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Public service accountability at social security agency for health (BPJS Kesehatan) in Makassar city

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ABSTRACT

The implementation of increasingly complex health services demands a strong management system Research on accountability of BPJS in Makassar is important because of the existence of a phenomenon and empirical observation that describes BPJS service system which is less accountable in public service therefore the authors wish to study in accordance with good governance in order to study and analyze the application of accountability in public service at BPJS Health the city of Makassar in the hope of becoming a reference for the government in order to improve and improve the system of public bureaucracy accountability. This research was conducted at BPJS Kesehatan of Makassar using a qualitative approach. Data collection was conducted by interview to find information consisting of three categories. The focus of this research was to use accountability as an analytical tool to explain health service accountability at BPJS Kesehatan of Makassar consisting of Program Accountability, Program with Program Implementation indicator, BPJS Accountability Executive, BPJS Accountability Targets, and BPJS Accountability Standard. Data analysis was conducted inductively. Public Service Accountability at BPJS Kota Makassar is measured from the program accountability. It indicates that the level of accountability of this type of accountability is good. This condition is seen from the work program and its achievements. The extent of participant coverage shows that the program is getting better each year. But in terms of human resources, there are many still lacking to support the program.

1. Introduction

National social security system is a state program aiming to ensure the fulfillment of basic needs for a decent life for each participant and/or family member. In order to realize the objectives of national social security system, it is necessary to establish an organizing body in the form of a legal entity based on the principle of mutual cooperation, nonprofit, openness, prudence, accountability, probability, compulsory membership, trust fund, and all results of social security fund management for program development and for the main interests of the participants, with three basic norms of the implementation of SJSN (National Social Security System) namely the principle of humanity, benefit, social justice for all Indonesian people which was indicated in the Law of SJSN No. 40 in 2004. The social security program is mandatory allowing it to cover the entire population in stages. All people must be a participant without exception in an effort to realize health insurance for the entire population (universal coverage), which must be set forth in a systematic, comprehensive and integrated road map (Tunggal, 2015).

Various efforts have been initiated by the government by organizing some social security forms in health sector, including civil servants, pension recipients, veterans, and private employees. For the poor, the government provides Jamkesmas (National Health Insurance for the Poor and Near Poor) and Jamkesda (Regional Health Insurance). However, these efforts are still divided, so that the health cost and service quality are difficult to control. To overcome this matter, the legal status of the organizing body held by PT Persero is changed to BPJS (Social Security Agency), a public legal entity owned by all participants that keep using the company management system for efficiency and effectiveness (BPJS Kesehatan, 2014).

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The transformation of organizing body causes the tasks and responsibilities of BPJS in providing services to the community to become more complex. BPJS as a public legal entity that coordinates directly under the President will manage the Health Insurance for all Indonesian people. Therefore, BPJS Kesehatan (Social Security Agency for Health) workload automatically will be higher than the previous BPJS because nowadays there is no limit to the number of participants. Moreover, the social insurance principle states that the participants are obliged to give a monthly premium. Therefore, a more qualified service is expected to be comparable with the funds spent.

The implementation of increasingly complex health service demands a strong management system. A form of strong management system is how to create accountability in service governance as one of the demands for a good public service. The service quality in BPJS membership will be the main public spotlight as it is the latest program of the government that requires all the community and businessmen to be National Health Insurance participant at BPJS Kesehatan. Stone et al. (1989) argued that public accountability is one of the pillars of good governance. The better the public accountability, the more effective a government is. Therefore, accountability is crucial in achieving good governance. Osborne (2010) in his book The New Public Governance stated, "Accountability is often conceptualized as a mechanism for enforcing control over public organizations and programs, but it is also a means of guiding the improvement of programs." Good administrative governance is characterized when people are able to accept and understand it well. In addition, it also must be accepted both internally and externally within the organization. Accountability facilitates the community in viewing the transparency of decision in the formation of good governance (Drüke, 2007).

Good governance is one of the latest paradigms in public administration science today, so in its implementation it must be politically acceptable, legally effective, and administratively efficient. According to Sedarmayanti (2004b), there are four main elements or principles that can give an overview of good public administration namely accountability, transparency, openness, and law. Effective public accountability will lead to good governance. Indeed, good governance is not limited to how the government exercises its authority well, but more importantly is how the community can participate. This dynamics of governance emphasizes the relationship among sectors in synergy between government, private and civil society as a form of public participation in governance and sustainable development (UNDP, 1997). This condition is the choice for the government in running its government in a democratic and accountable way because this thinking is the most prominent issue and is textually viewed as a new theory of public administration. The observable phenomenon in the development of public sector today is the increasing demand for public accountability by public sector organizations. The demand for public sector accountability is related to the necessity of transparency and provision of information to the public in the context of the fulfillment of public rights (Mardiasmo and MBA, 2002).

Any activity undertaken by public sector agencies requires accountability to the public who has provided funds to the government. Accountability is the basic principle from regulation and expectation in all institutional relationship. The private sector, nonprofit, community organizations must be accountable to the public and their stakeholders (Drüke, 2007). However, the establishment of a healthcare accountability system in Indonesia through BPJS does not seem to meet the expectation. Some parties give assessment and indication that the implementation of this social security program has not been accountable yet. For example, KPK (Corruption Eradication Commission) suspects the extent of corruption gaps that might occur in this institution. Therefore, BPJS accountability is needed. Publication of operational regulation, information and technique of implementation must be transparent to prevent false presumption so that the public can monitor the implementation and development together.

The other problems are weak supervision and socialization by the government and BPJS that cause several problems in the implementation of Social Security Agency. First, different treatment occurs for two groups of participants between independent BPJS member and Healthy Indonesia Card (KIS - Kartu Indonesia Sehat) member borne by the Government, including the circulation of fake National Health Insurance card in several places. Second, the operational costs that can be seen from budget deficit due to the imbalance of health facility claims with premium received.

Some studies also reveal inadequate accountability of health services. One of them is a research on free services in Makassar, which shows the lack of transparency in the form of accountability of related parties in the implementation of health service. The lack of information disclosure to the public regarding budgeting and management of hospital administration, and lack of socialization makes the community can only accept any service provided. Previous research on BPJS has been conducted at UNHAS (Hasanuddin University) hospital showing that accountability in the administrative accountability aspect has not been implemented optimally, while other aspects refer to other types of accountability has not been in line yet with expectation (Maryati, 2015)

Research on BPJS accountability in Makassar is important because BPJS service system is less accountable in public service. Therefore, we would like to conduct a research in accordance with good governance in order to study and analyze the implementation of accountability in public service at BPJS Kesehatan of Makassar. We hope the research

will become a reference for the government in order to improve the system of public bureaucracy accountability in health and information services for Makassar residents as well as participate actively in the effort to create a public service accountability system in accordance with legislation and health services at BPJS Kesehatan of Makassar.

2. Research methods

This research was conducted at BPJS Kesehatan of Makassar using qualitative approach. Data collection was conducted by interview to find information consisting three categories: (1) general health decision maker: Makassar Government and Regional House of Peoples Representatives, (2) specialist policy-maker who were also directly involved in the provision of health services: Head of Social Security Agency, Head of the Health Service Office and staff, Director of General Hospital of Makassar area and Staff, and several heads of Puskesmas (Community Health Center) in Makassar, and (3) healthcare user (patient and patient family). The focus of this research was to use accountability as an analytical tool to explain health service accountability at BPJS Kesehatan of Makassar consisting of Program Accountability, Program with Program Implementation indicator, BPJS Accountability Executive, BPJS Accountability Targets, and BPJS Accountability Standard. Data analysis was conducted inductively.

3. Results and discussion

To get an idea about the extent of accountability implementation in health services, several types of accountability were used as analytical tool to explain the accountability of health services at BPJS Kesehatan of Makassar consisting consisting of Program Accountability, Program with Program Implementation indicator, BPJS Accountability Executive, BPJS Accountability Targets, and BPJS Accountability Standard. This type of accountability refers to the obligation of BPJS Kesehatan to act as the party who is responsible for all actions and policies established. Based on Chandler and Plano theory, Program Accountability is how an organization develops a quality work program in the form of development activities to realize the vision, mission and goals of the organization. Program accountability is related to the consideration of whether the objectives of the established program are achievable or not. In addition, the alternative programs that can provide optimal results with minimal, effective and efficient cost as well as qualified Human Resources (HR) that can run the program shall be considered.

3.1. Implementation of BPJS program

National Health Insurance Program - Healthy Indonesia Card (JKN- KIS) organized by BPJS Kesehatan enters its 4th year. There are a lot of hope, praise, and also criticism that accompanies the journey of the program that aims to improve the health status of community. As a public legal entity that is given the mandate to implement JKN-KIS program, the performance of BPJS Kesehatan throughout 2016 is also considered more positive. This is certainly a very important base to achieve Universal Health Coverage (UHC) in health insurance for all Indonesian people in 2019.

Implementation of JKN-KIS program has been passed with the achievement of improved performance. On the data obtained from the Health Office of Makassar, the implementation of JKN program continues to increase every year. From the data on the field, it can be seen that JKN program implemented by BPJS Kesehatan increases every year. In terms of membership, from the data obtained in the last three years, until 2017 it has been amounted to 1.292.604 from 1.469.601 Makassar population. This shows that the membership of BPJS Kesehatan continues to increase and has reached 88% from Makassar population. The number is close to the target of BPJS Kesehatan that initiates Universal Health Coverage (UHC) in 2019. Participation, annual visit at BPJS Kesehatan Facilities, including the number of referrals, general admissions and childbirth that continue to increase in the last three years shows that this program has given benefit to Indonesian people.

This program has also made Indonesia a focus of world attention. Due to the number of participation and citizen potential protected by JKN-KIS program, it becomes one of the largest health insurance systems in the world when compared to other countries that implement national health insurance system. From the data, it is seen that BPJS is fairly new at the age of 4 years compare to other countries. However, the program has already covered 70% from the total population of Indonesia. In addition, other countries take a long time to reach UHC for example South Korea takes 26 years, Belgium 118 years and Germany 127 years. As a comparison, Germany is known as a pioneer in the field of social insurance that is the basis of the modern social security system. The first social insurance was held in Germany in 1883 with a number of social security agency called sickness funds. They were no restriction at that time, so initially there were thousands of them and all of them were nonprofit agency. The large number of agency had caused inefficient and costly social security implementation in Germany. However, due to the complexity of health insurance issues and the need for large sum of money to ensure sufficient funds, mergers or displacements occurred because the agencies were bankrupt. If initially the number reached 5,000 and more, now the number is only 200s. The process of merging or dying due to bankruptcy occurs naturally for the efficiency and effectiveness of organizing. The system used by Germany is to require people with wage below 45,900 Euros per year to apply for the compulsory social insurance program. While those

who earn above that are allowed to buy health insurance from private companies, but once the choice is taken, they must continue to purchase private health insurance. As a result, many people who earn even above the limit have social insurance. Today, 99.8% of the population has health insurance and only 8.9% choose private health insurance. A small proportion of the population (such as the military and the poor) obtains insurance through special program (Grebe, 2015; Ruckert and Labonte, 2012).

While in Asia, South Korea began its social security by developing compulsory health insurance in 1976 after 13 years fails to develop voluntary (private) health insurance. Health insurance that must start from employers who have a large number of workers continue to be deducted. In 1989, the entire populations have had health insurance held by more than 300 nonprofit organizations. Now all the organizations are merged into National Health Insurance Corporation (NHIC), an autonomous/independent nonprofit public agency that practically cover the entire population (Lee et al., 2016). The retirement pension was implemented in 1988 where the employers with 10 employees or more are obliged to pay pension assurance. Since 2003, all employers with one or more employees are required to join a pension program run by National Pension Corporation (NPC). It is public agency that is not regulated or excluded from private law (company law). Both NHIC and NPC are a national-scale nonprofit organization under the supervision of the centrally managed Department of Health and Welfare. No other agency that is given the authority to manage the social security program aiming to secure social justice. Unlike NHIC that manages the entire population, except for the active military and the poor that are amounted only 3% of the total population, NPC only manages pension for private employees and informal sector. Pension for government employees, soldiers, school teachers, miners, and farmers are managed separately from NPC (Yang, 2005). At this time the entire population of South Korea has received health insurance and pension insurance from the two national agencies.

3.2. Executive of BPJS accountability

Regulation of BPJS Kesehatan No. 1 of 2014 mentions that the implementation of Health Insurance consists of membership, membership premium, health service provider, quality control and cost control, reporting and utilization review. Based on the regulation, it is explained that the programming is coordinated with the Ministry of Health and the implementation at the Health Facility level is held by the chairman of medical committee (BPJS Kesehatan, 2014).

Health service conducted at the health facility referred to in the Regulation are health service facilities to conduct individual health service, whether promotive, preventive, curative or rehabilitative by Government, Local Government and/or Community. Implementation of BPJS Kesehatan service is conducted by stages. First, at First Level Health Facility (FKTP) service specifically at health center then continued at Advanced Level Health Facility (FKTL) specifically at the hospital.

First Level Health Service is a non-specialist (primary) individual health covering outpatient and inpatient services. First Level Outpatient is a non-specialist private health service conducted at a First Level health facility for observation, diagnosis, treatment and/or other health services. First Level Inpatient is a non-specialist individual health service and is conducted at First Level health facility for observation, treatment, diagnosis, treatment and/or other medical services, where the participant and/or family member is hospitalized for at least 1(one) day.

Advanced Level Referral Health Facility, hereinafter abbreviated as FKRTL, is a health facility conducting specialist or sub-specialist personal health services that includes advanced outpatient, in-patient and in-patient care in a special care unit. Advanced Referral Health Services is a specialist or sub-specialist individual health service that includes advanced outpatient care, advanced inpatient care, and in-patient care in special care unit. In this study, we conducted observation at RSUD (Regional Public Hospital) Daya, the Referral Center of Makassar North Gate determined as Type B General Hospital.

The health development policy is focused on strengthening the quality of Primary Health Care service primarily through improving health insurance, access and quality of basic health service and referral supported by strengthening health system and improving health financing. Healthy Indonesia Card becomes one of the main means in supporting health sector reform in achieving optimal health service, including strengthening the promotive and preventive efforts.

Implementation of BPJS health service is conducted by stages (First at First Level Health Facility (FKTP) specifically at Puskesmas). Gatekeeper Concept is a concept of a health care system where First Level health facilities that serve as primary health care providers function optimally according to their competency standards and provide health service according to medical service standard. The purpose of optimizing Puskesmas as Gate Keeper is to optimize the role of First Level health facilities in the health service system, optimize the function of health facilities to provide health service in accordance with competence standard, improve the quality of health service in advanced health facilities by service screening that need to be referenced to reduce the workload of hospital, organizing the referral system, increasing the participant satisfaction by providing quality health services.

The important role of FKTP as Gate Keeper is expected to function optimally and provide better health quality to the participants. By optimizing the role of FKTP, it will reduce the burden of state in health financing because it can reduce morbidity and

visit to the advanced level health facilities. As a result, the first level health facilities are distributed greater in order for more public to access to health services.

3.3. BPJS accountability target

Public services in health sector provided by the government to the community are not solely conducted by the government to carry out its duties in fulfilling the needs of the community. The element of accountability for the services that have been given to the community must be fulfilled too. So the principle of accountability is needed in the implementation of public services. According to Sedarmayanti (2004a), accountability is intended to find answers to what, who, whom, whose, and how questions related to the service. Accountability is also an instrument to control activities, especially in achieving good results on public services. Based on these statements, the principles of accountability and public services are interconnected since the government as a service provider for the community must be accountable for the performance. The community as the service recipient from the government is also entitled to know the government performance in terms of service delivery. Related to the above explanation, BPJS, FKTP, and FKTL as service providers are required to provide maximum service for the community and carry out accountability. But based on observation, it shows that the comparison between Human Resources and community served is not comparable especially the health workers, which is the main driving factor in achieving the goals and success of health development program.

The program targets as set forth in Law of BPJS article 37 are reported in the form of a program management report audited by public accountant to the President with carbon copy to DJSN (National Social Security Council) no later than 30 June of the following year. The form and content of the program reports are proposed after consultation with DJSN. Subsequently, the management Report of the program shall be determined by the Board of Directors upon approval by the Board of Supervisors. Subsequently, it is published in the form of executive summary through an electronics mass media and at least 2 (two) printed media with national scale, no later than July 31 of the following year to the Community.

3.4. BPJS accountability standard

Efforts to realize quality public services within government institutions can also be performed by cultivating the concept of public accountability. This is in line with Hugger's opinion stating that government institutions are actually created and held by the public, therefore employees in government institutions must be responsible for their performance to the public. It consists of behavior, attitude, action, and decision made in order to carry out the duty and authority given by the public.

In the context of health service, health as a basic human right should be accessible to all people. In discussing this issue, it is a good idea to refer to work of Denhardt and Denhardt (2001) on the concept of NPS (New Public Service). One of the roots of NPS is Democratic Citizenship theory. In this theory, the government has an obligation to guarantee the individual rights of citizens through various procedures. Denhardt and Denhardt (2001) said, "The role of government is to make sure that the interplay of individual self-interest operates is freely and fairly". It means that the citizens involve themselves in the determination of government policy. Borrowing the term by Mansbridge (1994), it is called as "public spirit".

NPS does not place its citizens as customers as in NPM (New Public Management) paradigm. Citizens are the state fundamental in which the state is responsible for assuring the various interests. Denhardt and Denhardt (2001) said that citizens are not merely a "customers", but rather an "owner". Citizens are not like customers who choose something as they like. Instead, citizens demand the government to provide something that they think is important. On the other hand, the government is generally responsible to citizens as constituent; not to "customers" who are limited to their personal interests only. And ultimately the main orientation of the state is not the profit or citizen satisfaction, but their accountability as a public organization regulated by law. BPJS programs have been implemented under Law of BPJS No. 24 of 2011 on Social Security Agency, which is a follow up of Law No. 40 of 2004 on National Social Security System.

From the explanation above, the health care system in Indonesia should be based on NPS values, not NPM. So treating citizens as citizens (not customers) is an important agenda within the health care reform in Indonesia. People should get their right of health, not buy it. The National Health Insurance Program (JKN) organized by BPJS Kesehatan has been running for four years in Indonesia. Apparently in the implementation of JKN program, there are still many obstacles that must be addressed in stages before heading to 2019 where the entire Indonesian population has become a participant BPJS Kesehatan. Until now the health BPJS program still suffered from 3 main problems. Among them are participation, operational cost, and service. The first obstacle is about membership, which requires a faster activation because the new membership activation only can be used only after 14 working days.

From the information, it can be found that the activation process that takes several days causes problems for the service users. However, BPJS explains that the purpose of such action is to prevent excessive ratio of claims at the beginning if the person is sick. The community is expected to change the mindset from the habit from treating to preventing illness. BPJS Kesehatan requires a good

public mindset to educate the community not to register into insurance after get sick, with the insurance principle that is “Have an umbrella ready before the rain" and because it not a social assistance. This regulation is set forth in Regulation of BPJS Kesehatan No. 1 of 2015 on the procedure of Registration and Premium payment for Non-Wage Workers (PBPU) and Non-Worker Participants.

The community has not understood the membership listed in one particular health facility that requires treatment in other places well. From this information, participants should have access to health services at First Level health facilities where they are registered, except they are outside the area of First Level health facilities or if they are in a medical emergency. After the membership is active, the service flow uses a tiered referral pattern that begins from the primary to tertiary service system in order to avoid accumulation in one hospital. For emergency such as accident or disease that cannot be handled in primary care, they can go directly to the hospital.

The second major obstacle is the operational costs specifically the cost-management procedure system from the health facility. Here, there is still late payment or underpaid payment by BPJS due to the system that often troubled. In addition, there is still a lack of understanding of BPJS financing procedures. From the description above, the obstacles of BPJS program occurred in the system does not in accordance with what is desired by BPJS users, in this case is at Puskesmas and hospital. Consequently, there are late of payment claim financing or unpaid. In addition, there is a lack of understanding from the community about the types of disease and drug that are not covered by BPJS. They also do not quite understand the tiered procedure. In overcoming the lack of operational cost, Puskesmas and Hospital continue to evaluate and then give advice to doctors to prioritize the provision of generic drugs to be more efficient and effective in dealing with disease treatment. In addition, community participation is very influential in operational cost where tiered procedures are performed so that for certain diseases can be handled at Puskesmas without having to be referred to the hospital to make a more efficient operational cost.

Moreover, there is a stigma in the community that BPJS service takes time. In short, the service quality becomes the main concern for the community. This weak performance is caused by the small number of workers that makes the serve given does not meet the expectation.

4. Conclusion

Public Service Accountability at BPJS Kota Makassar is measured from the program accountability. It indicates that the level of accountability of this type of accountability is good. This condition is seen from the work program and its achievements. The extent of participant coverage shows that the program is getting better each year. But in terms of human resources, there are many still lacking to support the program. Human resources need to be improved in quality so that they can work better in the field in order to make this program running effectively. The program target is correct because it has been regulated by law. To sum up, even though there are still disadvantages, this program has been running according to predetermined standards.

Compliance with ethical standards

Conflict of interest

The authors declare that they have no conflict of interest.

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