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EVALUATION OF SOCIAL SECURITY OF BPJS KESEHATAN PROGRAM

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ABSTRACT:

This study aims to evaluate the implementation of social security of BPJS Kesehatan program which is provided to participants for non-contributory modality (PBI), contributory modality (non-PBI) for salaried workers, non-salaried workers and non-employees. This study measures the targets set by the achievements of the social security of BPJS Kesehatan program using the discrepancy evaluation model method.

The evaluation of achievement of social security of BPJS Kesehatan program is to carrieout through the design, installation, process and results of the implementation of the social health insurance program on aspects of contributions and health services at primary care facilities and hospital facilities.

The results show that the social security of BPJS Kesehatanprogram for the participants non-contributory modality (PBI), contributory modality (non-PBI) for salaried workers, non-salaried workers and non-employees still need to be increased for further to achieve universal and comprehensive health insurance coverage.

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INTRODUCTION:

The failure of social security of BPJS Kesehatan program is experienced due to the current operational losses that it was to failure to meet the health insurance costs of participants that it requiered social engineering such as suggested by Adinolfi and Borgonovi (Adinolfi & Borgonovi, 2018), that to cope with the problem of the loss of the social security of BPJS Kesehatan system which has failed, it can begin with the assumption that problems can be overcome by social engineering and charismatic leadership. The main purpose of social security of BPJS Kesehatan program is to guarantee equity to the participants. This is different from private health insurance which prioritizes efficiency over equity. The trust of the health insurance participant in the role of participant complaint healing is a management model to pursue by the nonprofit health social security provider. All management activity is to emphasis rests on the scale and measurement of participant complaints healing. All of these mechanisms are taken as a general effort to get over the failure of the current health social security system.

In responding the failure of the health social security system, the Ministry of Finance (Ministry of Finance, 2019) said that in order to achieve the sustainability of the National Health Insurance (JKN) program, it is need a comprehensive improvement in aspects of participation and contribution of premium, health insurance benefit costs and strategic purchasing. From the aspect of participation and contribution of premium, the BPJS Kesehatan must streamline the efforts of extensification and intensification and collectibility of contributions of premium, particularly in the segment of salaried worker participants (PPU) and non-salaried worker participants (PBPU). BPJS Kesehatan must also speed up the process of data cleansing, the validity and integrity of problematic membership and updating of the membership data. For data cleansing, especially for participants non-contributory modality, a large role of the Ministry of Social Affairs is needed in providing Integrated Social Welfare Data (DTKS).

In following up the audit findings of Indonesia’s National Government Internal Auditor (BPKP), the BPJS Kesehatan must work together with relevant stakeholders, such as local governments, in increasing compliance with both private and government agencies to work with the BPJS Kesehatan, in order to register all employees as partisipants of Nasional Health Insurance Program (JKN) and report their income as according to the actual data. BPJS Kesehatan must try harder to increase the level of non-salaried workers (PBPU)contributions, which it is only reached 53.72 percentat the end of 2018.

In the aspect of the cost of health insurance benefits, BPJS Kesehatan needs to strengthen the implementation of fraud prevention systems. BPJS Kesehatan must ensure that hospitals have and adhere to Standard Operational Procedure (SOP), Medical Service Standards (SPM), and Professional Standards that can prevent fraud. Hospitals and Health Offices must also have a Fraud Prevention Team and JKN Program Fraud Prevention Guidelines and Policies.

Based on Ministry of Finance data, since 2014, the JKN program has continued to experience a deficit. The amount of the JKN program deficit before taking into account the Government's interventions amounted to Rp1.9 trillion (in 2014), Rp9.4 trillion (in 2015), Rp 6.7 trillion (in 2016), Rp13.8 trillion (in 2017) and Rp19.4 trillion (in 2018). In order to help overcome this deficit, the Government intervened by providing a State Investment (PMN) of Rp5 trillion (in 2015) and Rp6.8 trillion (in 2016), as well as providing State Budget (APBN) expenditure aid of Rp3.6 trillion (in 2017) and Rp10.3 trillion (in2018). BPJS Kesehatan must

also improve claims management such as cases of misreading claims, upcoding claims, multiple claims, fictitious claims, claims by dead status participants, or claims by non-active participants.

From the strategic purchasing aspect, BPJS Kesehatan needs to pay attention to the determination of hospital classification and management of capitation funds. BPJS Kesehatan need to work together with the Ministry of Health and the local level of Health Office and do to review the hospital class as an agreement in cooperation between BPJS Kesehatan andhospitals. Thus, the classification of hospitals in accordance with the criteria required in Minister of Health Decree Number 56 of 2014 which includes aspects of service, human resources, and infrastructure.

BPJS Kesehatan must ensure the require condition of capitation payment in followed with the number of doctors and the number of participantsand make effective of the implementation of Capitation-Based Fulfillment of Service Commitments (KBK). Meanwhile, the Ministry of Health and the Ministry of Home Affairs need to make regulations related to the use of funds to prevent the use of capitation funds from becoming unused at the Public Health Center(Puskesmas).

For restoring the Health Social Security system organized by the BPJS Kesehatan before all that conditions above done, the premium increase policy cannot be worked optimally.

LITERATURE REVIEW:

The social security system is an expression of affection between healthy participants and sick participants. The cooperationbetween healthy participants and sick participants that it is call gotong royong in supporting health social security is a social capital in the health social security system. In relation to social capital according to Greenberg, Gullota and Bloom, (Greenberg, Gullotta, & Bloom, 2016) citing the journey of Lexis De Tocqueville across America in 1835 - 1839 expressed a sense of affection between individuals in the contribution of the risk that occurs in such a way that, over time, a sense of social affection. becomes a relationship of mutual support and trust that hopes for one another. This attachment leads to: (a) increasing the potential for the protection of social security as a whole and the social welfare of each individual at risk of illness, and, (b) increasing the potential for community involvement as members of the social community and protecting against the risk of losing time in carrying out work where they become part of the health social security system. Both of these potentials contribute to increasing the protection of public health insurance in a healthier and more effective direction in social security.

On social security, catastrophic illness, related to leadership cope with it, Caldwell (Caldwell, 2017) states that most studies related to catastrophic events show social security safeguards retrospectively on havoc events. In a leadership situation, events that occur or are related to disaster, there is no problem with being associated with a bad decision, but instead opposes being socially organized and involves the bureaucratic social system that is used, the system that supports social in dealing with it. This concerns leaders related to the national social security system

Government and Local Government interventions, to take leadership initiative to cope with the failure of the national social security system to overcome the problem of losses suffered by the BPJS Kesehatan as according to, Laub (Laub, 2018) that it should be done with the principles of The Tao Te Ching, which presents a paradox about how a leader who let

themselves suffer, in order to show how powerful the policy is taken even if it does not benefit him, namely those who choose to be the last to receive service and take a stand first place to face the risk, sincere and sincerely work with unconditionally serve others, and show how great responsibility the natural answer that accompanies his leadership then to disqualify himself as someone differ from another leader. This is paradoxical leadership, a truth that seems to conflict between personal interests and chooses a common interest to uncover new and stronger truths. When leaders choose power to lead others, they must choose different types of power to move the world. Tao Te Ching talks about this different power, a power that by logical reasoning is now difficult to accept, but whose power is flowing, like water, which over time, even the most difficult stones cannot hold it.

In relation to the reform of Indonesia's current health system, according to Sidorkin and Warford (Sidorkin & Warford, 2017) the most prominent concern is the current framework of science and technology mastery in the 21st century, which has revealed the thoughts of the decision makers worldwide policy. In the social security system, this is related to the assumption that there is a decline in participation in the labor market that is cognitively routine, awareness to increase knowledge about health insurance decreases, while the non-routine cognitive labor force market, awareness that drives in social security, increases even though they did not have social security membership from the beginning. Therefore, educational reform is needed related to the knowledge of social security protection for students in mastering social security information that is more in accordance with the times, not only in the new economic framework which is related to global awareness; financial, economic, business and entrepreneurial literacy; citizenship literacy; health literature; creativity and innovation; critical thinking and problem solving; communication and collaboration; information literacy; media literacy; Information and communication technology literacy; flexibility and adaptability; self-initiative and direction; social and cross-cultural skills; productivity and accountability; leadership and responsibility; and environmental literacy but also in social security protection.

In relation to social security with social capital, according toDadabaev, Ismailov, & Tsujinaka (Dadabaev, Ismailov, & Tsujinaka, 2017) the role of social capital in social security protection in the routine cognitive labor market as mentioned above, which although this concept is relatively new, originally appeared from the term 'social capital' in the literature associated with the study of Loury in 1977, (Loury, 1977). The term 'social capital' describes the collection of resources available in the family and in the community which ultimately strengthens children's mental development and influences their structured socializing abilities. Porath (Porath, 1980), calls this 'F-Connection', a complex system of relationships between family, friends and the company.

Social security in the context of insurance and risk, the American Institute of Certified Public Accountants (American Institute of Certified Public Accountants, 2018) states the interrelation of the insurance function to unify the risks of many people who face similar risks. Payments known as premiums, the insurance bearue entity seeks to free policyholders from all risks or part of the risk by dividing the total cost of the risk among the participants in large numbers. The long-term nature of coverage that involves the risk of death - the risk that increases with age - is a characteristic that distinguishes life insurance from other forms of insurance. Traditionally, life insurance is a legal entities provide life and health protection products to protect against loss of financial risk caused by death or loss due to illness. This insurance legal

entity also provides annuity products to protect the risk of one's financial resources for a longer period. The center of gravity here is on the insurance needs of participants.

In the development of social security as a protection against risk, in comparison, in China, according to Kai Liu (Liu, 2016) the development of Social Health Insurance has not really gained consensus from policy makers and scholars to be used as a main measurementof China's national health reform, which began in 2005. Basically there are two debates related to health reform: first, a point of view called the "government-oriented point of view" and "second, a market-oriented point of view." The essence of the policy-makers' point of view before the health reform was to subsidize health care facilities, arguing that the main problem of the Chinese health insurance system lies in saving subsidies for health care facilities. On the side of a market-oriented point of view, more pampering health services to excessive development. This prompted the government to take on the role of primary health care provider, replacing the dominant role of doctors in market-oriented health care facilities. On the other hand in the point of view that supports the provision of health services that are oriented to the government, there is a tendency to support the return of the government's strong role, which is basically, the traditional model of public health services. This strong role was also carried out in the Mao era. In contrast, the essence of the market-oriented point of view of current developments is to subsidize the demand for health services; that is, to support registration into a health social insurance scheme. Although this is also a major cause of health problems in China in terms of saving government subsidies. This is contrary to the model of health service guarantee in the Mao era, which was more oriented towards the global trend of cooperation between public and private in the field of public services. This point of view encourages the establishment of a national health social insurance system that is in favor of the public interest through a health social insurance legal entity that is not carried out by the individual himself. Health Insurance Institutions are believed to have great bargaining power, which allows negotiations with health service facilities to improve the efficiency, quality and utilization of health services. In a new round of health service reforms implemented in China in 2009, the government invested an additional 800 billion Yuan to carry out health reforms, of which about two-thirds were used to subsidize the demand side of the health social insurance legal entity. This shows how important social health insurance reform is in reforming the health insurance system in China.

Comparison with the implementation of social insurance coverage in Korea, stated by Wang (Wang, 2017) which states that Korea, every Korean citizen must be insured by health insurance run by the state, namely National Health Insurance (hereinafter referred to as NHI). In turn, citizens must pay insurance costs based on their income to the State Health Insurance. Then, what about people who are not economically active, who do not have stable income and therefore cannot pay insurance costs? Fortunately, the Korean NHI system also recognizes that population is eligible for insurance. They can enjoy medical benefits by relying on their family members who are insured under the NHI, that is, those who pay insurance costs. If there is one insured person in a family, other family members can get a free ride on their eligibility. In addition, family members who are not economically active, regardless of their sex or age, they can obtain health services through insurance participants from their family members who are economically active without tangible financial contributions. Even more surprising, at NHI Korea, the number of insurance participants covered by economically active family members reached 42% of the total population covered by insurance (as of 2015).

In Europe according to Lerouge (Lerouge, 2017) related Social security is categorized into psychosocial risk and company management related among employers' responsibilities related to the Framework of Work Questions addressed to Europe on Worker Safety and Health in the workplace. This provision requires employers to security safety and manage all types of risks by increasing freedom and to improve the security of safety systems and procedures as part of the safety of health insurance. Apart from work, a number of policies and guidelines relevant to social security including health have been developed and apply to all of Europe. Social security protection includes legal instruments (such as European Union regulations, decisions, ILO convention legislation), European Union Courts and decisions of European Human Rights Courts as well as non-binding, voluntary policies (or non-burdensome policies) that can be displayed as you wish, consent, opinions, proposals, conclusions from European Union institutions (consisting of Commissions, Councils, Parliaments), Regional Committees and European Economic and Social Committees, as well as social work partners and work coordination of actions, and specifications, guidelines, and others. initiated by approved European and international commissions, institutions and organizations. The entire judicial process for health insurance relate it to all participants.

In comparison with social insurance in European countries, Companje et.al (Companje, Hendriks, Veraghtert, & Widdershoven, 2009) suggest that health insurance and medical costs are funded from premiums in countries such as the Netherlands, Belgium, Germany, Hungary , and Poland is an important part of modern health social security in the European Community.In addition to health care systems that are financed from tax revenue, such as in the United Kingdom, Spain, Italy and Scandinavian countries. Insurance agencies in various countries insure millions of people, receive and pay billions of euros every year, and are big companies.Modern health insurance funds and health insurance companies are important links in the overall fulfillment of this large and complex health insurance. Many outsiders - as well as those who live and work in the insurance world - are unaware that these modern institutions have a fascinating history that has expanded over the centuries, and that, even today, traces of this history can be seen in health insurance organizations, national health fund structure and health insurance fund activities. The social insurance system which is implemented as a health insurance fund is rooted in Western Europe. In countries such as the Netherlands, Belgium and Germany, some of the large-scale health insurance funds - with hundreds of thousands or even millions of people insured - owe to the existence of insurance companies mainly related to local initiatives taken in the 19th century, when a group of people with a social conscience (eg community leaders, entrepreneurs, doctors) work together to provide safer safeguards and medical services for those in need. On the other hand, membership is carried out by workers in the company or workers themselves who join to build social security funds independently taken from their wages. It is this historical continuity and geographical proximity that makes it possible to compare the development of health insurance in Germany and Belgium with the Netherlands.

In relation to moral hazard, Finkelstein (Finkelstein, 2015) put forward moral hazard in health insurance as a health insurance protection that aims to increase demand for medical services. Why does moral hazard occur? Basically there are two ideas in the literature. The first, known as the danger of moral ex ante. The idea is that if you have health insurance and that health insurance will pay for your medical bills when you are sick, then you have an incentive to invest in maintaining health, because when you are sick, financial consequences will be borne by others; therefore, you will eat, drink and be happy. You may smoke more, drink more alcohol,

exercise less, and so on. The second idea, known as danger from ex post morals. This idea, assumes that health insurance can affect your investment in your health; at some level of health, you will choose to use more medical services because the price of that health service is lower. The moral hazard at the ex post is basically about the demand curve and the increased price sensitivity of demand for health services. The higher the demand for health services, the lower the price of health services.

In the United States, in relation to the development of social security programs, in the Medicare program, according to the Institute of Medicine report, (Institute of Medicine, 2006), wide variations in organizational structure and specific service QIO (Quality Improvement Organization) make generalizations, committee evaluations Medicare Beneficiary produces the following conclusions:

- The quality of health services received by Medicare beneficiaries has improved over time.
- The available evidence is inadequate to determine the extent to which the QIO program contributed directly to the improvement.
- The QIO program provides national infrastructure that is potentially dedicated to promoting quality health services.
- Program value can be increased through the use of strategies designed to focus QIO's attention on providing technical assistance in support of quality improvement, to broaden their governance base and structure, and to improve management of CMS (Content Management System) related data systems and program evaluations.

By comparing health social security programs in Asia, Europe and America, in essence philosophically health medical or medical philosophy, Thompson and Upshur (Thompson & Upshur, 2018) suggests, three concepts that are common in medical philosophy are "health", "illness" and "disability". On the surface, health will appear solely because there is no disease, and disease is a deviation from health. However, this is not the way to use the definition of a developing health term. Defining "health" in terms of "well-being" seems to only drive the problem of the definition of health to other terms that are also not defined in good condition. The Merriam-Webster Dictionary defines well-being as: happy, healthy or prosperous. That, of course, redefines "health," which is the term we are trying to define. If the emphasis is on "happy", this will differ from person to person and from time to time. Two individuals in the same situation might be different in whether they are happy in the situation. Judgments like these are based largely on individual values. Next is disease. Disease is an important concept in clinical medicine. The drug is used as an effort to prevent, diagnose, treat, and improve health. One of these activities promotes several aspects of health to some extent but the underlying focus is on disease. Apart from illness, there is disability. This of course, depends on the meaning of "disability itself", which shows consensus, those with physical disabilities. To the extent that such consensus is true, the word "disability" also means a lack of the body's ability to function normally: physically or mentally.

Excavate deeper into the philosophy of health, Thompson and Upshur (Thompson & Upshur, 2018, p. 25) argued in principle that certain scientific theories characterized by feature such as syntactic existence can be converted into semantic existence, and on the contrary.

Scientifically, the reason for choosing one existence over another is pragmatic choice. Semantic existence reflects the actualization of theories in biology and medicine pragmatically. Therefore, pragmatically, this is a preferred existence. Syntactic existence from the beginning, had older, had a greater influence in the half era in the last half of the twentieth century. At that time, this allowed a number of theoretical features to be explained, in the first stage, easier than observation. Early observations show that mature scientific theories are formalized mathematically.

Philosophically, in relation to solving the problem of health social security of BPJS Kesehatan, the existence of syntax considers theory as axiomatic deductive structure. In that case, it is structured in the same way as some mathematical domains. A standard example of scientific theory, to support this view, is Newtonian mechanics. Newton managed to formulate some very general order (law) from which all other regularities can be derived.

By definition, health insurance according to Lieberthal (Lieberthal, 2016) regardless of the role that health insurance plays in the economy, regardless of the role that the health care system, and the political system, health insurance is also a product that is often misunderstood. In essence, health insurance is a "pass-through" entity similar to a gas station. Just as most people rely on gas stations to store gas and then sell it to them on request, most people might deal with health insurance as a card in their wallet to use whenever they have a request (or need) for health services. Health insurance is also related to health services in the same way as a mortgage on someone's home - people get satisfaction from making a residence in their home just a mortgage. In the same way, people get satisfaction by being healthy, even if they don't pay their health insurance premiums. However, health insurance allows people to pay for health services that they cannot pay for themselves, just as mortgages allow people to live in homes they cannot afford to pay at once.

Furthermore, Lieberthal said that health insurance, like all shape of insurance in general, was finally approved based on its effectiveness in restoring anyone after obtaining health approval. However, health risk management and health services did not adequately explain its use and the effectiveness of the health insurance structure. When it health insurance is reliable it easily monetized. With health complaints, like losses on health problems, cannot be easily monetized, this is what is meant by health insurance companies that are higher than those who are able to improve the level of health of someone health needs as just like before.

A public health insurance provider has an assessment of the cost of claims in insuring the population by using an expected value calculation that is different from the value used by individuals to assess their health as contingency calculations below. The basic insurance pricing formula is shown in equation.

E [Loss] = E [Frequency] * E [Severity]

Health insurance providers are most interested in expected losses, also known as claim costs. Expected losses can be assessed at the level of coverage of the population, individuals, or even certain group interventions. For example, in the U.S. population, the average expenditure on health services is the same as the expected frequency when someone uses health services during

the year (utilization) multiplied by the cost of care for health service meetings on an average (price) basis.

In measuring service quality, National Acedemic science (Science, 2006) reported that the American Congress recommended that the NQCB should produce useful information for three purposes that addressed different audiences:

- Accountability - Information must be available to help stakeholders make choices about service providers. These stakeholders include patients who identify doctors, hospitals, or other providers to seek services; buyers and health plans choose providers to be included in their health insurance networks; and quality control organizations make accreditation and certification decisions.
- Quality improvement - The information provided must be of value to the stakeholders responsible for improving the quality of care, including doctors, and administrators and members of the board of health care organizations.
- Population health - Information must be useful for stakeholders who make decisions about access to services (e.g., benefits and protection of public insurance); those involved in community-based programs and efforts to address racial and ethnic disparities and promote healthy behavior

In Indonesia, citing several provisions of the national social security system that are regulated in the National Social Security System Act and the Social Security Organizing Body Act, social security implementation refers to the mechanism that is, health insurance is administered on nationally based with the principle of social insurance and the principle of equity and be held with the aim for ensuring that participants get the benefits of health care and health protection in meeting their basic health needs.

With the national health insurance system recognized in the provision, as underlying the Health Insurance System organized by the BPJS Kesehatan. At present, social security participants reach 222,278,708 members according to data in October 31, 2019. In addition, the provisions for the protection of health Social Security of BPJS Kesehatan are also carried out on the principle of welfare, namely; benefits; and social justice for all Indonesian people. In the implementation, carried out with the principles a. mutual cooperation; b. non-profit; c. openness; d. conscientiously; e. accountability; f. portability; g. membership is mandatory; h. trust funds; and i. the results of the management of the Social Security Fund are used for development programs and for the benefit of participants. This Social Security Provider is prepared with a public legal entity, which is not intended for profit. With the aforementioned provisions, the regulations on social protection in Indonesia are quite advanced, but related to a higher willingness to be equipped with protection differ with the ability to implement them.

As it is known that the JKN contributions are planned for all BPJS Kesehatan participant segments such as:

- Recipients of non-contributory modality (PBI), rose from Rp. 23,000 to Rp. 42,000 per person. The fee amount also applies to Participants registered by the Regional Government (PBI APBD). PBI contributions are paid in full by the APBN, while Participants registered by the Regional Government (PBI APBD) are paid in full by the APBD.

- Government contributory modality (non-PBI) for salaried workers, (PPU-P), consisting of ASN / TNI / POLRI, initially the contribution rate was 5% of basic salary and family allowances, of which 3% was borne by the Government and 2% was borne by ASN / TNI / POLRI concerned, changed to 5% of basic salary, family allowance, position allowance or general allowance, professional allowance, and performance allowance or additional income for Regional Civil Servants, with a limit of Rp 12 million, of which 4% is borne by the Government and 1% is borne by ASN / TNI / POLRI concerned.
- Business conributory modality (PPU-BU), initially 5% of the total wage with a wage upper limit of Rp8 million, of which 4% was borne by the Employer and 1% was borne by the Worker, changed to 5% of the total wage with an upper limit wages of Rp. 12 million, of which 4% is borne by the Employer and 1% is borne by the Worker
- Contibutory modality non-employees fees (PBPU) / Independent Participants: Class 3: up from Rp. 25,500 to Rp. 42,000 per person; Class 2: up from Rp51,000 to Rp110,000 per person; Class 1: up from IDR 80,000 to IDR 160,000 per person.

The design, a 100% increase only applies to PBPU / independent participants Class 1 and Class 2. For Class 3, fees only increase by 65% to Rp42,000. If the member feel unable to pay the increase in contributions, Class 1 and Class 2 participants can make a Class decline, from Class 1 to Class 2 or Class 3; or from Class 2 to Class 3. For Class 3 who feel inadequate with the amount of this contribution, and obviously unable, can be included in the Integrated Social Welfare Data (DTKS), so they are entitled to enter the PBI (non-contributory modality) which the contributions are paid by the Government.

Internationally, health social security is usually given to the 40% of the population who have the lowest income, not just those in the poor category. Indonesia adopted this convention, as outlined in the RPJMN (national midterm development plan). With this approach, PBI can in fact be given to up to 107 million people (assuming the current population of Indonesia is 269 million).

PROBLEM STATEMENT:

1. How to design of Social Security of the BPJS Kesehatanprogram that is currently being carried out to address issues that have not been fully able to meet overall health insurance and cover all health services. This was seen especially in the fulfillment of health services to participants.
2. How is the installation of Social Security of the BPJS Kesehatan program currently through systems, procedures, mechanisms in the midst of the inability of participants to meet health insurance contributions.
3. How is the process of implementing the Social Security of the BPJS Kesehatan program carried out in terms of formal aspects and approaches taken to ensure health to all participants.
4. What is the result of the implementation of Social Security of BPJS Kesehatan program to protect the health needs of all residents with coverage of health services for all complaints of illness.

RESEARCH METHODS:

This study uses the Discrepancy Evaluation Model research to see two important components, namely standards and program performance. To reveal how big the gap between the two is about the design and implementation of the Social Security of BPJS Kesehatan program.

DISCUSSION AND CRITICS:

The design to cope with the failure of the BPJS Kesehatan in organizing the National Health Insurance Program, in addition to raising fees, according to Adinolfi and Borgonovi (Adinolfi & Borgonovi, 2018), that to cope with the disadvantages of the implementation of the Health Social Security system that is organized by BPJS Kesehatan is surmount by social engineering and charismatic leadership. The House of Representatives Commission IX (DPR Commission IX, 2019) shows an agreement with the government to solve the problems of the JKN program by conducting social engineering, namely maintaining the amount of BPJS Kesehatan participants' contributions to PBPU participants and class 3 for contributory modality as independent non salaried (BP) through subsidies. The main objective of social health insurance is to ensure equality in equity with participants that the target to be achieved.

On catastrophic health social security, Caldwell (Caldwell, 2017) states that most studies related to the causes of catastrophic events show health social security protection is retrospectively measured from disaster events. In this context BPJS Kesehatan has conducts early detection through mobile and web applications, online referral systems, finger print verification, digital coding and claim audits. This is different from the treatment of catastrophic disease prevention as a treatment of the catastrophic events faced as stated above. Based on 2014-2018 events, the average cost of catastrophic services reached 28.08% at a cost of Rp. 15.7 trillion per year.

Escavate deeper into the philosophy of health, Thompson and Upshur (Thompson & Upshur, 2018, p. 25) on characteristics such as syntactic existence by maintaining an increase in BPJS Kesehatan contributions on the one hand and still ensuring that the contribution of Class 3for independent subsidized participants, which turned into semantic existence, scientifically, following pragmatic choices. Therefore, pragmatism is a preferred existence. Based on mathematical observation. Data of JKN Class 3 program participants who are non-salaried recipients and non-contributory modality participants, 19,914,743 participants will need a subsidy of Rp3,943,119,114,000. The equation below,

19,914,743 participants x (Rp42,000 - Rp25,000) premiums x 12 months =Rp3,943,119,114,000

Lieberthal (Lieberthal, 2016) suggest that health insurance, which was ultimately assessed based on its effectiveness in rehabilitate participants after suffering from health complaints. However, health risk management and health services faced by BPJS Kesehatan are not enough to simply explain the implementation and effectiveness of health social security. At present time the increase in the contribution of the National Health Insurance Program, complained that if it is not increased, the loss will be even greater because it can be easily monetized, with the increase in contribution, the effectiveness of the health social security payment will be relied upon properly at the first place. When health complaints, such as losses as a part of the risk of organizing social health insurance due to an increase in contributions are

rejected, it cannot be easily monetized, therefore an assessment of the implementation of health insurance by BPJS Kesehatan is due to their inability to return the level of loss in full operation or the state of administrationx in the previous condition. This means that there is an inability to administer health social security at this time by BPJS Kesehatan management.

According to the BPJS Kesehatan (Idris, 2019) the number of BPJS Kesehatan participants reached 222,278,708 of populations. Meanwhile, BPJS Kesehatan failed to pay until December 2019 that reaching amount Rp32.8 trillion. At the end of 2020 as a prediction, BPJS Kesehatan will fail to pay Rp39.5 trillion, the next year 2021 will fail Rp50.1 trillion, the following year 2022 will fail to pay Rp58.6 trillion. The year 2023 will fail to pay Rp67.3 trillion and the projected 2024 will fail to pay Rp.77 trillion as a prediction.

Government and Local Government Interventions, to take leadership initiative over the failure of the national healts social security system to overcome the problem of losses suffered by the BPJS Kesehatan according to, Laub (Laub, 2018) with the principles of The Tao Te Ching, as carried out by the Minister of Health by giving his first salary to be given to BPJS Kesehatan as a form of responsibility for the high loss problems faced by BPJS Kesehatan. This attitude is different from the leaders in the BPJS Kesehatan environment who have not applied these principles. The implementation of health social security reached 83.39% of the population or 222,278,708 populations. This membership includes 96,055,779 participants who received contributions from the Central Government, 37,887,281 participants who received contributions from the regional government, 17,544,349 participants who received the wages of state administrators, 34,868,000 participants who received wages from business entities, 30,923,267 people who did not receive wages and a number of 17,544,349 people who participated in the wages of state administrators. 5,000,032 non-worker participants. At present time, health social security provided by BPJS Kesehatan is in arrears of Rp21.2 trillion for hospital. This has an impact on hospital cash flow in health services.

Citing Lieberthal (Lieberthal, 2016) as a public council that organize healthsocial security has an insurance fund that insures the population by using the calculation of the expected value of premium that differs from the value that it is used by each person to be able to get health services as in the following of risk contingency. Formula for determining risks experienced by BPJS Kesehatan as follow,

E [Insolvent Payment] = E [Number of Participants] * E[Additional contribution requirements]

In 2019

Rp.32,800,000,000,000 = 222,278,708 populations * (additional contribution requirements) or The additional contributions need to increasto Rp147,562 or Rp12,297 per month

In 2020

Rp. 39,500,000,000,000 = 222,278,708 populations "(additional contribution requirements) orThe additional contributions need to increase to Rp177,705 or Rp14,109 per month

In 2021

Rp50,100,000,000,000 = 222,278,708 populations * (additional contribution requirements) orThe additional contribution need to increase to Rp.225,393 or Rp18,783 per month

In 2022

Rp.58,600,000,000,000 = 222,278,708 populations * (need for additional contributions) orThe additional contributions need to increase to Rp263,633 or Rp21,969 per month

In 2023

Rp.67,300,000,000,000 = 222,278,708 populations * (need for additional contributions) orThe additional contributions need to increase to Rp302,773 or Rp25,231

In 2024

Rp. 77,000,000,000,000 = 222,278,708 populations * (additional contribution requirements) orThe additional contribution need to increase to Rp346,412 or Rp28,868

In comparison with social insurance in European countries, as stated by Companje et.al (Companje, Hendriks, Veraghtert, & Widdershoven, 2009) stated that health insurance and medical costs funded from contributions, the local government responded by changing the payment of PBI membership allocation directly to the hospital, even though this action is against the law. All contributions to participants paid by the local government directly to the hospital according to the service that it needed to the PBI member.

In comparison with Korea and Taiwan, stated by Wang (Wang, 2017) every citizen must be insured by health insurance run by the state, as well as BPJS Kesehatan. In turn, every citizen must pay premiums based on their income and for those who cannot afford to pay, it by the state. Some local governments have taken a different stance to overcome the hospital cash flow problem, spesifically applying for bank credit to cover hospital cash flow for contributions that it paid to PBImembers. This aims to overcome the hospital cash flow loss, but although there are hospitals in this case that are forced to make referral of patients to other hospitals because there is no supply of drugs when it should not be necessary behavior in the health nasional social security system.

In contrast to one of the hospitals in Tulung Agung, East Java, taking various efforts in the efficiency and effectiveness of health services by implementing an innovation strategy in the field of information technology, building a stronger character of health services, which emphasizes health services for patient rehabilitation as the main effort. The impact of cash flow on BPJS Kesehatan arrears is not significant influence to service to the community. This is an accordance with NAS, National Academic Science (National Academic Science, 2006) for three purposes that address different public concerns, namely Accountability - Quality Improvement - Population Health

In bring about to moral hazard, Finkelstein (Finkelstein, 2015) states that moral hazard occurring in health services in hospitals is an ex post category of moral hazard carried out by participants. As a result of increased demand for health services, there has been a decline in the ability of hospital to financing them. As a result, there are costs that are greater than increased of the demand. In addressing the problem of cash flow due to arrears of payment of claims at BPJS Kesehatan, over taken by bank credit which is not part of the health social security implementation system that is frame work in mutual cooperation.

CONCLUSION:

Health social security BPJS Kesehatan will develop by focusing on mutual cooperation as a constitute of social capital among families, workers, employers, and state administrators. Health social security of BPJS Kesehatan leaders need to implement principles that prioritize the provision of benefits to the whole participants so that the mutual cooperation of the entire population in one side and strong leadership in the other side, that it will be able to secure the sustainability of the health social security system in the future.

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