STRATEGY ANALYSIS OF MUHAMMADIYAH GAMPING HOSPITAL FACING NATIONAL HEALTH INSURANCE

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Abstract

National Social Security System, Act Number 40 Year 2004 mandated that National Social Security System as National Health Insurance starting January 1, 2014. As a private hospital that follow the program, Muhammadiyah Gamping Hospital has to prepare strategies for it. This study aims to analyze the strategy of Muhammadiyah Gamping Hospital facing National Health Insurance. The analysis used a quantitative of Strenght, Weakness, Opportunities, Threats (SWOT) analysis to determine the actual position of the hospital so it can choose the right strategies. Data collection using in-depth interview method, quesioner, and document review. The sample of the research are 4 people who are the directors of Muhammadiyah Gamping Hospital. Quantitative SWOT analysis puts the hospital in quadrant III, which means that the hospital is in a position of having many weaknesses but has many opportunities, then they have to make a strategy changes. In this research there are many strategies that can be done. Some strategies are making Clinical Pathway, recalculate unit cost and utilization Hospital Information Technology and bridging with BPJS system. This study show that Muhammadiyah Gamping Hospital has to make a strategy changes according to the position of hospital in quadrant III.

Keywords: SWOT analysis; Hospital strategy; National Social Security.

INTRODUCTION

National Social Security System, Act No. 40 of 2004 mandated that the National Health Insurance of the National Social Security System started January 1, 2014. Hospitals as a provider of facilities and services in the implementation of the program are required to be ready. With the effectiveness of this program will have an impact on the hospital in the financial field, terms of service, and other related areas. The target market of hospitals will increase with the enactment of the program, with increased visits expected to improve financial performance, if hospital can provide efficient and effective services. [1]

Private hospitals are given the freedom to choose whether to join the National Health Insurance program or not. With the target of gradual program implementation, it is expected that by 2019 all Indonesian people already have Health Insurance. So, if the entire community already has a guarantee for health, fee for service system or out of pocket is not much applied again. Private Hospitals have to prepare for Universal Coverage if their existence do not want to be disturbed. Hospital is expected to prepare themselves, implementation of the program must be successful, benefiting the entire people of Indonesia.

Muhammadiyah Gamping Hospital is one of the private hospitals that located on Special Region of Yogyakarta. As a new private hospital that facing National Health Insurance, it is necessary to have a good strategy. So, it is very interesting to see how the hospital prepares themselves to face National Health Insurance 2014. Based on the above problems, the authors consider it necessary to conduct research on it. The authors will analyze the strategy of hospitals in facing the National Health Insurance and determine the strengths, weaknesses, opportunities and disturbances of the hospital related to it.

RESEARCH METHODS

This research used qualitative research method with descriptive analytic design. The subjects of this study amounted to 4 people who were the board of directors and managerial hospitals.

Stages of the study started from in-depth interviews, questionnaire making, and document review. The interview stage started from the selection of informants to

be interviewed, i.e. from the board of directors and the managerial line of policy makers in the hospital. The next stage, the researchers composed or designed questions that revealed all matters relating to the program and the hospital. The second meeting began with specific questions regarding hospital strategy, and also included the strengths and weaknesses of the hospital, as well as hospital opportunities and barriers.

Data was obtained from interviews would be categorized into internal and external factors. Internal factors were the strengths and weaknesses of the hospital, while external factors were opportunities and obstacles owned by the hospital. From these factors, a questionnaire was developed which aimed to assess the weight and rating of each factor. The weight and rating would be filled by the respondent based on whether or not a factor was important and whether or not it was affected. After the quantitative data was obtained, the data would be processed with SWOT analysis to determine the hospital was in a particular quadrant.

Related documents would be studied and reviewed such as hospital strategy plan, hospital profile, service performance, and other related data.

RESULTS

From SWOT analysis result according to strategic plan of Muhammadiyah Gamping Hospital was in position categorized into quadrant I, at this position, hospital had perfect strategic position.

From SWOT analysis of the study, the calculation showed the total strength value was 1.8506 while the weakness was 1.9215, from the reduction of strength score with the weakness, that was -0.0709. This meant that the hospitals had weaknesses. For external factors, the value of opportunity amounted to 2.5875 and the threat of 1.2008, so from the reduction of the value of opportunity with the threat, obtained value of 1.3866. From the results of SWOT analysis showed that the hospital was in a position to have weaknesses and opportunities that could be categorized into the quadrant III.

The strengths of the hospital in facing the National Health Insurance were: (1) having great teamwork from staff and employees, (2) the strategic location of the hospital was on the main road, (3) grand new buildings and large areas for expansion plans. The weaknesses were: (1) Bureaucracy was long and tiered, (2) the status of the hospital was type C, (3) good facilities caused maintenance cost increased, operational costs could increase as well. Some opportunities were: (1) the opportunity to raise the class type of hospital from C to B, because the facility had been fulfilled, just needed to meet the existing requirements, (2) opportunity to raise the status to type B education, with the increasing number of patients, especially the 3rd grade, (3) NHI program could be as media of socialization to public and patient about Muhammadiyah Gamping Hospital. Some threats were: (1) Many primary health facilities did not know that hospital were already working with NHI programs, it might be possible to refer to the other health facilities, (2) underprivileged commitments from medical worker to stay in the hospital, (3) the residents around (Bantul) were not included in the region of hospital services, which covered only Sleman and Kulonprogo.

Table 1. Score Difference Of Each Factor In SWOT Analysis

Strength score	1,8506
Weakness score	1,9215
Difference of strength and weakness score	-0,0709
Opportunity score	2,5875
Threat scores	1,2008
difference of opportunities and threats score	1,3866

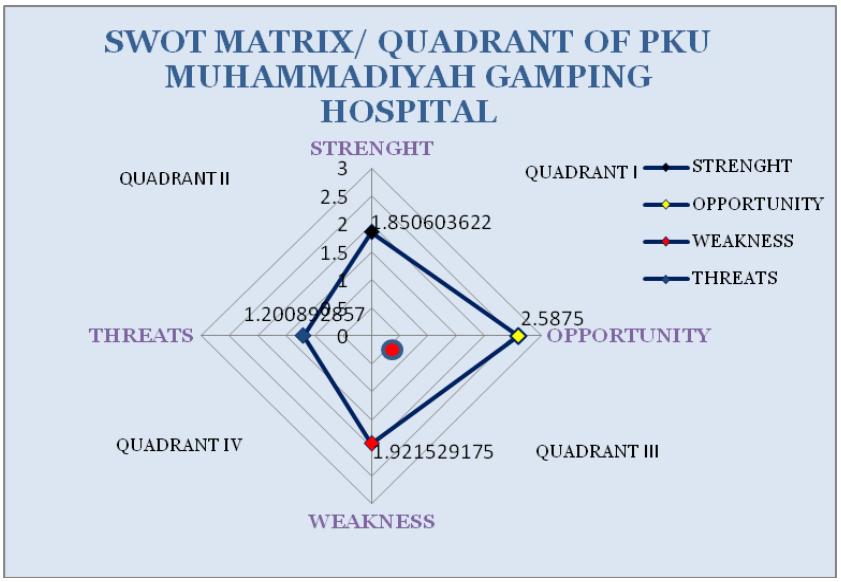

Figure 1. SWOT matrix/quadrant of Muhammadiyah Gamping Hospital

DISCUSSION

The SWOT analysis conducted by the authors was a SWOT analysis related to the hospital strategy in facing the National Health Insurance in particular. While SWOT analysis conducted by Muhammadiyah Gamping Hospital was a general analysis that was not directly related to the National Health Insurance, and it was not a specific analysis to deal with it. So the result could be different because of the major focus difference in the making of the analysis.

The quantitative SWOT analysis of Muhammadiyah Gamping Hospital perform showed that the hospital was in quadrant III, meaning that the hospital had to change the strategy to overcome the weakness and maximize the opportunity that was still very open.

There were some differences from the strategy of the hospital and the strategies derived from the SWOT analysis, therefore, the authors would try to discuss some of the strategies that needed to be changed and strategies that could still be maintained to overcome the problems associated with the National Health Insurance as follows:

1. Making Clinical Pathway (CP), at least for 10 cases that were often obtained, so there were instruments for quality control and cost control.

   Clinical pathway was an integrated service planning concept that summarized every step given to patients based on evidence-based medical standards and evidence-based nursing care with measurable results and within a certain timeframe during hospitalization. [2]

   Clinical pathway combined the standard of care of every health worker systematically. The actions given were uniformed in a standard of care, but still paid attention to the individual aspects of the patient. There were four main components of Clinical Pathway including: [3]

   a. Timeframe, described the steps based on the day of care or the stages of service,
   b. The framework contained the entire healthcare team's care activities, and the activities were grouped according to the type of action,
   c. The Results Criteria, containing the results of the given care standard, included long-term criteria (describing the overall outcome criteria of care), and short-term criteria,
   d. The Variance Recording Sheet, taking notes and analyzing the deviations from the standard set out in the Clinical Pathway, the patient's condition was not in accordance with the standard of

care or standard could not be performed, all of which were recorded in this variant sheet.

With the CP, it could be ascertained the actions undertaken by the doctor in accordance with standard operating procedures. So the health services to patients would be further improved. The quality of health care was defined as 'consistently satisfying the patient' By providing health services that were efficacious, effective and efficient according to the latest clinical guidelines and standards, which met patients' needs and satisfy service providers. "Patient satisfaction and patient needed fulfillment that could be considered as a priority peak in achieving hospital service quality."[4]

This strategy was still well suited by hospitals in the hope of producing instruments for quality control and cost control. With the existence of these instruments, the actions taken by the hospital would be more effective and efficient.

2. Determining unit cost to know the real cost of service.

Unit cost was the cost per product unit or cost per service. Unit cost was defined as the result of the division between the total cost required divided by the number of units of products produced goods and services. [5]

The benefit of unit cost in outline was to measure the performance and the level of efficiency and quality of health services, so that the quality control and cost control could run optimally. With unit cost, hospitals could compare the cost of hospital procedures with tariffs on Indonesia Case Base Group (INA CBG's). If there was a gap between hospital tariff and INA CBG's tariff then the hospital could adjust to the cost's efficiency without sacrificing service to the patient.

A public hospital study discussed the INA CBG's payment claim system. The study found that public hospital management felt that the new system generated more financial surplus. That perception was not in line with accounting principles. Based on the concept of accounting, surplus was determined by comparing income and expenses, while the surplus perception raised was based on the comparison between the old and new health insurance claim rates. Furthermore, public hospitals reached a surplus because they received donations from the government for salary and investment related costs. Public hospitals did not take into account and incorporate salary and investment related costs into the determination of their financial performance. [6]

3. Utilization of information technology for a more optimal service, using semi paperless and bridging systems with health insurance claims system.

Each service to the patient in the hospital would be issued SEP namely Participant Eligibility Letter. With the issuance of this SEP, was expected to cut the queue of health insurance participants in advanced health facilities such as public hospitals or private. With the development of this information and technology, the participants could register themselves in the SEP machine at the hospital, it was no need to queue at the health insurance office in the hospital.

Previously enacted this system, registration was done by the participants manually. Participants must be queued at the existing health insurance counters in the hospital and health insurance participants who had received a referral letter from primary health care facility (*Puskesmas*) must pass through four stages of queue.Semi paperless systems that were imposed in hospitals would improve the quality of care for patients. In a study of the use of shared EMR (Electronic Medical Record), data and information in the system could efficiently be taken and combined with new data and information to make a resume about further knowledge of patient illness, history of disease, treatment. The stored data would be preserved and not easily lost, but the data presented should be interpreted further by the doctors, in order to understand the description of patient travel more detailed. Some systems were made

sometimes difficult because programmers were often people outside the medical environment. So the doctor should be more observant and critical related form of data presented in the shared ERM (Electronic Medical Record). [7]

At Muhammadiyah Gamping Hospital, medical record writing had been using electronic/ computerized. Many obstacles faced with this system. In poly specialist, the recording was often not done alone by the doctor concerned, but with the help of nurses. This could cause a little trouble if there was poor communication. Wrong diagnosis and treatment could happen. In poly specialists, doctors in charge were the majority of senior doctors who were still difficult to use the computer. When this was forced it would take a long time because of difficulty in typing complaints or diagnosis of patients.

In the emergency room, the majority doctors were still young, so there was no problem in using the computer. Only the problem was when the emergency room patient increases, the time required to enter patient data related to the disease and the complete history became insufficient and narrower. So it could be the data entered was not too complete. The solutions are providing training to physicians regarding the EMR shared system and adding officers for electronic medical record data input. The most immediate solution was to add a special officer in charge of filling out electronic medical records, but its weakness would facilitate the occurrence of input if the officer was a person who was outside the medical environment.

4. Recruitment of human resources both medical and non medical.

In accordance with the PMK No. 56 year 2014 about the classification and licensing of hospitals, hospital type / class B had requirements that must be met related to human resources. From the article, it was obtained information that the number of nursing personnel at least in accordance with the number of beds. It could be concluded that with the number of beds in the hospital as many as 105 and would be added again to 220 with the construction of new buildings and blocks, then the nursing personnel should have at least added a number of existing beds. It was necessary as a requirement to raise the class of hospital to class B. If still a Class C then the ratio of nurses with beds was 1: 3. This was what the management needed to study further.

With the implementation of INA CBG's, it was necessary to find the person who understood claim payment and coding. People who would enter coding (coder) must be understand about the diagnosis of disease. Often a coder was a person who was not familiar with the medical world or even not at all from a medical background. Then this would increase the incidence of incorrect coding, which led to unpaid payment. As suggestion, the coder should be a doctor too so they could understand the coding and what it did. But the cost of recruitment of medical personnel would surely be higher than if we were recruiting workers outside the medical environment.

5. Cooperating with primary health facilities for the referral system.

Collaboration with primary health care facilities and networking must be owned by the hospital as primary health care facilities were the main “suppliers” of patients with health insurance. A few moments ago it was initiated to establish a primary health facility in cooperation with health insurance, and finally it was done with the establishment of the Firdaus Clinic located in the Wirobrajan region. With the clinic, the patient's referral to advanced level could be directed to Muhammadiyah Gamping Hospital.

6. Overcoming the bureaucratic flow that was still tiered.

The bureaucracy at Muhammadiyah limestone hospital was still quite complicated and long, because it was still on the Muhammadiyah Yogyakarta Hospital, while the working area of the hospital was far in the city of Yogyakarta, while Gamping into Sleman region. But this problem had been resolved because Muhammadiyah

Gamping Hospital had been separated and stood alone as a private hospital type C. So the flow of bureaucracy would be shorter than before.

7. To socialize the program, internal training and knowledge sharing to all medical personnel in the hospital.

   Socialization was something that must be done if the new system was running, because the new system definitely required different handling. The hospital staffs were front-line in receiving questions from patients on matters relating to the National Health Insurance. Here the party of the executing agency also had an obligation to socialize the program and related requirements of payment claims.

   Sharing of knowledge in hospitals had a major role in improving the quality of care in terms of accuracy of diagnostic coding in hospitals.[8] By sharing knowledge between health personnel in the hospital, it could help minimize any error of coding diagnosis, because this error led to claim payment properly.

   The form of sharing knowledge that had been implemented in Muhammadiyah Gamping Hospital at this time was routinely held morning report. The morning report was not only to know what patient was being treated in the hospital, but also to increase the knowledge to the related medical personnel, whether specialist doctor, ward doctor, nursing staff and pharmacy. This knowledge was concerning patient therapy, diagnosis, and also possible follow-up actions. In addition, in improving knowledge and service performance for the better, wrong coding could be inevitable.

   By ensuring the continuity of training both internal and external to the employees, it would improve the service to the patient, so that the services provided were more efficient. [9] With a more efficient service, quality control and cost control could be accomplished and costs could be reduced in such a way that it was more efficient. Then the financial performance of the hospital would be good in facing this era of national health insurance.

8. Service differentiation and expansion of service coverage.

   With the target of raising the type / class of the hospital to type B education, the scope of service needed to be expanded in accordance with the requirements stated in the Minister of Health Regulation no. 56 year 2014 on the classification and licensing of hospitals, also on Government Regulation no. 93 of 2015 on Educational Hospital.

   Hospitals must complete the scope of services in accordance with the Minister of Health Regulation. By increasing the scope of services, the target market was wider, this would impact the more service used by the community, the higher the income of the hospital, provided that the service could be done effectively and efficiently.[1] What was needed to be considered was to increase the type of service without offset the ability to absorb strong market and financial, it would be a boomerang for the hospital. So, it was better if the hospital that had the weakness was rethinking in taking this opportunity. It was wiser to have hospitals rely on existing services first. Then, the strategy for extending the coverage of these services could be considered inappropriate with current hospital conditions.

9. Review for new space and building procurement.

   The type of hospital was determined by the availability of space, especially the existing beds in the hospital, to raise the class/type of hospital, it must be considered its availability was adjusted with the Minister of Health Regulation no. 56 year 2014 on hospital classification and licensing.

   Procurement of class 3 should be considered, because as an educational hospital, a Class 3 ward must be available and sufficient, but not to excessive because it was also associated with fees and claims of payment. Claims for class 3 wards were lower than the upper class. While the service costs tended to be the same, so if not

managed properly, it would harm the financial of the hospital.[10]

10. Procurement of facilities and health equipment to adjust to the target of raising the hospital class to type B.

To complete the facilities and medical devices, it must refer to the rules written in the Minister of Health No. 56 year 2014 on hospital classification and licensing. Procurement of this facility should consider the ability of the hospital in managing the existing facilities, did not merely pursue the requirements to raise the type of hospital, because with more facilities, the cost of maintenance and maintenance of goods would be higher too. What was needed to be considered was the benefits of these tools in supporting the service to be better and efficient. It was better to overcome the weaknesses of the hospital than to take an uncertain chance as to whether it benefited the hospital or not.

The authors recommended that some existing strategies needed to be reviewed by the hospitals in facing of the National Health Insurance such as Human Resource Recruitment, Service Differentiation and the extension of service coverage, new space and building procurement. As well as the provision of facilities and medical devices to adjust to the target of hospital type B. Vision of the hospital was to become the primary education hospital, but with the circumstances and positions hospitals in quadrant III then the strategy was needed to be changed. The authors suggested to hold internal training for health workers in the hospital as a motivation as well as increasing the commitment of hospital employees.

REFERENCES

1. Djamhuri A, Amirya M. Indonesian Hospitals under the “BPJS” Scheme: a War in a Narrower Battlefield. J Akunt Multiparadigma. 2015;6(3):341–9.
2. Firmanda D. Clinical Pathways Kesehatan Anak. Sari Pediatr. 2006;8(3):195–208.
3. Feuth S, Claes L. Introducing clinical pathways as a strategy for improving care. Int J Care Pathways [Internet]. 2008;12(2):56–60. Available from: http://icp.sagepub.com/content/12/2/56.full
4. Mosadeghrad AM. Healthcare service quality : towards a broad definition. 2013;26(3):203–19.
5. Hansen, D. R., and M. M. Mowen. "Environmental cost management." Management accounting 7 (2005): 490-526
6. Ambarriani AS..Hospital Financial Performance in the Indonesian National Health Insurance Era.2014;4(1):367–79.
7. Tully MP, Kettis Å, Höglund AT, Mörlin C, Schwan Å, Ljungberg C. Transfer of data or re-creation of knowledge - Experiences of a shared electronic patient medical records system. Res Soc Adm Pharm. 2013;9(6):965–74.
8. Rangachari P. The strategic management of organizational knowledge exchange related to hospital quality measurement and reporting. 2008;17(3):252–69.
9. West MA, Guthrie JP, Dawson JF, Borrill CS, Carter M. Reducing patient mortality in hospitals: The role of human resource management. J Organ Behav. 2006;27(7):983–1002.
10. KEMENKES. 2014. Peraturan Menteri Kesehatan No. 56 tahun 2014 tentang Klasifikasi dan Perijinan Rumah Sakit.