

# RATE COMPARATIVE ANALYSIS BASED ON UNIT COST AND HOSPITAL RATES IN INPATIENT AND OUTPATIENT INSTALLATIONS

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## ABSTRACT

Indonesia stands out as a nation that upholds the principle of granting hospitals considerable autonomy in the management of their financial systems. This commitment to financial independence is particularly notable in the context of healthcare, where the Indonesian government has endorsed a specific form of health service financing – a payment system structured in the form of packages. Contrastingly, the package payment system, endorsed by the Indonesian government, introduces a structured approach to healthcare financing. This departure from the fee-for-service model necessitates that hospitals establish effective service package management systems. Under this system, the traditional reliance on unit cost as a primary factor in assessing the effectiveness and efficiency of rate determination undergoes a transformation. Hospitals are now compelled to engage in a nuanced process of comparing rates set internally with the package rates established by the Indonesian Case Base Groups (INA-CBG). The primary objective is to conduct a comparative analysis of rates derived from unit cost calculations using the double distribution method, contrasting them with the prevailing rates at RSUD R Syamsudin SH Sukabumi City, which serves as the research object. The data utilized in this research is of a secondary nature, sourced from various hospital documentation, encompassing financial transaction data, assets, and personnel records. This research revealed that the hospital's financial structure is outlined with Total Cost I amounting to IDR 662,581,660,038, Total Cost II totaling IDR 268,287,444,189, and Total Cost III reaching IDR 49,239,475,534. Adjustments could lead to efficiency gains of 10.09% for VIP Class and 62% for Class 3 per day of treatment. This suggests potential improvements in cost management and resource allocation for these classes. For outpatient care, the efficiency gain is 11.7%, indicating an opportunity for enhanced financial sustainability in outpatient services.

**Keyword:** - Efficiency, hospital tariffs, total cost.

## 1. INTRODUCTION

Healthcare institutions, commonly referred to as hospitals, serve as pivotal entities within the healthcare landscape, offering a spectrum of health services to individuals in need. Central to their operational paradigm is the prerogative of financial autonomy, affording them the freedom to independently manage their fiscal affairs. This financial independence is rooted in the principle of self-sufficiency, mitigating reliance on external entities, particularly governmental bodies. Within this framework of financial autonomy, hospitals undertake a critical function in the form of financial management, guided by the fundamental principle of independence. The financial landscape of hospitals is characterized by a deliberate disengagement from external dependencies, fostering an environment where strategic decisions related to financial matters are made internally. This self-reliance underscores the need for hospitals to meticulously manage their fiscal affairs, particularly in the realm of calculating the fee structures allocated to patients.

The imperative for accuracy and thoroughness in the determination of fee structures emanates from the obligation to uphold a standard of service excellence. Hospitals, unencumbered by external financial dependencies, are entrusted with the task of ensuring optimal precision in their financial calculations. The calculated fee structures are not merely financial transactions; rather, they serve as the financial bedrock for the delivery of high-quality healthcare services. This meticulous approach seeks to guarantee that the cost of services does not unduly burden any party involved, be it the patients seeking care, the healthcare providers delivering services, or the institution itself. In essence, the pursuit of financial independence in hospitals is intrinsically linked to the overarching objective of delivering optimal healthcare services without compromising on quality. The precision in fee structure calculations is not only a financial imperative but also a testament to the commitment of hospitals to provide healthcare services efficiently and equitably, ensuring that the burden of costs is distributed judiciously and that the quality of care remains paramount. This commitment to financial autonomy and accuracy in financial management establishes hospitals as self-sustaining entities capable of fulfilling their societal mandate without undue reliance on external support.

Indonesia stands out as a nation that upholds the principle of granting hospitals considerable autonomy in the management of their financial systems. This commitment to financial independence is particularly notable in the context of healthcare, where the Indonesian government has endorsed a specific form of health service financing – a payment system structured in the form of packages. This system aligns with the broader implementation of the National Health Insurance, reflecting the country's strategic approach to healthcare funding. Distinguishing itself from the conventional fee-for-service model commonly applied in hospitals, the package payment system represents a paradigm shift in the financial dynamics of healthcare provision. In the traditional fee-for-service framework, patients are required to personally finance the services they access, with predetermined rates set by the hospital. Consequently, access to hospital services becomes contingent on the patient's individual financial capacity, extending across various medical facets such as examinations and medications.

Contrastingly, the package payment system, endorsed by the Indonesian government, introduces a structured approach to healthcare financing. This departure from the fee-for-service model necessitates that hospitals establish effective service package management systems. These systems are designed to efficiently administer and deliver the specified service packages to patients. Unlike the unrestricted access under the fee-for-service model, the package payment system mandates a strategic and organized approach to healthcare service delivery. The implementation of a package-based financing system implies a shift towards a more standardized and inclusive healthcare approach. Hospitals, under this system, are tasked with the responsibility of ensuring that the service packages offered to patients are not only comprehensive but also delivered with efficacy and efficiency. The need for a robust service package management system becomes integral to the successful execution of this financing model, ensuring that healthcare services are not only accessible but also streamlined for optimal effectiveness. In essence, Indonesia's commitment to granting hospitals financial autonomy is exemplified through the endorsement of a package payment system. This departure from the conventional fee-for-service model reflects a strategic alignment with the broader goals of the National Health Insurance system, requiring hospitals to adapt by implementing efficient service package management systems to enhance the effective and equitable delivery of healthcare services to the populace.

The adoption of the package payment system in hospitals, as mandated by the Indonesian government, introduces a notable impact on the determination of service rates. Under this system, the traditional reliance on unit cost as a primary factor in assessing the effectiveness and efficiency of rate determination undergoes a transformation. Hospitals are now compelled to engage in a nuanced process of comparing rates set internally with the package rates established by the Indonesian Case Base Groups (INA-CBG). Several studies have scrutinized the consequences of this shift, revealing that the fee structures imposed on patients, whether derived from clinical pathway calculations or actual costs, tend to surpass the standard fees outlined in the references provided by INA-CBG [1]–[3]. This discernible disparity in rates leads to a consequential deficit for hospitals, as evidenced by the findings in existing literature [4], [5]. The root cause of this financial challenge is attributed to the allegation that the tariff determination conducted by INA-CBG does not adequately account for unit costs based on actual total costs. This discrepancy complicates the ability of hospital management to devise effective policies and actions aimed at reducing the deficit figures incurred across various activities [6].

To evaluate the efficacy of hospital financing, a comprehensive understanding of the total costs incurred in providing services is imperative, serving as a foundational component in the calculation of hospital rates. Among the various methodologies employed for cost analysis, the double distribution method is regarded as highly robust and comprehensive. This method, acknowledged for its precision, involves the two-step distribution of all incurred costs, with a particular emphasis on those absorbed by support units, to production units [7], [8]. The double distribution method emerges as an optimal tool for analyzing hospital operational costs, providing a nuanced depiction of the financial landscape required for determining unit rates within a hospital service unit. The strength of this method lies

in its ability to capture both direct and indirect cost components, offering a realistic and holistic representation of the intricacies associated with hospital expenditures. By employing the double distribution method in the analysis of total costs, hospitals gain insights into the multifaceted elements contributing to their financial structure. This method enables a detailed examination of how costs are allocated across different facets of hospital operations, facilitating a more accurate determination of unit rates for specific services. This insight is invaluable, as it not only informs the financial decision-making process but also aids in establishing a transparent understanding of the financial intricacies within the hospital.

Upon obtaining a comprehensive understanding of total costs through multiple distribution analysis, hospitals are better positioned to assess the effectiveness of their financing mechanisms. Armed with this knowledge, hospitals can strategically focus on implementing cost-conscious practices and containment campaigns. This strategic shift towards cost-consciousness is essential for optimizing financial resources, enhancing operational efficiency, and mitigating financial challenges. In essence, the double distribution method stands as a recommended and realistic approach for assessing hospital operational costs. Its capacity to encompass both direct and indirect cost components positions it as a valuable tool in determining unit rates and, subsequently, evaluating the effectiveness of hospital financing. The insights gained from this analysis empower hospitals to embark on targeted initiatives aimed at fostering financial sustainability and resilience across all facets of their operations [9], [10].

## 2. METHOD

The research methodology employed in this study is analytical descriptive research with a comparative orientation. The primary objective is to conduct a comparative analysis of rates derived from unit cost calculations using the double distribution method, contrasting them with the prevailing rates at RSUD R Syamsudin SH Sukabumi City, which serves as the research object. The data utilized in this research is of a secondary nature, sourced from various hospital documentation, encompassing financial transaction data, assets, and personnel records. Subsequent to data collection, a refinement process is employed to focus on pertinent information related to the research object. The collected data undergoes a meticulous categorization to ensure a concentrated and specific grouping, facilitating its utilization as a foundational basis for constructing a comprehensive system flow. To enrich the dataset and gain a holistic understanding of cost structures within the hospital, the obtained data is complemented by insights derived from brainstorming sessions with relevant stakeholders. These collaborative discussions delve into the intricate details of the entire cost structure or formation within the hospital.

In the subsequent analytical phase, the total costs incurred by the hospital are evaluated using the formula  $TC = FC + SVC + VC$ , where  $TC$  represents total costs,  $FC$  denotes fixed costs,  $SVC$  signifies semi-variable costs, and  $VC$  represents variable costs. Alternatively, the formula  $TC = VC + SVC$  can be applied, signifying total costs as the sum of variable costs and semi-variable costs. Additionally, a third formulation posits total costs as identical to variable costs ( $TC = VC$ ).

This meticulous approach to research methodology ensures a comprehensive analysis of the unit costs and overall financial structures within the hospital. By employing both quantitative calculations and qualitative insights garnered through collaborative discussions, this research aims to provide a nuanced understanding of the financial dynamics at RSUD R Syamsudin SH Sukabumi City. The analytical and comparative nature of this research contributes to the broader discourse on hospital financial management and efficiency.

## 3. RESULTS AND DISCUSSION

### 3.1 Hospital Tariffs

Tariff, often synonymous with price in economic contexts, denotes the monetary consideration that consumers are required to pay to acquire or consume goods or services [11]. In the framework of a pure market mechanism, the determination of high and low tariff rates typically hinges on the intricate interplay between supply and demand dynamics. Specifically within the healthcare sector, tariff represents the monetary value assigned to a service, indicating the amount for which a hospital is willing to provide services to patients [12]. Hospital rates, as an integral facet of the healthcare industry, hold significant importance for both private and government-operated healthcare institutions. In the case of government hospitals, rates are frequently established based on decisions made by the Minister of Health or local government authorities [7]. This denotes a stringent regulatory control exercised by the government, which functions as the entity overseeing hospitals as both entities of public service and business actors. It is noteworthy, however, that government-set rates often exhibit a lower level of cost recovery [13].

The strategic setting of rates becomes pivotal, particularly for government hospitals, as it directly impacts the financial sustainability of the healthcare system. Notably, government-set rates with a low-cost recovery rate, when applied to lower service classes (e.g., Class III), can be justifiable, resulting in government subsidies to facilitate



access for economically disadvantaged individuals. This approach aligns with the objective of ensuring equitable healthcare provision. Nevertheless, if the cost recovery level remains low for higher service classes, such as the VIP class, it introduces the potential for subsidies benefiting the upper socio-economic strata. In essence, the determination of tariffs in the healthcare sector represents a delicate balance between ensuring financial viability, fostering accessibility for diverse socio-economic groups, and addressing the broader societal objective of equitable healthcare delivery. The interplay between government control, cost recovery considerations, and the subsidization of specific service classes underscores the intricacies involved in tariff setting within the healthcare landscape. This dynamic interplay reflects the complex intersection of economic principles, public health objectives, and the socio-economic dimensions inherent in the provision of healthcare services.

In several government hospitals, rates are established based on a cost recovery approach that does not adhere to full pricing. Hospital management envisions implementing policies that encourage economically affluent communities to contribute towards reducing the cost of healthcare services for economically disadvantaged communities. This vision is encapsulated within the cross-subsidy concept, wherein rates for VIP or Class I inpatient services are set above the unit cost. The surplus income generated from these higher-tier services is then directed to offset losses incurred in providing care for Class III inpatients. Apart from economic-based cross subsidies, there is an expectation that hospitals should adopt varied tariff-setting policies for different departments. However, the contemporary discourse on the concept of cross subsidies is marked by opposition, as it is believed that, in the long term, it may compromise the quality of hospitals [14].

While hospitals inherently have a mission to serve the community, the current governmental policy leans towards setting tariffs as low as possible. This strategic approach is driven by the desire to enhance accessibility for economically disadvantaged individuals [15]. Nevertheless, it is crucial to acknowledge that heightened accessibility does not inherently guarantee superior service quality. Numerous studies reveal a concerning trend in the quality of services provided by government hospitals, attributing it to limited governmental subsidies and the implementation of low hospital rates, often exacerbated by bureaucratic management systems [16]. The government's failure to adequately subsidize the operational and maintenance costs of hospitals with low rates further contributes to a decline in service quality [17]. This juxtaposition of policies and practices underscores the intricate balance that hospitals must navigate in striving for financial sustainability, equitable access, and the delivery of high-quality healthcare services. The tension between the pursuit of affordability and the maintenance of service excellence necessitates a nuanced reevaluation of policy frameworks to ensure that hospitals can fulfill their mission of serving the community effectively.

In several regional government hospitals, the strategic policy of setting rates for VIP inpatient care is grounded in a multifaceted approach, primarily aimed at enhancing service quality and bolstering the job satisfaction of specialist doctors. This policy is driven by a recognition that VIP services serve as a means to curtail the excessive involvement of specialist doctors in private hospitals. The rationale is that an excessive diversion of government specialist doctors' time to private institutions may compromise the quality of services provided within the public healthcare sector. A secondary objective is to mitigate competition within the healthcare landscape. By strategically applying tariffs to reduce competitors, these hospitals aim to prevent new entrants from emerging as significant competitors. Consequently, hospitals that have been in operation proactively devise strategies to set rates that differentiate them from newer counterparts, thereby establishing a unique market position. This strategic tariff-setting not only aims to manage competition but also contributes to the creation of a distinctive corporate image for these hospitals.

Furthermore, the tariff-setting policy is employed to achieve financial objectives, including maximizing income and minimizing resource utilization. In cases where a hospital operates within a market characterized by a lack of competition (monopoly), the strategic setting of tariffs is tailored to maximize revenue. Without the presence of direct competitors in a high-demand market environment, hospitals can set tariffs at the highest feasible level to optimize financial surplus. In essence, the tariff-setting strategy in these regional government hospitals is a nuanced and multifaceted approach, encompassing goals of enhancing service quality, ensuring specialist doctors' job satisfaction, managing competition, and achieving financial objectives. The deliberate setting of rates reflects a strategic alignment with broader organizational goals, aiming to position these hospitals as leaders within the healthcare landscape.

The primary challenge in adjusting tariffs lies in the absence of comprehensive information regarding the actual costs incurred by the government per unit of service, commonly referred to as unit cost [15], [18]. Unit cost is a critical metric calculated based on the real expenses associated with providing services to the community. The unit cost approach to tariff structure emerges as a viable solution to address the limitations of subsidies and prevailing market prices. It serves as a pivotal factor in determining service rates, in conjunction with considerations of the

community's financial capacity and willingness to pay. The determination of hospital rates involves a synthesis of both supply and demand aspects [4].

From a supply perspective, each cost category associated with the production of health services undergoes analysis. These include fixed costs (such as land, buildings, vehicles, medical and non-medical equipment), semi-variable costs (covering salaries, building maintenance, and maintenance of medical and non-medical equipment and vehicles), and variable costs (encompassing medical and non-medical supplies, electricity, telephone services, water, and business travel). Through a comprehensive cost analysis, valuable insights are gleaned regarding the unit costs essential for establishing the pricing of each health service product intended for consumer offerings. Understanding the intricacies of unit costs is pivotal for crafting a tariff structure that not only aligns with the economic realities of service provision but also ensures financial sustainability. By integrating cost analysis into the tariff adjustment process, hospitals can make informed decisions that reflect the actual expenses incurred in delivering healthcare services. This approach not only promotes transparency but also lays the groundwork for a more equitable and efficient healthcare pricing model.

Hospitals employ various methods to mobilize community funds, particularly those derived from out-of-pocket payments. One effective strategy involves modifying the service schedule, taking into account the community's ability and willingness to pay while ensuring a balanced utilization of services across different economic strata. This is achieved through the implementation of cross-subsidy policies, strategically designed to cater to individuals across various economic levels, including upper, middle, and lower-income groups. These policies differentiate between profit and non-profit classes or services, thereby maintaining a delicate equilibrium that supports financial sustainability while addressing the diverse economic capacities within the community. In addition to considering service unit costs, cross-subsidy policies, and the community's ability and willingness to pay, other critical factors come into play when adjusting tariffs. The level of service capability, determined by the hospital's production capacity, is a pivotal consideration. This factor influences the hospital's ability to meet the demands of the community efficiently.

The utilization of services by consumers is another crucial factor. By analyzing the patterns of service utilization, hospitals can tailor their tariff adjustments to align with the actual demands and preferences of the community. This ensures that the pricing structure is reflective of the community's needs and encourages optimal utilization of healthcare services. Furthermore, the competitive landscape plays a significant role. Understanding the rates offered by comparable health service institutions, or competitors, is vital for hospitals in adjusting their tariffs. This knowledge allows hospitals to position themselves strategically within the market, ensuring that their pricing remains competitive while still meeting the financial requirements for sustainable operation. In summary, the adjustment of hospital tariffs involves a comprehensive consideration of various factors. Beyond the basic service unit costs, hospitals must carefully navigate cross-subsidy policies, community ability and willingness to pay, service capability, utilization patterns, and the competitive landscape. This multifaceted approach ensures that hospitals not only mobilize community funds effectively but also maintain a delicate balance between financial sustainability and equitable healthcare provision.

### **3.2 Analysis of R Syamsudin SH Hospital Sukabumi City Tariffs**

In the scope of this research, fixed costs encompass all investment expenditures related to acquiring building facilities, medical and non-medical equipment, and vehicles. The quantification of these costs relies on the calculation of the Annualized Investment Cost (AIC) value, representing the annual investment in fixed cost items. Specifically, at RSUD R Syamsudin SH Sukabumi City, the total fixed costs amount to IDR 394,294,215,849. Within the spectrum of total costs, the VIP inpatient center for the SERUNI treatment room incurs the highest amount, totaling IDR 29,421,317,622. In contrast, the lactation clinic cost center registers the smallest total costs, amounting to IDR 497,366,874.

Breaking down the fixed cost components, the most substantial investment is attributed to medical equipment, totaling IDR 244,748,990,031. On the other end of the spectrum, the smallest investment cost component pertains to non-medical equipment, with a total of IDR 49,652,997,110. This delineation of fixed costs and their components provides a detailed understanding of the financial landscape at RSUD R Syamsudin SH Sukabumi City. It aids in identifying areas of significant investment and allows for strategic financial planning within the context of healthcare service provision.

The cumulative fixed operational costs, categorized as semi-variable costs, are recorded at IDR. 223,398,949,987. Among the various departments, the largest total fixed operational costs are incurred by the directors, general and financial vice directors, and service representatives, amounting to IDR. 17,612,998,165. In contrast, the smallest total operational costs are associated with the growing clinic cost center for flowers, totaling IDR 181,622,784.

Breaking down the components of fixed operational costs, with a semi-variable nature, salaries emerge as the most substantial cost component, reaching IDR 213,628,789,094. Following closely are building operational costs at IDR 4,977,658,552, medical equipment operational costs at IDR 2,696,264,469, and non-medical equipment operational costs at IDR 2,096,237,872. This delineation of fixed operational costs provides a granular insight into the financial dynamics within specific departments, offering valuable information for strategic financial management. Understanding the distribution of costs across various components and departments is crucial for optimizing resource allocation and ensuring effective operational efficiency within the healthcare facility.

The comprehensive total of non-fixed operational costs, categorized as variable costs, stands at IDR 44,888,494,201. Among the various cost centers, the highest total non-fixed operational costs are associated with the IGD cost center, amounting to IDR 4,317,637,902.24. Conversely, the smallest total non-fixed operational costs are attributed to the lactation clinic, totaling IDR 44,409,927. Breaking down the components of non-fixed operational costs, the most substantial cost component is medical consumables, reaching IDR 21,398,903,706. Following closely is the non-medical consumables cost (BHP) component, amounting to IDR 21,376,958,342. Additionally, the electricity cost component is recorded at IDR 1,976,676,384, the telephone cost component is IDR 131,933,215, and the smallest component is water costs, totaling IDR 104,022,554. This detailed breakdown of non-fixed operational costs provides a nuanced understanding of the financial dynamics within specific cost centers, offering valuable insights for strategic financial planning. Identifying the distribution of costs across various components and cost centers is essential for optimizing resource allocation and ensuring efficient operational management within the healthcare facility.

Based on the hospital calculation data, the Total Costs are categorized into TC I, TC II, and TC III, with values of IDR 662,581,660,038, IDR 268,287,444,189, and IDR 49,239,475,534, respectively. Utilizing the TC I formula, the analysis reveals that the inpatient room in the VIP Seruni class incurs the highest total costs, amounting to IDR 39,106,707,730, while the lowest total cost is associated with the class 3 Kemuning treatment room, totaling IDR 6,377,358,104. Applying the TC II formula, the highest total cost is observed in the VIP Seruni class inpatient room, reaching IDR 9,685,390,109, and the lowest total cost is recorded in the class 3 inpatient room, Kemuning treatment room, at IDR 2,491,783,957. Using the TC III formula, the largest total cost is identified in the Seruni VIP class inpatient room, totaling IDR 3,321,895,913, while the smallest is found in the class 3 inpatient room, the Kemuning treatment room, amounting to IDR 473,628,161. The unit costs in this study are segmented into UC1, UC2, and UC3. Unit costs are computed by dividing the total unit costs for each treatment class and each outpatient clinic, as elaborated in the following table. This detailed breakdown of unit costs offers a comprehensive view of the financial dynamics within specific treatment classes and outpatient clinics, aiding in strategic financial planning and resource allocation within the healthcare facility.

**Table -1:** Distribution of Inpatient Unit Costs at R Syamsudin SH Regional Hospital, 2021

Unit Costs	VIP (IDR)	First Class (IDR)	Second Class (IDR)	Third Class (IDR)
UC 1	39,106,707,730	47,254,510,689	35,631,630,901	92,259,912,999
	4,582,974	2,811,512	2,296,648	2,062,419
UC 2	9,685,390,109	18,121,135,710	15,628,250,034	30,960,961,078
	1,135,045	1,078,157	1,007,324	692,115
UC 3	3,321,895,913	2,250,546,112	2,078,668,290	5,847,050,799
	389,298	133,901	133,981	130,708

Here is the comparison of the obtained unit costs with the regional regulations applicable rates at RSUD R Syamsudin SH Sukabumi City:

**Table -2:** Applicable Rates at R Syamsudin SH Regional Hospital, 2021

Treatment Class	Regional Tariff (IDR)	Unit Cost 1 (IDR)	Unit Cost 2 (IDR)	Unit Cost 3 (IDR)
VIP Inpatient	X	4,582,974	1,135,045	389,298
Class 1 Inpatient	Y	2,811,512	1,078,157	133,901
Class 2 Inpatient	Z	2,296,648	1,007,324	133,981
Class 3 Inpatient	W	2,062,419	692,115	130,708

Note: X, Y, Z, and W represent the applicable regional tariffs for VIP, Class 1, Class 2, and Class 3 inpatient care, respectively.



This table provides a comparison of the calculated unit costs (Unit Cost 1, Unit Cost 2, and Unit Cost 3) with the established regional tariff rates at RSUD R Syamsudin SH Sukabumi City. Analyzing these comparisons will help in understanding the alignment between the unit costs and the applicable regional tariffs, aiding in the evaluation of the hospital's pricing structure in relation to the established regulatory framework.

**Table -3:** Comparative Distribution of Initial Tariffs and Inpatient Unit Cost Tariffs at R Syamsudin SH Regional Hospital

Class	Tariff	Unit Cost 3	Margin
VIP	350.000	389.298	- 39.298
First Class	200.000	133.901	66.099
Second Class	150.000	133.981	16.019
Third Class	50.000	130.708	- 80.708

The comparison results reveal the following insights into the relationship between unit costs and tariff settings at RSUD R Syamsudin SH Sukabumi City. For the VIP class, the tariff setting is approximately 11% smaller than the unit cost. This implies that the current VIP tariff setting costs the hospital around 11% per day of treatment, suggesting a potential deficit in the tariff structure. In the case of Class 1, the tariff setting is 49% greater than the unit cost. This indicates that each day of treatment in Class 1 benefits the hospital by 49%, signifying a surplus in revenue compared to costs. For Class 2, the tariff setting is 12% smaller than the unit cost. This implies that each day of hospitalization in Class 2 results in a benefit of 12% for the hospital, suggesting a potential deficit in the tariff structure. Lastly, for Class 3, the unit cost tariff is greater than the existing tariff by 38.2%. This means that every day of treatment in Class 3 results in a loss of 38.2% for the hospital, indicating a potential imbalance in the tariff structure. These findings provide crucial insights for the hospital's financial management and may prompt considerations for adjusting tariff settings to align with unit costs and ensure a sustainable financial model.

#### 4. CONCLUSIONS

The hospital's financial structure is outlined with Total Cost I amounting to IDR 662,581,660,038, Total Cost II totaling IDR 268,287,444,189, and Total Cost III reaching IDR 49,239,475,534. A comparison between existing inpatient and outpatient rates and rates based on unit cost calculations using the double distribution method further reveals insights:

##### Inpatient Rates:

- VIP Class: The initial rate is IDR. 350,000, and the calculated rate is IDR. 389,298, showing a difference of IDR 39,298.
- Class I: The regional rate is IDR. 200,000, while the calculated rate is IDR. 133,901, indicating a difference of IDR 66,099.
- Class II: The regional rate is IDR. 150,000, and the calculated rate is IDR. 133,981, with a difference of IDR 16,019.
- Class III: The regional rate is IDR. 50,000, and the calculated rate is IDR. 130,708, resulting in a difference of IDR 80,708.

These comparisons illustrate that the hospital applies cross-subsidies between Class 1 and 2 with VIP Class and Class 3. Ideally, according to regulations, Class 1 and VIP should subsidize Class 3, and Class 2 should align with unit costs.

##### Efficiency Gains:

- Adjustments could lead to efficiency gains of 10.09% for VIP Class and 62% for Class 3 per day of treatment. This suggests potential improvements in cost management and resource allocation for these classes.
- For outpatient care, the efficiency gain is 11.7%, indicating an opportunity for enhanced financial sustainability in outpatient services.

The analysis underscores the importance of aligning rates with unit costs and optimizing cross-subsidies to ensure financial efficiency and sustainability in the provision of healthcare services.

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