Implementation of the Referral System Policy in the National Health Insurance Scheme at Community Health Centers, Ngawi District, East Java

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ABSTRACT

Background: It has been reported that there are some obstacles in the implementation of the National Health Insurance, one of which is its referral system. Community Health Center is expected to serve as a gatekeeper, such that most of the health problems can be tackled at the Community Health Center. However, anecdotal evidences had shown that the referral system did not run as expected. This study aimed to examine the implementation of the referral system in the National Health Insurance scheme with special attention on the policy context and resources availability at Community Health Centers in Ngawi, East Java.

Subjects and Method: This was a qualitative study conducted in Ngawi, East Java. The institutions under study included 3 Community Health Centers of different strata Geminggar Community Health Center (highest strata), Ngawi Community Health Center (medium strata), Kasreman Community Health center (lowest strata). The other institution under study was Ngawi District Health Office. The informants for this study included 24 patients of various categories at Community Health Center: subsidy recipients, class I, class II, and class III. The other informants included 1 staff from District Health Office and 6 staff from Community Health Center. The data were collected by in-depth interview, observation, and document review. The data were analyzed by data reduction, presentation, and verification.

Results: The policy on the referral system of the National Health Insurance (NHI) was good but its implementation was poor. Outpatient referral was still high because of community ignorance regarding referral system. It was often the case the referral was based on patient request. The referral system problem also stemmed from the shortage of medical doctors and health equipment at the Community Health Center. Nevertheless, the availability of medicine and funding at Community Health Center were sufficient. The sources of funding included General Allocation Fund (DAU), Special Allocation Fund (DAK), Special Allocation Fund for Operational Affairs (BOK), and capitation. Community Health Center only managed capitation and BOK.

Conclusion: There is a need for socialization to the community regarding the current referral system of the National Health Insurance either through the media or the BPJS representative at the Community Health Center. In addition, there is a need for recruitment of doctors with a clear salary regulation, and health equipment upgrade at Community Health Center.

Keywords: Referral system, resources, National Health Insurance

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BACKGROUND

Health is right for every human being. As it was mandated by the 58th annual WHA (World Health Assembly) 2005 in Geneva, it expected every country worldwide to de-velop Universal Health Coverage (UHC) for all population with social insurance mechanism since it is in accordance with the main component of Universal Health Coverage (UHC) that each person needs quality

healthcare and to protect them from financial risk toward expensive price of healthcare. Considering that matter most countries worldwide including Indonesia attempt to develop the mandate of WHA resolution with social insurance mechanism.

The government of Indonesia makes a serious effort to develop health insurance by issuing legal protection of Law No. 40 / 2004 on the subject of National Social Security System (NSSS) or also known as National Health Insurance (NHI). On 1 January 2014 Social Security Agency called BPJS was established. The legal protection is Law No. 24/ 2011 and is guided by Presidential Regulation No. 28/ 2016 on the subject of the Third Amendment of Presidential Regulation No. 12/ 2013 on the subject of National Health Insurance (NHI). Social Security Agency or also known as BPJS implements the mandate with not for profit principle and perform its role function based on the principles of humanity, mutual cooperation, benefit and social justice for all Indonesian.

The points or concepts of National Health Insurance include: health financing, healthcare provision, regulation and production of health resources. The healthcare service is provide by Community Health Centers as the First-Degree Healthcare Facilities (FDHF) and both government-owned and private-owned hospitals as Advanced Referral Healthcare Facilities (ARHF).

Community Health Centers function to give comprehensive healthcare service by giving priority to promotive and preventive healthcare service. Community Health Centers as primary healthcare facility is expected to be able to become gatekeeper in the healthcare service scheme of National Health Insurance era, therefore it is expected that most of healthcare services are tackled at Community Health Center. Community Health Center as the gatekeeper itself has 4 functions or roles, namely as the first contact, as the continuity, as the comprehensive service and as cross-sectors and hospital collaboration or cooperation.

There are a lot of obstacles found during journey of almost three years in implementing National Health Insurance (NHI) one of them is in term of healthcare service provision. In addition, the intervention model of healthcare service whether it is promotive, preventive, curative, rehabilitative are not yet optimally unconducted (Boerma, 2014). A study by Ali et al. (2014) in Siko and Kalumata Community Health Center stated that the implementation of referral system is not yet well performed because of poor understanding of the officers, consumable medicines and materials are late to be delivered, the availability of facilities and medical instruments that does not meet the needs of the patients makes patients are referred easily since they do not obtain the appropriate service. It also enables the emerging of problems on the implementation of National Health Insurance (NHI) in various places in Indonesia.

Preliminary study conducted in Ngawi Regency found several problems in the implementation of NHI from the aspect of provision of healthcare service, either from the quality that comes from employees' performance, inadequate human resources or the unavailability of facilities. From the aspect of referral system, it is less able to function well because of at one's own request referral pattern and less functioning re- referral.

The study aimed to analyze the implementation of national health insurance policy on referral system by evaluating the context of the policy and the availability of resources in Community Health Centers of Ngawi Regency, East Java.

SUBJECTS AND METHOD

1. Design of the Study

The study employed descriptive qualitative method. The method used for selecting the Community Health Centers as the location of the study was Purposive Sampling, in which Community Health Centers were selected based on stratification conducted by Health Office hence it obtained the result as follow Gemarang Community Health Center as the highest strata, Ngawi Community Health Center as the medium strata, and Kasreman Community Health Center as the lowest strata.

2. Informants of the Study

Subjects of the study were from Health Office and Community Health Centers who were selected by mapping information, in which they were the ones who understand the policies and implement national health insurance. Patients were selected by using purposive sampling method with the criteria: they were categorized into subsidy recipients, class I, II, and III of self reliance members. Therefore, the informant of the study were 1 person of Health Office, 6 persons of Community Health Centers and 24 patients.

3. Data Collection and Analysis

The data were collected by using in-depth interview, observation and secondary document study. They were analyzed through data reduction, presentation, and data verification.

RESULTS

1. Context Evaluation

The main problems in implementing referral system were intractable people and there were a lot of at one's own referral. The policy or regulation issued by Government of Ngawi Regency along with Health Office in the implementation of national health insurance were already sufficiently good, one of them was by initiating Jamkeskab or

Regency Health Insurance which was employed by underprivileged population. Based on the aspect of policy and regulation in Community Health Center on the implementation of national health insurance, they issued Joint Regulation of General Secretary of Health Ministry and the President Director of BPJS No. 2/ 2017 on Service Commitment Based Capitation.

The regulation functioned as the replacement for the previous regulation which was Joint Regulation of General Secretary of Health Ministry and the President Director of BPJS No. 3/ 2016 on Service Commitment Based Capitation.

One of the benefits of the new regulation was to control the ratio of referral in Community Health Control which was later adjusted with the amount of capitation received by Community Health Center. The other benefit was optimizing the function of Community Health Center's role as the gatekeeper as well as aimed to improve service commitment of Community Health Center. However in its implementation, it was still difficult since it was less relevant with the real condition in Community Health Centers of Ngawi Regency. The reason was the lack of human resources in the form of doctors and medical equipment which was still in the process of development.

The payment of service commitment based capitation that was adjusted with the number of referral and without considering the frequency of patients' visits seemed less satisfying for Community Health center. It was because the remuneration obtained was disproportionate with the fund managed for the operational activities in the Community Health Center. In other aspect there was no other options for Community Health Center so that they had to follow the regulation.

2. Input Evaluation

The availability of resources in Ngawi Regency in some aspects still need to be improved. Human resource, in particular doctor was insufficient since the number only met the capacity of a half of Community Health Centers in Ngawi Regency. Gemarang and Ngawi Community Health Centers had two general practitioners and dentist, whereas Kasreman Community Health Center only had general practitioner without any dentist.

The availability of medical equipment was about 55-60% of the medical equipments should be available in Community Health Center. In accordance with Health Minister's Regulation No.75/ 2015 the availability of medical equipment in Community Health Center should be at least 80%. The funding source of Community Health Center was sufficient. Some were managed by Health Office, such as Special Allocation Fund (DAK), General Allocation Fund (DAU), cigarette excise, and BK (special equipment aid from Province Government). Non Physical DAK or is known with Special Allocation Fund for Operational Affair (BOK) as well as capitation fund were self-managed by Community Health Center.

The number of medicines resources was sufficient for annual planning and budgeting. The planning proposal was addressed to Health office and the medicines were sent from GFK. The medicines which were not provided by GFK would be provided by Community Health Center independently by using capitation fund.

DISCUSSION

1. Context Evaluation

The implementation of national health insurance policy of the Government of Ngawi Regency by means of initiating the policies issued by the Regent of Ngawi namely the establishment of Regional Public Service Agency (BLUD) for each Community Health Center, implementing accreditation of first degree healthcare facilities, the occurrence of Jamkesmas (National Health Insurance for the underprivileged), and initiating Jamkeskab (Regency Health Insurance for the underprivileged).

With the existence of BLUD it is expected that each Community Health Center may perform initiative in recruiting health workers which are not yet available, doctors in particular. In addition, it can make another income for the Community Health Center to fund their activities. The absence of explicit payment system in BLUD turns into obstacle particularly in doctors recruitment, thus it is not yet necessarily that they are willing to work in Ngawi Regency.

The establish of Jamkeskab was issued by the Regent of Ngawi since there were a lot of underprivileged population who were not yet covered in Jamkesmas. There are still obstacles in the implementation since it is difficult to set the criteria of underprivileged. Inaccuracy happens since officers from Social Office did not conduct direct survey and recording in the field toward the underprivileged population.

The initial foundation to determine the criteria for the underprivileged was raskin (rice for the poor), however because it was not in target, the underprivileged population did not obtain their rights in the form of rice for the poor, Jamkeskab neither smart card for education. For Jamkeskab, the population recorded in the list were asked to register themselves independently to BPJS Kesehatan (for health) by paying class III premium for only once, henceforth the Government of Ngawi Regency would pay for the premium.

The implementation of NHI policy conducted by Health Ministry and BPJS is by issuing regulation which is the Joint Regulation of General Secretary of Health Ministry and President Director of BPJS No. 2/ 2017 on the subject of Service Commitment based Capitation (KBK) which is the replacement for Joint Regulation of General Secretary of Health Ministry and President Director of BPJS No. 3/ 2016 on the subject of Service Commitment based Capitation (KBK).

The newest regulation is meant to improve the service commitment in Puskesmas. The basis of capitation payment in Community Health Center is the number of referral, the number of contacts, chronic diseases visits (prolanis) and healthy family visits. If the referral is not suitable with the regulation in which 155 disease diagnosis should be settled by the doctor's competence in Community Health Center, thus the Community Health Center will only obtain less amount of capitation or it is decreased. In addition the capitation payment does not consider the number of patients' visits.

Even though the policy is less relevant, however there is no other option instead to keep on implementing it. It is less relevant because of several reasons, first, they lack of doctors and dentist resource, hence the capitation obtained by Community Health Service is small from the beginning, second, because of the lack of medical resources, it leads to service quality which does not meet the standard, hence in several Community Health Centers the number of referral is still high and it make the capitation even smaller, third, with the existence of service commitment based capitation makes it more difficult for Community Health Center since the amount of capitation is only sufficient for remuneration and operational fund.

The evaluation on referral ratio uses the calculation on referral of non-specialist diseases is divided by the whole referrals in first-degree health facilities multiplied by 100%. Therefore, if the referral ratio is less than 5% then the Community Health Center is considered in the safe zone, yet if it is 5% or more, means it is exceeding the target and considered in the unsafe zone and the capitation will be reduced. Furthermore, if the criteria of referral system are considered in unsafe zone then the healthcare facilities should improve its service to keep the referral ratio not big and if the referral remains high outside non-specialist diseases, it will be evaluated and it still affects the amount of capitation.

It happens also with the values of number of contacts, chronic disease service program and health visit in the scheme of Healthy Indonesia Program (PIS) also has calculation weight on their own thus will affect capitation obtained by Community Health Center. The lowest limit of capitation receiving is adjusted with the Joint Regulation of General Secretary of Health Ministry and President Director of BPJS No. 2/ 2017 which is 90% in which all services performed by Community Health Center are in the unsafe zone or the target is not accomplished, whereas the highest limit of capitation given is 100% in which the service commitment based services performed by Community Health Center are all in the safe zone. The 90% calculation means the payment is only 90% of the entire amount of money should be paid to Community Health Center by considering the number of members in the Community Health Center and the accomplishment of the number of contacts, visits ratio, prolanis visits and family visits which are functioned to support Healthy Indonesia Program (PIS).

Even though it seems burdening for primary healthcare facilities however in the other side Service Commitment based Capitation aims to improve quality and service commitment which occur in Community Health Center. Community Health Center as the spearhead first-degree healthcare is expected to be qualified and able to tackle health problems whether it is preventive, promotive, curative, and rehabilitative, in addition, as the optimization grader of the function of Community Health Center as the gatekeeper in healthcare service of national health insurance era. Community health Center also measure how the cooperation and coordination between primary healthcare facilities and advanced referral healthcare facilities which are located in one working region, in this term is in Ngawi Regency.

2. Input Evaluation

The procurement of human resource for health or known as (HRH) in Community Health Center is adjusted with Workload Analysis system for Health which is mentioned in Health Minister's Regulation No. 33/ 2015 on Human Resource in Community Health Center, also by considering the regulation in Health Minister's Regulation No. 75/ 2014 on Community Health Center, and then Health Minister's Regulation No. 81/2001, and the guidelines from East Java province. The Workload Analysis calculates time norm, working hours, and working time. Therefore if it is combined between Workload Analysis and is calculated in accordance with service standard of 10 minutes, the number of doctors to cover healthcare service is extremely insufficient. And then, if the basic calculation refers to Health Minister's Regulation No. 81 /2001 thus the ratio between doctors and number of population is 1: 2500 population to give healthcare service. The last, if it is added with considering

Health Minister's Regulation No.75 /2014 then for urban Community Heal Center with non inpatient care, the number of doctor is 1 whereas with inpatient care is 2. For rural Community Health Center with non inpatient care, the number of doctor is 1 whereas with inpatient care is 2. Both for urban and rural Community Health Center the number of dentist with or without inpatient care is 1.

The number of doctors in Gemarang, Ngawi and Kasreman Community Health Center did not meet the standard which refers to Health Minister's Regulation No. 33/ 2015 or else Health Minister's Regulation No. 81/ 2001. The impact in performing healthcare service was that it also did not meet the standard operational procedure of 10 minutes and it rarely performed consultation after patient examination, in addition it also affected to capitation and service quality.

Seeing the current condition even though BLUD is established in each Community Health Center, the Community Health Center is not able to independently hire doctors because they cannot afford it, furthermore the payment system regulation for BLUD is not yet explicit therefore Community Health Center is only waiting for the policy from Health Office for adding doctors, and at the mean time, optimizing the role of the existence health workers both nurses and midwives for healthcare service, in which they can be civil servants, employee paid with honorarium, or intern who work in Community Health Center.

The availability of medicines supply in Community Health Centers is sufficient and timely, and then the procurement of medicines in Community Health Center is in accordance with National Formulation (Fornas). Medicine procurement method is conducted by Community Health Center by making annual planning of medicine pro-

curement and proposes it to Health Office of Ngawi Regency, and for the unavailable medicines, Community Health Center will provide it by using capitation fund. The storing method is quite good, the oral medicines are usually stacked because of the limited space, vaccines and liquid medicines are stores in special place.

The procurement of medical equipment refers to Health Minister's Regulation No. 75/ 2014 and supplemented by guidelines from province government which is the copy of the Health Minister's Regulation, and it separates the procurement between Community Health Center with and without inpatient care. The availability of medical equipment in Gemarang, Ngawi an Kasreman Communiy Health Center is about 55%-60% of the stipulated standard in the existing regulation which is 80% thus it needs improvement in the future. The procurement method is Community Health Center proposes to Health Office and then they are only waiting for the equipments to come, checking, managing and making inventory. Health Office will invite calibration expert from out of town to make calibration on the medical equipments for the Community Health Centers.

Financial resource of Community Health Centers is sufficient and probably abundant, however the one that is independently managed by Community Health Centers is only Special Allocation Fund for Operational Affair (BOK) or now is known as non physical Special Allocation Fund (DAK) and capitation. Other sources of fund in the form of General Allocation Fund (DAU), Special Allocation Fund (DAK) and BK (special equipment aid from Province Government), cigarette excise are managed by Health Office.

Non Physical DAK or is known with Special Allocation Fund for Operational Affair (BOK) in the future will be used for Community Health Effort (UKM) activities. Whereas capitation is used to pay remuneration and the rest is allocated for medical equipments, medicines, and other beneficial interests of Community Health Centers.

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