A COMPARISON OF RATE FOR THE INTENSIVE AND NON-INTENSIVE CARE UNITS UNDER THE INDONESIAN CASE BASED GROUP SCHEME AT CLASS B PRIVATE HOSPITALS

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ABSTRACT

Background: The national health insurance (JKN) of Indonesia has implemented the Indonesian Case Base Groups (INA-CBGs) rates for health care payment. The INA-CBGs tariff rates are based on tariff on diagnosis grouping by using clinical and homogeneity of resource utilization approaches. The health care payment follows the CBGs code based on patient's disease diagnosis and does not consider the costs based on health services received by each patient. However, there is still problem of difference between the hospital real cost ofhealthcare and the INA-CBGs tariff. This study aimed to compare tariffs for the intensive and non-intensive care units under the Indonesian case based group scheme at class B private hospitals.
Subjects and Method: This was a descriptive study conducted at a private class B Hospital in Jakarta. The sample for this study included patients who were treated with the non-intensive and intensive care room. The data were obtained from November 2017 to October 2018. The data were analyzed descriptively.
Results: Hospital tariff was higher than INA-CBGs tariff, except for CBG N-4-10-2. The hospital tariff of the intensive care room was higher than non-intensive care room. There was a ≥10 million Rupiah difference in rate among CBG G-4-19-III, I-1-15-I and I-4-19-III.
Conclusion: Prospective payment of INACBGs has not been able to address difference in tariff for the same CBG cases with different room type.

Keywords: JKN, INACBGs rates, hospital rate, intensive space, private hospital

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BACKGROUND

Health insurance for all people was a human right, and it was recognized by all nations in the world, including Indonesia. This recognition was stated in the United Nations Declaration on Human Rights. Recognition of citizens' basic rights to health in Indonesia has been admitted through the philosophy and the foundation of the Pancasila, especially the fifth principle. This right was also enshrined in Article 28H of the 1945 Constitution and Article 34, and stipulated in Law 36 of 2009 which emphasized that everyone has equal rights in gaining access to resources in the health sector and obtaining safe, quality and affordable health services. Conversely, everyone also has an obligation to participate in social health insurance programs (President of the Republic of Indonesia, 2004).

The government was responsible for the implementation of public health insurance through the National

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Health Insurance (JKN) for the health of individuals. JKN is a guarantee in the form of health protection so that participants got the benefits of health care and protection in fulfilling basic health needs given to everyone who has paid contributions or paid by the Government.

JKN developed in Indonesia was part of the national social security system which was conducted by using the mandatory social health insurance mechanism. Social Security was a form of social protection to ensure that all Indonesians were protected in insurance systems, so that they can fulfill the basic needs of proper public health (President of the Republic of Indonesia, 2004, 2011). This JKN program was carried out by a specially designated board by the government, namely the Health-Social Security Organizing Agency (BPJS).

In the fifth year since the implementation of JKN in Indonesia, the number of BPJS Health participants was 217,549,455 (data of February 1, 2019), which mean that it has reached 77% of the Universal Health Coverage target (BPJS, 2019).

The utilization rate of hospitalization was 8.72 million cases in 2017, it increased by two times from the beginning of JKN starting in 2014 (DJSN, 2018). From a number of these cases, which the values have reached 132 Trillion (Jatmiko, 2017), approximately 26% were absorbed for the top 4 catastrophic diseases (Wibowo, 2017), namely heart disease, kidney failure, cancer, and stroke, which required intensive care.

The utilization rate of catastrophic cases up to 2016 was 11,124,535 cases (Ministry of Health, 2017), where this number always increased every year. The Advanced Referral Health Facility (FKRTL) that collaborated with BPJS also increased from 2014 by two times, the position at the end of 2018 was 2674 FKRTL, and almost 50% were private hospitals (BPJS, 2019).

Along with the increase in health facilities in collaboration with Health BPJS, which in this case was the hospital, and with the increasing number of utilization of inpatient cases would definitely broaden people's access to receive national health insurance benefits from the government. However, not a few patients and even fellow Advanced Level Referral Health Facilities (FKRTL) have difficulty in finding available ICU room for BPJS Health care patients (Samodro, 2017).

BPJS has required the hospitals to report the availability of hospital beds to be more transparent for the community (BPJS, 2017), but this was considered ineffective, because many hospitals have data that was not updated in real time and the intensive room on the dashboard was already used by another patients (Siregar, 2017).

JKN that has been running used a prospective payment system, namely a payment system where health service tariffs have been established before health services were provided to patients, the model set in line with the prospective system was a case based group (CBG) model. The CBG payment model in Indonesia was developed with the term INACBG. INACBG was a health service package rate that

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covered all components of hospital costs, from non-medical services for medical treatment.

INACBGs rates on certain CBGs were of the same value with the cases carried out in non-ICU and intensive (ICU) care. While from the comparison of RS tariff rates, the case with the same CBG was of course higher if the car was carried out in intensive room than in a regular room. The use of ventilator would increase INACBGs rate. This was the reason why the hospital seem to limit the availability of their ICU beds for JKN patients.

SUBJECTS AND METHOD

1. Study Design

This study was an observational analytic study. The study was conducted at a private class B hospital in Jakarta.

2. Sampling Technique

The sample data was obtained by purposive sampling from November 2017 to October 2018, which was data with the same CBG code, but the treatment was carried out in two types of treatment rooms, namely regular (non ICU) and intensive (ICU) rooms, and with same treatment grouping class. The exclusion criteria were CBG ventilator procedures, because the CBG was only in the ICU treatment room.

3. Data Analysis

The data were analyzed descriptively. Data was presented in the form of descriptions and tables.

RESULTS

There were 7 CBG samples with the same severity of treatment, both in the ICU and in the regular choir room. From all samples, it was found that the hospital rate was greater than the INACBGs rate, except for the CBG E-4-10-II in non-ICU care rooms, which were cases of diabetes and nutritional/ metabolic disorders of moderate severity and on CBG N-4-10- II in the ICU care room, which were cases of kidney tumors and urinary tract and kidney failure moderate level, the hospital rates were lower than the rates of INACBGs.

Table 1. Comparison of rates (RP) INACBGs with rates (RP) ICU and Non ICU hospital

NO	CBG	CBGS Rate	ICU Hospital Rate	Non ICU Hospital Rate	The difference between hospital rates
1	E-4-10-1 1	6,852,200	15,582,247	3,461,267	12,120,980
2	G-4-14-1 1	9,673,300	12,492,786	10,837,780	1,655,006
3	1 -1-15-11	8,877,800	39,112,869	35,796,292	3,316,577
4	1 -4-19-11 1	10,214,100	24,394,312	11,009,319	13,384,993
5	N-1-12-1 1 1 *	23,198,900	46,933,134	24,700,217	22,232,917
6	N-4-10-1 1	5,784,900	5,686,019	7,411,086	-1,725,067
7	N-4-10-1 1 1	8,508,800	14,818,811	10,814,335	4,004,476

Short Length of Stay (LOS) by 2 days (table 2), causing a positive difference in hospital rates. However, if it was compared between hospital rates in the two types of treatment rooms with the same CBG code, it was found that

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hospital sated in the ICU were all higher than the hospital rates in the regular treatment room, except for CBG N-4-10-II due to short LOS which was explained earlier. Where at the N-1-12-III CBG (making new one, revising, and moving heavy dialysis severity devices) has the highest difference, which was above 20 million rupiah between ICU and non-ICU care rates, and CBG E-4-10-II (diabetes and moderate nutritional/metabolic disorders) and I-4-19-III (conduction and cardiac arrhythmias severe severity) have a difference of over 10 million rupiah.

From Table 2 and Table 3, it was found that the average length of stay of patients who had been admitted to the ICU was 7 days, different by 1 day from the average length of stay of patients with the same CBG but treated in the regular care room (table 3). However, for the average hospital rates, there were differences in the average rate of Rp. 7,885,698 between the ICU and non ICU rooms at the same CBG.

Table 2. Comparison of rates (RP) INACBGs with rates (RP) ICU and ICU hospital

NO	CBG	CBGS Rate	ICU Hospital Rate	LOS	The difference between hospital rates
1	E-4-10-11	6,852,200	15,582,247	6	-8,730,047
2	G-4-14-11	9,673,300	12,492,786	5	-2,819,486
3	1 -1-15-11	8,877,800	39,112,869	3	-30,235,069
4	1 -4-19-111	10,214,100	24,394,312	9	-14,180,212
5	N-1-12-111 *	23,198,900	46,933,134	17	-23,734,234
6	N-4-10-11	5,784,900	5,686,019	2	98,881
7	N-4-10-111	8,508,800	14,818,811	7	-6,310,011
	Average			7	-12,272,883

Table 3. Comparison of rates (RP) INACBGs with rates (RP) of non ICU hospital

NO	CBG	CBGS Rate	Non ICU Hospital Rate	LOS	The difference between hospital rates
1	E-4-10-11	6,852,200	3,461,267	3	3,390,933
2	G-4-14-11	9,673,300	10,837,780	7	-1,164,480
3	1 -1-15-11	8,877,800	35,796,292	10	-26,918,492
4	1 -4-19-111	10,214,100	11,009,319	5	-795,219
5	N-1-12-111 *	23,198,900	24,700,217	10	-1,501,317
6	N-4-10-11	5,784,900	7,411,086	5	-1,626,186
7	N-4-10-111	8,508,800	10,814,335	4	-2,305,535
Average				6	-4,417,185

DISCUSSION

CBG cases that were treated in the ICU generally have moderate and severe severity levels, which were usually followed by a longer treatment day compared to the same CBG but were not treated in the ICU. The difference

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in longer care days between the two types of care rooms certainly has an impact on the higher rates of patient care.

The prospective payment system was a payment system with health service rates that have been established before they were provided to patients. With a bulk system like this, patients got health services according to their needs without any quality reduction. Through this rating system, the cost of health care costs can be predicted and suppressed to a certain extent, so that it did not burden patients and payers, but also can still provide a surplus number of health care providers. Determination of a prospective payment system for hospitals was determined by using a CBG system (Thabrany, 2008, 2014).

Understanding the CBG can be simplified by type of payment with unit costs per diagnosis rather than per type of medication or non-medical services provided to a patient in one episode of service. The CBG payment model in Indonesia was developed with the term INACBG. INACBG was a health service package rate that covered all components of hospital costs, from non-medical services to medical treatment.

In the INACBG system, patients were grouped into one episode associated with service costs. Each group has the same clinical characteristics, so the use of resources and costs incurred was also more or less the same. This grouping was based on cost data and disease coding data from selected hospitals. The INACBG rate/ cost system was 1077 CBGs consisting of 789 CBGs for inpatient care and 288 CBGs for outpatient care, with three severities, namely mild, moderate, and severe (Minister of Health, 2016). This high-paying payment made the hospital to work efficiently so that the costs set were sufficient to treat a single patient's episode.

Intensive Care Unit (ICU) was a unit of a hospital that was, specifically, with specialized workers and equipment that specifically intended for observation, care and therapy of patients suffering from life-threatening diseases, injuries or complications with dubious prognosis. Critically ill patients need special monitoring and living allowances that must be carried out by a team, including doctors who have a knowledge base, technical skills, time commitment, and were always physically in place to carry out titration and ongoing care. This treatment must be sustainable and proactive, which ensured that patients were managed in a safe, humane, and effective manner by using existing resources, in order to provide high quality service and optimal results. Because of this specificity, of course the ICU was one of the units with the highest investment costs of a hospital, which certainly has an impact on the high rates set at ICU services (Hanafie, 2007).

This study showed that there were no changes in the rates of INACBGs for cases of illness requiring ICU care. The INACBGs system issued by the Ministry of Health only facilitated changes in ICU rates if patients were subject to positive pressure ventilation. A few non-ventilator ICU patients also experienced long days of treatment with the same package rates as patients treated in regular care rooms. This can be a trigger for private hospitals working with Health

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BPJS to be reluctant to develop ICU services and care rooms and were reluctant to be transparent and accurate in providing information on ICU room availability for JKN patients. Therefore, there was a backlog of cases with severe severity in government class A hospitals and national referral hospitals, where in fact these cases can be served in private class B hospitals.

From the presentation of the results of the rate comparison above, where for the same CBG but the maintenance was carried out in two different spaces (ICU and non ICU) the INACBGs rate obtained was the same value. The policy recommendation that can be given for improving JKN service quality was to revise the INACBGs rates contained in Ministry of Health Regualtion No. 64 of 2016, with the addition of top ups for ICU care cases, where top up cannot be given if patients were treated in a normal room even though with the same CBG.

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