a major public health problem, so there needs to be supervision to reduce the number of caesarean sections that are considered unnecessary, one of which is through the classification. The existence of health insurance for the Indonesian people, including BPJS which covers the cost of caesarean operations, allows for an increase in the incidence of caesarean sections. The purpose of the study was to analyze the financing status of the BPJS based National Health Insurance (JKN) program for caesarean section deliveries. This study used quantitative research with a cross sectional, the research sample was mothers who gave birth by caesarean section who used the BPJS National Health Insurance (JKN). This study discusses reporting for one year in 2023, participants who used BPJS national health insurance for caesarean section deliveries were 1117 participants. With the income of BPJS caesarean section services with hospital rates in UHC (Universal Health Care) 2019, will be implemented, while BPJS health according to Indonesia Law number 24 of 2011 is appointed by the government as a health insurance management agency. Data results show that the incidence of caesarean section using National Health Insurance (JKN) is still very high in hospitals. The management of hospitals needs to calculate service costs using unit costs so as not to experience a deficit and anticipate future management.

Keywords:*BPJS Healthcare;Caesarean Section; JKN; Insurance Concept and UHC.*

I. INTRODUCTION

Caesarean section delivery is a surgical process to remove the fetus through an incision in the abdominal wall and uterine wall. Delivery by the caesarean section method is carried out based on medical indications from both the mother and the fetus which can endanger the lives of the mother and fetus[1]. Delivery by caesarean section is the last alternative to save the mother and fetus when normal vaginal delivery is not possible. The increasing incidence of caesarean deliveries worldwide has become a major public health problem. The World Health Organization (WHO) sets the standard for caesarean sections in countries at around 10-15% per birth[2]. According to new research from the World Health Organization (WHO) in 2021, caesarean sections continue to increase globally, currently accounting for more than 1 in 5 (21%) of all deliveries. This number will continue to increase in the coming decades, with nearly a third (29%) of all births likely to occur by caesarean section by 2030[3]. Based on the results of the 2018 Basic Health Research (Riskesdas), the prevalence of caesarean sections in Indonesia was 17.6%, while the caesarean section rate in Indonesia was 17.6%. Caesarean section requires longer care compared to vaginal delivery; this condition also has the consequence of higher health care costs. The financing status of caesarean sections can come from personal or independent funds and use BPJS health insurance[4].

Currently, almost all diseases and operations can be covered by BPJS with the terms, conditions and procedures followed according to BPJS health regulations, one of the operations that can be covered by BPJS health is caesarean section (BPJS Health, 2018).The high incidence of caesarean sections, most of the financing status comes from BPJS, so supervision and audits need to be carried out to reduce the incidence of caesarean sections, one of which is by using the Robson classification[5].The development of health

insurance in Indonesia before 2014 was dominated by commercial health insurance managed by private insurance companies. Health insurance is only owned specifically for individuals who work in government agencies or individuals who work in private companies[6]. The National Health Insurance (JKN) program was born based on Law Number 40 of 2004 concerning the National Social Security System which mandates that the health insurance program is mandatory for all Indonesian citizens. The JKN program in Indonesia is managed by BPJS by implementing the principles of social insurance and the principle of justice and aims to ensure that participants receive health benefits and protection in meeting their basic health needs[7]. To organize social security for all Indonesian people in the health sector, in early 2014 the Indonesian government transformed PT. Askes (Persero) into BPJS. BPJS is tasked with providing health insurance for more than 121 million Indonesians.

The presence of health insurance BPJS has a positive impact on the insurance industry in the country. This is because the health insurance program implemented by BPJS Kesehatan can help introduce the importance of insurance to the public[8]. Since the enactment of Law in Indonesia No. 24 of 2011 concerning the Social Security Administering Body (BPJS), Indonesia is undergoing reform in health financing, although this policy still provides opportunities for Commercial Insurance to work together to implement JKN as partners. implementing the Benefit Coordination program and scheme, on June 21, 2016, the Government through the Regulation of the Health Social Security Administering Agency Number 4 of 2016 concerning Technical Guidelines for Benefit Coordination in the National Health Insurance Program issued regulations related to Benefit Coordination (COB). In this Regulation of the Health Social Security Administering Agency, what is meant by Health Insurance is a guarantee in the form of health protection so that participants receive health service benefits and protection in meeting basic health needs provided to everyone who has paid contributions or whose contributions have been paid by the government[9]. While Participants are everyone including foreigners who work for at least 6 (six) months in Indonesia, who have paid BPJS contributions.The number of participants in the National Health Insurance (JKN) Program organized by BPJS reached 222.5 million people as of December 31, 2020. This figure is equivalent to 81.3% of the population in Indonesia. The highest percentage is found in BPJS Kesehatan Contribution

Assistance Recipients (PBI) and companies or offices at 36.62% and 33.87% respectively. The next health insurance is BPJS non-PBI 24.12%, regional health insurance (Jamkesda) 9.56%, and private insurance 0.85%. Currently, out of a total of 26.78 million private workers, only 482,000 participants use the COB mechanism[10]. BPJS health insurance as the first guarantor has provided quite comprehensive benefits so that the burden of commercial health insurance claims can be reduced. This opportunity is not wasted by commercial health insurance companies in Indonesia. BPJS noted that there were an additional 52 health insurance companies that signed a cooperation with the COB scheme[11]. In 2015, there were 49 private insurance companies that collaborated with BPJS through the Coordination of Benefits (COB) scheme. For this reason, the role of Managed Care is very much needed in this condition[12]. The term "managed care" is used to describe a type of health service that focuses on helping to reduce costs while maintaining high quality of service[13]. The most common health plans available today often include managed care features. This includes provider networks, provider supervision, prescription drug levels, and more. It is designed to manage costs for everyone without sacrificing quality of service[14]. Managed care is a solution to the problem of high health care costs in health insurance.In addition, the evaluation also functions as a clarification and criticism of the values underlying the policy, helping to adjust and formulate problems in the next policy, so that it can be input to optimize effective prevention and mitigation efforts to be implemented in the implementation of the National Health Insurance program in Indonesia especially for the caesarean section birth in Indonesia[15].

II. METHODS

This type of research uses field research, with a qualitative descriptive approach with a design method. The method is used to analyze the calculation of the unit cost of a Caesarean section without complications based on the Activity Based Costing (ABC) method which can be used as a basis for considering the implementation of a Caesarean section using the ERACS method without complications in

the Group Hospital X care class in 2023. Then it can be used to compare the unit cost of a Caesarean section without complications with the ERACS and conventional methods. The data to be used in this study are primary data and secondary data. In collecting primary data, researchers conducted direct observations of the series of services for patients undergoing Caesarean section without complications from admission to discharge from hospital care[16]. Primary data was also obtained from direct interviews with the parties involved, namely Obgyn specialists, Anesthesia specialists, Pediatricians, registration, accounting, pharmacy staff, officers, midwives, and nurses involved since the patient entered the hospital, ER, delivery room, operating room, postpartum room, until discharge, as well as Caesarean section patients using the ERACS and non-ERACS methods.

Secondary data were obtained from literature studies conducted through searching for theoretical data related to the research object from Standard Operating Procedures (SOP), Clinical Pathway, hospital financial data, building inventory data, tools, supporting facilities, theories from books, research results, and previous journals. After the researcher collected the data, the researcher continued by processing the data through data analysis. The researcher used three data analysis techniques, namely data reduction, data presentation, and drawing conclusions. In the first stage, the researcher reduced the amount of data by carefully selecting data through observation, interviews, and documentationre[17]. Furthermore, the researcher organized the data that had been collected to make it easier to present. The data that had been collected, reduced, and then presented descriptively was what attracted the researcher's attention. In the final stage of analysis, the researcher presented arguments and conclusions based on the conclusions drawn from the data that had been presented[18].

III. RESULT AND DISCUSSION

The increase in caesarean operations also occurred in Indonesia. Data from the Indonesian Demographic and Health Survey (SDKI) showed an increase in the number of caesarean operations in Indonesia from 1991 to 2017 by 1.2-6.8%. Riskesdas in 2018 showed that the caesarean birth rate in Indonesia was 17.6%. The highest prevalence was in DKI Jakarta reaching 31.1% and the lowest in Papua at 6.7%[19]. Cesarean operations have become a trend, since last 10 years most mothers use caesareans because they do not feel significant pain or pain so that many want to see a doctor for a caesarean[20]. Now there has also been a growing suspicion in the community that children born by caesarean section produce greater cognitive or intellectual intelligence compared to children born normally because there are no contractions compared to other delivery methods[21].The increase in public interest in caesarean operations has also increased perioperative services. To increase the clinical benefits of caesarean operations, enhanced recovery care is an effective way to do it[22]. This can lead to the acceleration of the rehabilitation process and early patient discharge. ERACS (Enhanced Recovery After Caesarian Surgery) is a rapid recovery program after a Caesarean section in the form of a series of treatments ranging from preoperative preparation, intraoperative, and postoperative care to patient discharge[23]. The ERACS method is considered more effective than conventional methods, because it can reduce treatment costs and patients recover faster.

This is supported by the results of research by Fay et al. showing that the implementation of caesarean section with the ERACS method can reduce length of stay and save health care costs. Similar research was also conducted in other article showing that ERACS can provide faster functional recovery results, and can minimize complications, and reduce hospitalization time[24]. The ERACS concept is a development of the ERAS (Enhanced Recovery After Surgery) concept, where the ERAS concept was initially used in digestive surgery. The ERAS concept has been proven to reduce the length of stay of patients in the hospital, reduce postoperative complications, and increase patient satisfaction. Therefore, the ERAS concept was then developed for surgical procedures in other fields, one of which is in obstetrics[25].The calculation was done twice considering that in the second FGD, information was obtained that in calculating the basic cost for the tariff, Group Hospital X had not included the depreciation factor for Hospital assets. The calculation results above show that the general patient tariff that has been in effect so far is close to the calculation result of the unit cost when added with service fees[26]. The result also shows that

after the components that were calculated were similar, it turned out that the CRR increased, although slightly. This shows that the profit taken by the Group Hospital is very minimal for cases with uncomplicated SC procedures because it is close to the total costs incurred, both unit costs, facilities, and service fees. CRR calculation can also be done between INA CBGs tariff compared to the results of unit cost calculations and service fees for each class. During this study, there have been two revisions to the INA CBGs tariff standards, namely Minister of Health Regulation number 52 of 2016[27].

Months after it was issued, this Minister of Health Regulation was revised again with Minister of Health Regulation number 64 of 2016. However, changes in INA CBGs tariffs for SC cases only occurred in the first revision, namely Minister of Health Regulation number 52 of 2016. The CRR2 calculation was carried out twice, namely based on Minister of Health Regulation number 59 of 2014 and Minister of Health Regulation number 52 of 2016 from Minister of Health Regulation number 64 of 2016. This calculation assumes that the components involved in determining the tariff are the same as the components involved in calculating the unit cost. It is assumed that the investment cost has been calculated[28].The CRR2 calculation shows that the comparison of INA CBGs rates based on Permenkes no. 59 of 2014 with the results of the calculation of unit costs and applicable service fees is 55% for class II care and 60% for class I. This shows that the burden on hospitals to cover the operational cost deficit is around 35%. Hospital management needs to find other opportunities to cover the shortfall and increase revenue from other sectors. The CRR2 calculation based on Permenkes no. 52 of 2016 and no. 64 of 2016 shows a slight increase[29]. The bill received for providing SC services without complications in class II is 70% of the unit cost and service fees. For class I 72.5%. Although there has been an increase in the INA CBGs tariff, hospitals still have operational costs if they provide SC services without complications[30]. The difference in costs burdened by group hospitals is around 25 to 28%. This shows that the government has made efforts to adjust the tariffs closer to the real ones. However, it still needs to be improved so that the tariff standards set by the government can represent the conditions that occur in the field[31].

IV. CONCLUSION

The results of the study and discussion can be concluded as follows[32]:

a) Clinical Pathways for SC without complications have been prepared and can be implemented. In the research process, the preparation of Clinical Pathways for handling Healthy Newborns through Cesarean Section without complications was added considering that BPJS claims for healthy newborns are combined with maternal claims.
b) Clinical Pathways prepared in the previous stage have been implemented in BPJS patients.
c) The results of the unit cost calculation show a difference between the costs incurred by the Hospital in organizing SC without complications and the INA CBGs standard tariff. The INA CBGs ceiling cannot cover the Hospital's expenses in providing SC services without complications.
d) Cost analysis can be used as an evaluation of which items need to be cost efficient, which production units have high selling power so that they need to be developed as income generators, which production units have low selling power so that they need to be evaluated.
e) Cost analysis is expected to be a trigger in determining the direction of the Hospital X Group policy because cost analysis is able to present data well.

Hospital X Group's policy in facing the JKN program includes strategic steps: Reviewing the hospital tariff structure, Increasing the role of the quality control and cost control team as one of the cost containment tools by providing JKN service reports for each doctor in routine medical committee meetings per period, Increasing CoB as an opportunity for income generation by improving the quality of health services in hospitals[33].

V. ACKNOWLEDGMENTS

The authors are grateful to all support from the most important university team for their support to the research, learning, and sharing information’s also to the lecturers for the invaluable advice that made this study more complete.

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