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Searching for the Formula of Social Security Program of BPJS Kesehatan

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Abstract

It is very interesting to conduct a study to find out the basic health services of social security in order to find a solution to the problem of losses of BPJS Kesehatan in ensuring health protection for the members. This research uses the troubling method to measure causal relationships, listen to input from various parties and find ideas for appropriate solutions through the study of narratives approach that are expressed qualitatively research. The results of this study indicate the importance of social security program of BPJS Kesehatan to be carried out on the universal and comprehensive coverage while maintaining the sustainability level of the program and ensuring the protection of basic health as according to the medical needs of the members.

Keywords: health, social security, formula, protection, welfare, troubling method

INTRODUCTION

The problem of social secuity of BPJS Kesehatan according to the National Social Security Council, DJSN (DJSN, 2019) it is due to the expenditure of costs of benefit greater than income of contribution with a ratio for four years basis. The ratio of cost of benefit and income of contribution in 2014 was 104,46% and 2018 increasing to 115,28%. In an increasing series of cost of benefits of BPJS Kesehatan in 2014 was IDR 42,7 trillion, in 2015 was IDR 57,1 trillion, in 2016 was IDR 67,3 trillion, in 2017 was IDR 94,3 trillion and in 2018 IDR was 94,3 trillion. Meanwhile, the income of contribution in 2014 was IDR 40,8 trillion, 2015 IDR 52,8 trillion, 2016 IDR 67,4 trillion, 2017 IDR 82,0 trillion and 2018
IDR 81,8 trillion.

Another problem according to the DJSN (DJSN, 2020, p. 57) it is the trend of unit cost of advanced inpatient claims in 2014 – 2018. For patients with class 1 entitlements, the service based on the INA CBG rates that set by the Ministry of Health which are higher compared to the lowest rate for class 3 entitlements. On average, it is 50% higher than the unit cost of treatment

claims in class 3 entitlements. In addition, there are differences in the unit cost of claims based on the hospitals categories of class A for referral hospitals and the referral hospitals of national that special owned by the Ministry of Health, especially located in the Capital City. This difference of the referral hospitas can be seen for the same classification of INA CBG measures, the average claim cost in DKI Jakarta in 2018 was IDR 7,8 million per visit while in West Papua it was only IDR 3,3 million.

According to the DJSN (DJSN, 2020, p. 124) in addition to the diagnosis of a disease claim submitted from the health facility claim to BPJS Kesehatan, the distribution of disease based on diagnosis or case mix (CBG) is important information for health facilities or local governments in preparing procurement plans or consumable estimates about them, such as the needs of drugs, consumable medical materials, medical devices, and health staff. In addition, the distribution of disease is important information for health officials in various regions in preparing the main tasks and responsibilities of Public Health Efforts (UKM). Meanwhile, a secondary diagnosis is a diagnosis that it was defined by the Health Facilities in Advance (FKTL). The regulation of INA CBG rate also regulates rates according to medical procedures. The distribution of advance outpatient (RJTL) and advance inpatient (RITL) in medical procedures in 2014-2018 shows that the highest frekuency procedure in RJTL service are hemodialysis, while in RITL services that the highest in 2014-2018 are Other microscopic examinations of blood.

LITERATURE REVIEW

For comparison with health care security programs, according to the American Institute of Certified Public Accountants (AICPA, 2018, p. 256). In the United States, most states have separate regulatory provisions for regulating the payment of social security. These provisions are generally designed to protect the members, and usually apply to the requirements of claims, proof of membership, gettng paid, including payment of claims as accordingly and unaccordingly condition, late payment which are legally condition that are required to be resolved promptly in the respective states. In addition, certain states have statutory provisions requiring insurance companies to provide periodic comparative reports of paid benefits in Social Security Master Reports. In this report, in addition condition, it is to identifying which ones include social security and non-social security member and also to determine the efforts that it need to be made to maximize the benefits for the members. Social security as a legal entity are obliged to return the funds to the state if they are not claimed.

In comparison of the functions of social security institutions in the United States according to Fatkullina et.al. (Fatkullina, Sulaymanova, & Salakhova, 2018) citing Khozinov, the mechanism of return the fund to the state as an institutionalization process is a process which it is an institutional mechanism of an institution that aims to consolidate social security in these institutions by classifying the status of codification, collectors of social security funds and financing in the framework of state interests. It is a legal framework that the administrative system work for social institutions shift from legal entities with certain ethical standards to public legal entities with legislative administratiion law standards which it is more concerned with the legal interests of the wider community.

In implementing the legislative administration law framework especially, the function for protection of the workers in the workplace according to Flohimont (Flohimont, 2017), Belgian and French social law share a broadly similar approach in terms of viewing at psychosocial risks, which they are harmonize labor law and social security. This can be seen primarily with regard to risk prevention and harmonization with individual compensation as the main protection when the workers sufferf from injuries or illnesses due to work. Although prevention beside complementary concept in the social security system, it is an intrinsic part of the labor law itself. In the Belgian sosial law system, work-related accidents that occur in companies are protected by the protection of social security laws which require that the protection of health services must be submitted to the Committee for Prevention and Protection at Work which it is not only checks the incident, but also takes into account for the future events in planning of annual preventive measures. These activities are used as standard of workers protection and implemented by companies which it is to incorporating them a legal principle as "dynamic risk management". The provisions of the Belgian labor law, obliging employers to implement preventive measures, throughout the process of production activities to prevent workers from risks that they have faced, which it is logically measured against the application of social security laws, in particular compensation of the risk that it is use for work-related disability, work-related accidents, and occupationaldiseases under social security law.

In the French social law system, the interaction between the two provisions of labor law and social security is relatively the same as a legal theory in preventive measures based on concepts, norms and institutions that they have been established to ensure protection of occupational accidents and occupational diseases and preventive measures from the administration bodies such as social code of reference in the French Labor Code of Ethics. This code of conduct not only regulates the obligation of prevention but also establishes a rational methodology for fulfilling social security protection for workers.

In a world of social security that is an ideal for addressing the problem of psychosocial risks from the perspective of the whole of social law, which it is occurs as a result of the interaction between labor law and social security law, harmonization is very significant. However, in the context of social security law, it focuses more on work-related accidents and occupational diseases.

In Japan, according to Lerouge and Naito (Lerouge & Naito, 2017) the social security law system can provide useful alternative solutions. Classification of occupational accidents and diseases which are compiled in a classification list includes 36 events that may cause a risk in the workplace such as stress or others that result in serious accidents, then life- threatening. However, it is admittedly difficult to analyze an event like this stress because overwork is very likely to be the cause of accidents. Although the neglect of occupational risks for example due to electric shock currently it is not included in the list of work-related accidents of impact on health that increasing of gaining recognition as a cause of occupational disease.

In Japan, the list of occupational disease classification factors includes stress as a factor of checking for labor inspectors. The stress is classify for checking since 2009. For social security

administrators, stress checking affects the ability to work so that it can be a factor that may cause occupational disease. Judges in court play an important role in determining job classification because of this stress. Therefore, in Japan the real follow- up issue of stress is through the courts and although it is still a matter of debate among politicians.In contrast to the stress that occurs due to fraud, Kratcoski and Edelbacher (Kratcoski & Edelbacher, 2018) argue that the concepts of fraud and corruption can be defined in several ways, depending on the context in which these provisions are applied. Based on the history of civilization, fraud and corruption have occurred in almost every time, both in the past and now. To see that corruption and fraud have existed as a humanitarian problem, it can be seen from the big impact in all civilizations, including those that occurred under kings, tsars' rulers, or military dictatorships, or religious leaders and power controlled by elected officials in society democratic. With regard to corrupt practices, it occurs when someone in a position of power has the opportunity to make their own decisions with the opportunities for corruption that exist by allocating resources. Fraud is broadly defined as any deliberate action that is commited to the purpose of gaining profit by breaking the law. This crime is manifested in many different ways, both between individuals through mass communication systems such as the telephone, television and the Internet.

Corruption according to Kratcoski and Edelbacher (Kratcoski & Edelbacher, 2018, p. 278) in the response of society as the idea that social and cultural norms tend to define acceptable behavior and also that is the deviant of behavior and even becomes part of a criminal action that it cannot be acceptable. This behavior then explains why the actions of corruption become deviant or criminal actions which are categorized as very dangerous in destructing of people's lives. Corrupt actions are categorized as very dangerous actions in people's lives. It is categorized into actions such as giving gifts, bribery and more severe extortion and organized crime.

Deviant actions in health social security, including moral hazard, according to Samad (Samad, 2019), there are two ideas of moral hazard in the literatures. First, moral hazard is known as the moral hazard ex ante. The idea is that if you have social security and that social health insurance will pay your medical bills when you are sick, then you have an incentive to invest to keep your health at a healthy level, because when you are sick your financial burden will be borne by the Social Security Administration Body, therefore, you will eat, drink, and be merry. You may smoke more cigarettes, drink more alcohol, exercise less, and so on.

Second, the moral hazard which is known as the danger of ex post morals. This idea assumes that social health insurance can affect your investment in your health. At certain levels of health, you will use more medical services because the price of these health services is lower then when you get the protection is provided by the Social Security Administration Body. The moral hazard in this ex post is basically about the demand curve and the increased of sensitivity to demand prices for health services due to the members behavior. The higher of the demand of health services, the lower of the price of health services.

According to Kumar and Reinarzt (Kumar & Reinartz, 2018), social security administration body need to prioritize target segments on demand for health services that provide to the potential members for higher contribution yields to health service goals. This strategy is

known as the mar-com strategy. Targeting the demand for participant health services in an effective way by maximizing Return on Investment through a marketing communication mechanism. In this communication, naturally, some media are more effective at targeting a certain groups of social security members than others. The aim is to overcome deviant actions such as fraud, corruption or moral hazard. The challenge is to choose media that are effective in achieving socialization goals through the mar-com strategy and achieve them cost-effectively.

In increasing socialization, according to Mohanty and Vyas (Mohanty & Vyas, 2018), the concept of a marketing strategy that needs to be done is with social media networks in a knowledge value chain. In a network linked to the value chain knowledge is described as an added value process in which the social security administration body is involved. Based on this understanding of added value, (knowledge value chain) with special emphasis on the organizing agency for its own problem assurance. The knowledge chain model, which they are consists of three main activities which includes knowledge of social security when elaborating on knowledge resources, plus three secondary activities that support and guide the performance of social security services. The knowledge value chain (KVC) model is a knowledge management framework that consists of first, the knowledge infrastructure, second, the knowledge management process, and third, the interactions between the components that produce knowledge performance. A model whose emphasis on integrating multiple perspectives from various interest groups needs to be considered. The KVC model is a series of knowledge management stages that they are categories, namely, first, the process of activating knowledge management, second, the ability of the social security administration body, third, the performance of the social security administration body. The process of adding value to knowledge management develops along with the capabilities of the systems and procedures in utilizing the infrastructure of the social security administration body. The knowledge management process is a major activity in the added value process. With KVC biosciences, move from exploration to exploitation as the basis for it is implementation, which then proceeds to preclinical and clinical trials. The concept of increasing the added value of knowledge is aimed to commercialization that measure it and at the end to determines whether or not an added value is successful in the socialization of health insurance programs, especially if there is a comprehensive and universal level of coverage, including technology licensing. It is also at in the end recognized by the government. The knowledge value chain as a sequence of knowledge management activities is measured by increasing socialization value, then which it is then formulated as a knowledge value chain model. To ensure this activity on the right track, the survey is need to carried out to see the reciprocal impact between knowledge and socialization of health services for the members.

Implementation of the Health Social Security program through the dissemination of knowledge management, which it is related to Artificial Intelligence. According to Mohanty and Vyas (Mohanty & Vyas, 2018, p. X) mention that to understand artificial intelligence, it takes three technological breakthroughs that become catalysts in network systems in making massive changes in parallel:

The first is Thinking, which it is a process of reasoning about something, it is a massive parallel process in which it is a billions of neurons in the brain, acting simultaneously, send signals to

other neurons through layers of the network. Then at the end result is an assessment of knowledge management against the necessary for change. Current achievements are of course imperfect in carrying out massive parallel processing if it has not reached yet knowledge management in the Graphics Processing Unit (GPU). The GPU is an open up new possibilities, whereby the neural of networks (which may occur loosely occurring based on the way neurons operate in the brain) to facilitate hundreds of millions of connections between nodes in millisecond processing. The second is Big Data: Human intelligence is taught over time. When the human brain sees something that it has never seen before, it takes time to figure out what the image is it. The same rules apply to Artificial Intelligence. Thanks to the digitization and proliferation of smartphones, humans have an access to vast amounts of real-world data. This human ability to collect, clean, standardize, and store real world data provides a huge training mechanism for Artificial Intelligence. As a result, human intelligence can start to begin to be incorporated into artificial intelligence technology, as a result of changing everything into things that very quickly become "smart".

Third, the better Algorithms: Many things happen in the human brain which it is used to analyze the environment. Humans use heuristics and mental mind maps as a basis for thinking. Although it is very difficult to construct a process of thingking in the effort to complie a process of reasoning as a result in a long program presentation, which it is mostly in the form of "IF then Then..." and these programs are not only enough to adaptive on the change but algorithms are used as a way of looking deeper, giving humans a way to generate reasoning from existing data, even from complex programs consisting of hundreds and thousands of conditions, by combining work patterns and recommendations. Humans can now collect large amounts of data and apply sophisticated algorithms to arrive at predictions. The only drawback is that some algorithms are so complex that sometimes they cannot understand the results obtained. Related to changes in artificial intelligence, which it is in related to environmental changes, according to Kesterson (Kesterson, 2018) the competency area need the ability to communicate of the health service to participants; the ability to do analytical skills in measuring medical indications, to have technical skills in dealing with problems, to carry out project management in completing the main services of health social security; the ability to do empowerment of owned resources, equipment and facilities; to have passion and enthusiasm in fulfilling tasks; to have leadership for the attitude that it taken, to train constantly that it could improve one's abilities, and personality development; to become a change agency for the better services; to influence by changing thinking patterns, to realizing something that becomes a goal and having confidence in carrying out duties and functions as an implementer of the social security system. In terms of state intervention in the social security system, Wang (Wang, 2015) carefully compared the welfare regimes of South Korea and Taiwan. The focus of the analysis is placed on how familiar their welfare regimes are existing, how much individuals from each regime depend on their families to meet their health social insurance needs. This highlights the diversity of family welfare regimes in East Asia. It also implies that it is difficult to choose a typical family health social security model for common family from cases that occur in East Asia. Although the social security administration body in South Korea and Taiwan have an orientation to ensure protection to families, the two countries have their respective variations in providing how much protection to families. In addition, the

various levels of family dependency of the two welfare regimes are determined by state intervention through social security policies as a result of different family dependency. Thus, the different nature of each regime is not a reflection of the reality of health social insurance protection but different influence of family tradition or culture. Even so, the results are determined by state intervention. In Taiwan, according to Wang (Wang, 2015) NHI Taiwan adopts the nuclear family model and part of the nuclear family, which it is in fact, it is not far from the norm of the western family. Especially, it was seen from the method that imposes insurance costs for NHI dependents. Taiwan adopts the individualistic principle which regards the family as an aggregate of individuals who are merely one unit of totality which it is given as part of the collectivity right. Considering these various realities shown by the family, Taiwan has built a health social security institution that is not separated from family members, so that the family is not viewed narrowly and individually, but it is this an ideal health social insurance protection? According to Pieters (Pieters, 2019) solving problems regarding social security which it is includes the standard of the instruments of the International Labor Organization Convention No. 102, (ILO Convention No.102) formulates the concept of the inability of social security members to work, due to disease, work accidents and / or diseases caused by epidemics. The social security scheme against work-related risks should be aimed broadly than just providing income replacement but also covering health services benefits and other benefits until returning to work. For this reason, a formula is needed that includes a broader social health insurance to compensate for the risk of lossing of income and benefits until returning work. The scheme should be apart from the health social security standard. People may experience the consequences of illness or accidents, causing them to no longer be able to carry out their normal jobs and therefore unable to earn an income of living. Therefore, social security provides income replacement for these people as an allowance in the event of incapacity to work. Management of the risk of disease, whether caused by disease or accident, it is carried out through a clinical pathway management system within standards and costs that it can be controlled. According to Gokhale and Pfleger. (Gokhale & Pfleger, 2019). The basic clinical framework for this pathway has actually been compiled for many years and it is still in use today. The tremendous effort in structuring this clinical pathway by Hippo phatway and developing of it into a number of systems that work around the clock, that it has resulted in the mechanistic details involved in the interactions between the components of the disease management pathway and the actions taken in diagnosing disease, which it is biologically represent insightful output of knowledge resulting from the process. It also produces a mechanistic array of handling paths. Various discoveries in formulating this clinical pathway and the development of continuous management insights, throughout the year. This is activities based on the Drosophila survey that finally presented on the Hippo Pathway system which it is describes various actions in disease management from the beginning, using biochemical approaches taken by geneticists such as treatment systems for cancer, formulated a model, which it was later called the Drosophila Model. The treatment of cancer focuses on dealing with biology and genetics which it is in the end at that time proved to be very helpful in making a leap in achieving progress on healing with a number of obstacles. Some of these leaps and bounds include

(1) the efforts of the Drosophila group to strenthening their findings in the Drosophila model, and (2) the extraordinary efforts made or while underway on the major finding components of

the network system.

Regarding classification of disease on clinical pathways, according to Leon (2018), one of them is taken through the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) and the International Classification of Diseases Tenth Revision, Procedure Coding System (ICD-10-PCS) as a procedure coding system, it is a clinical modification based on the World Health Organization (WHO) disease classification. The ICD-10-CM extends from the ICD-9-CM code to facilitate more precise coding of a clinical diagnosis. Meanwhile the ICD-10-PCS is a special classification of operations and procedures developed for use in the United States. This classification system regulates the handling elements and actions in groups according to the established criteria. In ICD-10-CM and ICD-10-PCS, the elements are groups of diseases, injuries, operations, and procedures, which they are grouped into sections and subsections according to their classification. The categories used are called the three-character code as used in the ICD-10-CM, and the seven-character code used in the ICD- 10 PCS. These groups are the basic classification that generally classifies treatments based on general medical statistics. This classification helps answer the questions about groups of disease causes that they are categorized under one particular classification and provides a coping mechanism according to the optimal handling capacity, followed by systematic tabulation of statistics, storring and retrieving data through the storage and collection of classified disease data. Each code is in alphanumeric form representing a unit of measurement in the ICD-10-CM category. In the current ICD-10-CM there have been additional specifications in many categories of diseases or injuries which they are expanded as the fourth, fifth, or sixth character which it is a separable part of the three- character category. In addition, some categories in the current ICD-10-CM even use to the seventh character value to provide additional information regarding the classification of the grouping. According to the American Medical Association (American Medical Association, 2018), the Social Security Act and the Centers for Medicare & Medicaid Services (CMS) in the United States, it was required that medical services must have documentation in health care providers that support claim withdrawals on one hand, and the doctor's consent on the other. Currently, the procedure must consistent, complete and updated documentation that it is an important component of patient care performed by nurses. This provision is intended to ensure the quality that it is regulated by the National Committee for Quality Assurance. This specific documentation criterion is required as medical record data for both inpatients and outpatients as well as according to the Joint Commission on Accreditation of Healthcare Organizations and the federal Conditions of Participation. In addition to serve as accreditation standards, the regulation such as this procedure are also intended to comply with federal regulatory requirements. Again, in addition, medical record documentation is a requirement that must be met in condition to obtaining licensing by state institutions and fulfills the conditions for receiving payment, as well as being a standard for the practice of professional medical services. The compliance meets these requirements and payments to be made accurately that they are highly dependent on developing the right disease classification code, and based on the documentation of the health care provider. In the future, the implications of complying with this documentation procedure will form the basis for developing a quality improvement mechanism for social security administration body.

According to the American Medical Association (American Medical Association, 2018), in the development of ICD-10-PCS in the United States, several additional in general characteristics were added to the provisions that regulate, among others: (1) the provisions, the diagnostic information is categorized that it does not included in the description of procedure. When a diagnostic procedure is performed for a disease or health disorder with a specific code, the diagnostic disease or disorder is not categorized as a procedure code. Diagnostic code, it is not a procedure of code as the basis for determining the disease or health disorder, (2) the explicit exclusion options that they are not exception of excluded in the ICD-10-PCS. Specific exclusion options should be defined as a minimum condition in each element of health care procedures, (3) the limited exceptions are limited to certain places that it is not included as a classification grouping. This it is because all the most important components of a procedure are specified in the ICD 10-PCS, so it is generally not necessary for the option to enter code non- exceptionally in limited places. However, a site-limited exclusion option can be included in the ICD-10-PCS. For example, in the use of newly developed tools or facilities, so that the option "use new devices" until the new device is explicitly added to the coding system,

(4) Exclusion level of specificity; has been included in the 10-PCS ICD. Procedure redundancy rate mechanisms are not part of system development. The code provides a variety of procedures that are uniquely defined as part of a procedure. The 10-PCS ICD code structure has been measured to produce optimal quality performance as an electronic performance application system. This is used to maximize the benefits of health services for which the data has been entered into a quality code before, (5) The use of the ICD-10-PCS search in the United States has been designed to achieve maximum level through compiling data arranged in certain codes. The code numbers are given, arranged with the same characters as a common code definition. Thus, these characters occupy the same position which it is provides flexibility and implementation of functions in the level of high data accuracy for further development, (6) The consistency of coded characters and numbers is arranged in certain codes, throughout the classification range which it is providing flexibility and implementation of function and service optimally, especially in data collection and analysis. Due to consistency in the definition of characters and numbers, this procedure will ultimately provide health services to patients as according to medical needs for even though the level of treatment is different. The comparisons of character definitions which it is carried out over time would exceed almost unlimited health care procedures, (7) the code reading. The ICD-10-PCS resembles such as language in the sense that it consists of semi-independent numbers combined by following a rule in a classification system, such as the way to arrange sentences that it is composed of combining words and their arrangement follows grammar rules and / or arranged according to language rules. Like words in the context which they are meant as a sentence, the meaning of each word has a single value from each sentence combination as an in this case the element of code of reading position is arranged in codes and numbers as its basic basis. In conducting clinical testing, according to Freeman and Klenner (Freeman & Klenner, 2015), the purpose of conducting a clinical evaluation of a case is to obtain an interpretation - that is, a synthesis and clinical laboratory test findings to reach a diagnosis of clinical synthesis, then the indications that lie on the certainty of interpretation and differential diagnosis which it is possible in obtain an interpretation but also may other interpretations. Based

on the probability of associated clinical findings, further additional testing, monitoring or prognosis is recommended. It would be obvious, for example, if you are modeling a phenomenon that occurs in high-energy physics or theoretical mathematics, it is very likely that we will choose a particular modeling tool. However, it is certainly different for individuals looking for a model like this to solve business problems.Doctors, health care providers and clinical pathologists all expect an "answer" as a continuation of the clinical diagnosis that made for the interpretation. Sometimes it will be based on a diagnostic anchor with very high self-confidence, while other times it will be lacking of it, but still in probability on relation to the diagnostic anchor even though by definition it is too broad. Sometimes, there are challenging cases which resemble a way of determining disease such as the same category of disease as the simile of a starlight crossing the open ocean 'with little or no passing through land. This is what you hope to continue to learn from the treatment of that particular disease and at the end of the journey is the diagnosis, you have clinical or postmortem evidence that unravels the threads and reveals its final conclusion to solve the mystery. That is why a dedication to taking the right steps in clinical investigation is necessarally in order to obtain the follow-up information that must be taken clinically later. This should be instilled in every clinician and clinical pathologist. Only by acquiring continuous knowledge, clinical results and the findings as well as ongoing laboratory testing can make us know whether the interpretation given is correct although it is necessary to continue studying on it. According to Fricton (Fricton, 2019), humans are complex creatures, human have multidimensional elements, and develop dynamically and live in a changing society and social order. However, the traditional biomedical model used in assessing the degree of human health is based on a scientific paradigm that it is unidimensional, reductionist, and inflexible. It is because the main basis aimed to understanding the pathophysiology on which it is based on the assessment of human health. While the pathophysiological mechanisms themselves occur differently in all certain chronic conditions, it is necessary to understand many factors that play a role in their assessment, the continuation of their assessment, and the type of progression of disease in humankind. These are the keys to successful to maintain health care management. With this perspective, it is why the traditional scientific protocols that used before often failed to provide an adequate framework for explaining, predicting, and influencing chronic disease and its outcomes. According to Rich, Singleton and Wadhwa. (Rich, Singleton, & Wadhwa, 2018) the sustainability of the health social security program can be used as a tool to formulate a leadership priority model, which it can be used in turn to improve harmony among stakeholders in the health social security program environment. The aim is to promote and prevent disease. A holistic view of leadership in the health social security programs requires the integration of a set of values to drive promotion and prevention efforts. In short quote, the sustainability of social security leadership is a vehicle for directing the leadership of health social security program priorities into the future. Based on the provisions of statutory regulations, following the academic draft of BPJS Bill (DPR, 2010) the apropriate orgaizaing body is a public legal entity on protectionship which it is in a specially formed by the BPJS Law. It is law to regulates the mechanisme of management of BPJS. This is in accordance with the mandate of constitution of the UUD 1945 article 23A which it is requires cumpolsory (mandatory) level of social security protection to be regulated by a law. This is legal entity to separated social security wealth and

management account from the wealth and government management (central and regional) to increase the efficiency and effectiveness of implementing public programs for all the people. It is admitted that at that time in 2010, Indonesia has been lagging behind in social security protection for more than three decades with other nations. However, due to the misconception of many Indonesian officials and experts who understand that social security is a program to help the poor, provide alms / charities, or to help the poor which it is temporary in nature, then that it is why systematic efforts for the entire population (universal coverage) do not develop during last time. Social programs for the poor or the poor health protections are not universal programs. What is meant by a universal program? it is a social security program that applies to everyone, quoting opinion of the leading economist Stiglizt (1999). In fact, Article 34 of the Constitution of UUD 1945 clearly assigns the state to developing social security for all people. In after the health social security program was implemented on January 1, 2014, until now, it is still causing various problems. The most prominent thing among patient complaints, such as the unfair treatment received by the members, then other problem by the inconsistency of the six-month protection for the members that affected after layoffs, or the loss due to the amount of contribution received not meet the benefit that it needs to provided to the members. In the current health social security system in Indonesia, according to Thabrany (Thabrany, 2016, p. 194) there is a problem in determining the capitation fee given to Community Health Center (Puskesmas), the amount of which should be formulated between BPJS Kesehatan and associations of health facilities (including IDI) but in fact it is only regulated through Ministry of Health Decree (Permenkes) No. 69 of 2013 concerning Standard of Health Service Rates at First Level Facilities and Advanced Level Health Facilities in the Implementation of Health Social Security Programs. These provision does not apply as well. Likewise, the amount of DRG / CBG costs which are grouped into DRG / CBG costs for the large and complete hospitals and small and incomplete hospitals, differ in size, even the health services provided are the same. This problem was not resolved immediately, because information on the implementation of the health social security system was not widely open.

RESEARCH METHODS

Generally, there are two reasons for modeling the problem, (1) if a problem has important financial and organizational implications, then it deserves serious consideration, which it makes possible to construct a model that allows a serious analytical inquiry, and (2) at a level of practical, there were often the solution is directed towards modeling a problem because it is believed it is important.

The problem method model in this study was built as a dialogue between researchers and resource persons, with a focus on their duty which it is qualitative narrative method. This problem method model grapples with contradictions and irony that occur qualitatively pragmatic, critical, and feminist. It is arrangement of questions the problem method model which it is structured with regard to the central premise of narrative research as a formula, namely 1) relationship, to find cause and effect, 2) listening, to find all the information needed and 3) not knowing, to formulate a true solution. That it is a completely new.

DISCUSSION

The problem of health social security of BPJS Kesehatan according to the National Social Security Council (DJSN, 2019) it is due to the expenditure of benefit costs greater than premium income, which it is according to Thabrany (Thabrany, 2016, p. 194) that it is one of the problems due to the determination of capitation costs given to Community Health Center (Puskesmas), and another problem is the comparison of large comprehensive hospitals versus small incomplete hospitals through the Ministry of Health Decree (Permenkes) No. 69 of 2013 concerning Standard Health Service Rates at First Level Facilities and Advanced Level Health Facilities in the Implementation of Health Social Security Programs. This problem was not resolved immediately, because the information on the implementation of the health socal security system was not widely open. According to the American Institute of Certified Public Accountants (AICPA, 2018, p. 256) the importance of regulating separate regulatory provisions to regulate health social security payments, as stated by Fatkullina et.al. (Fatkullina, Sulaymanova, & Salakhova, 2018) cites Khozinov, as a process of institutionalization of institutions aimed at consolidating social security in institutions, which according to Lerouge and Naito (Lerouge & Naito, 2017), the social security law system can provide useful alternative solutions without fraud and corruption as stated by Kratcoski and Edelbacher (Kratcoski & Edelbacher, 2018) that the concept of fraud and corruption can occur depending on the context in which the provisions are applied, or moral hazard which it is according to Samad (Samad, 2019) ex ante and ex post moral hazard, that it is make the members think that the health social security administration body will pay medical bills when they get sick, so that the financial consequences will be borne by the BPJS Kesehatan. Responding to this problem, BPJS Kesehatan then arranged for membership activation after 14 days, either new membership or changing addresses. Another problem, according to the DJSN (DJSN, 2020, p. 57) it is the trend of unit cost of advanced inpatient claims in 2014 - 2018 for patients with class 1 entitlements based on the INA CBG rates set by the Ministry of Health which they are higher in unit cost for class I entitlement inpatients compared to the lowest rates for class 3 entitlement treatment. This is according to Leon (2018) because a coding system procedure, which it was developed based on the classification of diseases, it does not have the same coding system yet, especially in financing elements of disease groups, injuries, operations, and procedures, or according to their classification. Categories of disease should be able to adopt the three-character code as used in the same ICD-10-CM, or the seven-character code as used in the ICD-10-PCS to help to answer the questions about a group of causes of disease in term to do categorized as specific one for class I entitlement and provide a mechanism for treatment and.systematically statistical tabulation including the storage and retrieval of disease in the classification of data. According to Komaryani (Komaryani, 2017) the INA-CBG rates in Indonesia with the Case mix System (grouping of cases of disease based on clinical characteristics and relatively similar / similar resource usage), which it is based on case grouping using, first, ICD 10 for Diagnosis (± 14,500 codes) , and secondly, ICD 9 CM for procedure / Action (± 7,500 codes). The INA-CBG tariff list is currently consists of 1,075 cases groups including 786 inpatient cases groups of class 1,2,3 entitlement and 289 outpatient case groups. The implementation of classification mechanism is run by using a Grouper from UNU-IIGH (United Nation University International Institute for Global Health). In simple terms the INA CBGs tariff

formula is formulated

INA-CBG Rate = Hospital Base Rate (HBR) x Cost Weight (CW) + Adjustment Factor (AF) Based on this formula, the tariff adjustment is set differently in the rates of Cipto Mangunkusomo Hospital, RSIP Harapan Kita Hospital, RSAB Harapan Kita Hospital, Dharmais Hospital, Class A to Class D Public and Private Hospitals. Referring to the American Medical Association (American Medical Association, 2018), the development of INA-CBG should refer to ICD 10-PCS in the United States, with some additional general characteristics or adjustment factors, including: (1) provisions, the diagnostic information is categorized as not included in the procedure description. (2) the explicit exclusion option which it is not excluded as explicit, it is not included in the ICD- 10-PCS, (3) exclution limited to a certain place is not included as a group of classification,

(4) The exclusion level of specificity is only carried out in a certain level, (5) The use of ICD-10-PCS data search that it is used to designed maximum achievement through compilation of data should be arranged in certain codes. (7) the code reading of semi- independent numbers combined by following a rule in a classification system. There are differences in class 1 entitlement, class 2 entitlement and class 3 entitlement of services to the members of health social security. This difference also includes INA - CBG rates and treatment room rate. The challenge is the difference in service classes does not provide faster recovery from illness or the members of 3 entitlement are not accepted at the hospital unless they move to class 2 entitlement or class 1 entitlement. According to the DJSN (DJSN, 2020) there are a number of beds for class 3 entitlement in the unit of Vertical Technical Hospital own by the Ministry of Health as 7,342 of beds (45.71%) of a total of 16,058 of beds. Based on National Health Protection (JKN) statistical data (DJSN, 2020, p. 29) the fulfillment rate of class I entitlement beds in 2018 reached 2,250 patients per 10,000 treatments (up to 43% from 2014). The class 2 entitlement reached 1,534 patients per 10,000 treatments (up to 777 in 2014). And the class 3 entitlemtn reaches 664 patients per 10,000 treatments (up to 114% from 2016). Meanwhile according to the DJSN (DJSN, 2020, p. 57) the unit cost service of class 1 entitlement based on these statistical data, there is a difference of 50% higher than the unit cost of class 3 entitlement treatment claims during 2014 – 2018. The unit costs for class I entitlement with INA CBGs in 2018 it was reached IDR 6,310,301, while the unit cost of class 2 entitlement with INA CBGs in 2018 reached to IDR 4,640,558, - and unit cost of class 3 entitlement with INA CBGs in 2018 reached to IDR 4,161,160. Based on the classification for 100 classifications of INA-CBGs according to DJSN as base as statistics data (DJSN, 2020, p. 114) in 2014, the cost of Advanced Outpatient Care (RJTL) reached IDR7,658 Trillion and the cost of Advanced Inpatient Care (RITL) reached IDR16,153Trillion. In 2018, the cost of Advanced Outpatient Care reached IDR 25,078 Trillion and Advanced Inpatient Care (RITL) reached 30,101 Trillion. In drafting the INA-CBG, there was unfair that the unit cost of class 3 entitlement treatment which it was 50% lower on average of unit cost of care of class 1 entitlement. This lack of unfair of the unit of cost of care shows that there are weaknesses in the preparation of INA CBGs by 50% which it is affect 50% of the costs borne by BPJS Kesehatan for class

I memberships. According to, Gokhale and Pfleger. (Gokhale & Pfleger, 2019) the pathway clinical framework can provide a fair solution in the preparation of CBG. This clinical pathway is intended as a systematic effort that works over time, to produce mechanistic details in interactions between the components of the disease management clinical pathway and the actions taken in diagnosing of the disease. This concept adopts the Hippo Pathway system by explaining the actions in handling by geneticists from Drosophila that it called the Drosophila model.

In term to do preparation of the INA CBGs formula as a stated above, Mohanty and Vyas (Mohanty & Vyas, 2018, p. X) consider three technological breakthroughs that they are needed to become catalysts in the network system that are, first, it need to do massive parallel changes that they are a part of thinking of network to become to knowledge management in the Graphics Processing Unit by the time of fraction per second. Second, Big Data is also needed that the intelligence of human taught from time to time which it has the ability to collect, clean, standardize, and store of the Artificial Intelligence data. As a result, information hat it is fed into almost any kind of service that it can be the end up to turning anything very quickly into "smart". Third, the algorithm that it is make it betterin the form of “if then Then” form.

Therefore, according to Kesterson (Kesterson, 2018) the areas of competence in artificial intelligent are communication skills, analytical skills, technical skills in problems solving on running out management, realizing something to the special purpose and having self confidence in carrying out duties and functions as an implementer of the health social security system. The state intervention in the health social security system needs to be carried out to increase the function. according to Wang (Wang, 2015) after careful comparison of the welfare regimes of South Korea and Taiwan as an example implies that it is difficult to choose an East Asian health social security model. According to Rich, Singleton and Wadhwa. (Rich, Singleton, & Wadhwa, 2018) the sustainability of the health social security program can be used as a tool to formulate a priority model for the nation's leadership. This is related to the philosophy, which in the academic paper of the BPJS Bill (DPR, 2010) states that the appropriate Organizing Body is a public legal entity as protectionship, which it is specially formed by the BPJS Law and manage by the BPJS administration body.

This is in accordance with the mandate of the constituents of the UUD 1945 article 23A which it is a levies compulsory (forcement) required to be regulated by law. This legal entity is separated from state wealth and state management from wealth and government management (central and regional) to increase the efficiency and effectiveness of implementing of public programs for all the people.

CONCLUSION

Searching for the formula of health Social Security for BPJS Kesehatan program cannot be separated from the values of mutual cooperation in between a form of social capital among families, workers, employers, state officials and other stakeholders. The right

formula is to maximize the protection efforts of the health social security program from the aspect of government policies, especially the improvement of applicable regulations, then carry out patient services of health protection of the members with high ethical standards and implement the principles of social security as a whole that prioritizes the provision of maximum benefits. So that, it need mutual cooperation and strong leadership which they are able to ensure the sustainability of the social security system in the future.

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