# INTISARI

**Latar Belakang** : Di era globalisasi ini, untuk dapat bertahan, tumbuh dan berkembang, setiap rumah sakit harus mempunyai perencanaan keuangan yang sehat, termasuk penetapan tarif yang sesuai. Selain analisa biaya melalui perhitungan *unit cost* yang akurat, penetapan tarif hendaknya juga mempertimbangkan kemampuan dan kemauan masyarakat untuk membayar, tarif pesaing serta tujuan penetapan tarif itu sendiri.

**Tujuan Penelitian :** Mengetahui tujuan penetapan tarif, menghitung *unit cost*, identifikasi kemampuan dan kemauan membayar masyarakat, besarnya tarif pesaing, mengetahui gambaran rencana tarif, identifikasi *Non Value Added Activity* dan analisis sensitivitas *unit cost*.

**Metode :** Penelitian ini adalah penelitian deskriptif kuantitatif dengan rancangan *cross sectional*. Data primer diperoleh melalui wawancara dengan direktur BPRSI Bali, observasi *non partisipatif* terhadap aktivitas operasi katarak dan melalui kuesioner terhadap masyarakat pengguna pelayanan SMF Mata BPRSI. Data sekunder dikumpulkan dari rekam medik, bagian keuangan dan sumber lain yang relevan. Subyek penelitian ini adalah direktur BPRSI, aktivitas untuk menghasilkan produk/jasa pelayanan operasi katarak dan pasien/keluarga pasien katarak yang berkunjung ke SMF Mata BPRSI Bali. Peneliti juga menggunakan tarif pesaing sebagai pembanding. Sampel penelitian ditentukan berdasarkan teknik *simple random sampling* dengan sampel 100 orang. Metode analisis biaya yang digunakan adalah *Activity Based Costing* (*ABC*).

**Hasil Penelitian:** Tujuan penetapan tarif rumah sakit adalah pemulihan biaya, peningkatan mutu dan pemerataan akses pelayanan. Hasil perhitungan *unit cost* operasi katarak katagori sedang (Rp.1.489.582), tindakan besar (Rp 3.951.393). Kemampuan masyarakat membayar, sebagian besar di atas Rp.105.000. Dengan menanyakan langsung diketahui bahwa 60% responden mampu membayar lebih dari Rp.2.000.000. Kemauan masyarakat membayar, untuk yang memilih operasi sedang : 60% diatas Rp.2.000.000, untuk operasi besar : 37% diatas Rp.4.500.000. Besarnya tarif pesaing untuk operasi sedang adalah :Rp.2.450.000 (RS Wangaya), Rp.2.500.000 (RS Gianyar), Rp.2.700.000 (RS Tabanan), Rp.4.000.000(RS Sanglah), Rp.4.040.000(RS Puri Raharja) dan Rp.5.150.000(SuryaHusada), untuk operasi besar masing-masing : Rp.5.700.000 (RS Sanglah) dan Rp.6.865.000 (RS Surya Husada). Besarnya usulan tarif operasi sedang adalah Rp. 2.500.000 dan operasi besar adalah Rp.5.500.000. Tergolong aktivitas *non value added* adalah aktivitas penjahitan luka pada operasi besar. Analisis *unit cost* berdasarkan jumlah konsumsi waktu dan jumlah tindakan menunjukkan bahwa terjadi inefisiensi pada kedua jenis tindakan.

**Kesimpulan dan Saran:** Pemulihan biaya, peningkatan mutu dan pemerataan akses pelayanan dapat dilakukan dengan perubahan tarif sesuai *unit cost*, kemampuan dan kemauan membayar, tarif pesaing dan perhitungan jasa pelayanan yang sesuai. Semua *unit cost* lebih rendah dari tarif yang berlaku. Beberapa responden sebenarnya mampu membayar namun tidak semua mau membayar tinggi terutama untuk operasi besar. Tarif pesaing lebih tinggi dari tarif BPRSI. Tarif yang diusulkan adalah Rp. 2.500.000 (sedang) dan Rp. 5.500.000 (besar). Berdasarkan analisis sensitivitas didapatkan bahwa masih terjadi inefisiensi pada kedua jenis tindakan operasi tersebut. Perlu peningkatan jumlah tindakan operasi sehingga *unit cost* dapat ditekan. Perlu penerapan Sistem Informasi Manajemen Rumah Sakit agar tersedia data lengkap dan akurat. Perlu tindakan efisiensi dengan mengelola aktivitas *non value added*.

Kata kunci : Tarif, *unit cost*, kemampuan dan kemauan membayar

# ABSTRACT

**Background:** In this global era, to be able to survive, grow and develop, every hospital should have healthy financial planning, including appropriate tariff regulation. Apart from cost analysis through accurate unit cost calculation, tariff calculation should also consider ability and willingness to pay of the community, tariff of competitors and the objective of tariff regulation itself.

**Objective:** To identify the objective of tariff regulation, calculate unit cost, identify ability and willingness to pay of the community, identify the amount of competitors' tariff, get on overview of tariff planning, identify non value added activity and analyze sensitivity of unit cost.

**Method:** This was a descriptive quantitative study with cross sectional design. Primary data were obtained through interview with the director of BPRSI, non participative observation on activities of cataract surgery and questionnaires from user community of ophthalmic installation service of BPRSI. Secondary data were obtained from medical records, financial department and other relevant sources. Subject of the study were the director of BPRSI, activities of cataract surgery service and cataract patients/family members of cataract patients visiting ophthalmic installation service of BPRSI Bali. Competitors' tariff was used as comparison. Sampling was based on simple random sampling technique with as many as 100 samples. Cost analysis used Activity Based Costing (ABC) method.

**Result:** The objectives of hospital tariff regulation were cost recovery, quality improvement and equal distribution of service access. The result of unit cost calculation of cataract surgery belonged to medium category (Rp 1,489,582), major surgery (Rp 3,951,393). Ability to pay of the community was mostly above Rp 105,000. The result of interview with respondents showed that 60% of respondents were able to pay more than Rp 2,000,000. Willingness to pay of the community for medium surgery was Rp 2,000,000 (60%) and for major surgery was above Rp 4,500,000 (37%). The amount of competitors' tariff for medium surgery was Rp 2, 450,000 (Wangaya Hospital), Rp 2,500,000 (Gianyar Hospital), Rp 2,700,000 (Tabanan Hospital), Rp 4,000,000 (Sanglah Hospital), Rp 4,040,000 (Puri Raharjo Hospital) and Rp 5,150,000 (Surya Husada Hospital); for major surgery was Rp 5,700,000 (Sanglah Hospital) and Rp 6,865,000 (Surya Husada Hospital). The amount of tariff proposition for medium surgery was Rp 2,500,000 and for major surgery was Rp 5,500,000. Activity that belonged to non value added activity was wound stitching for major surgery. The result of unit cost analysis based on the amount of time spent and number of interventions showed that there was inefficiency in both of these.

**Conclusion and suggestion:** Cost recovery, service improvement and distribution of service access could be made through tariff changes according to unit cost, ability and willingness to pay, competitors' tariff and calculation of relevant service fees. All unit costs were lower than the present tariff. Some respondents were actually able to pay but not all were willing to pay high particularly for major surgery. Competitors' tariff was higher than tariff of BPRSI. The proposed tariff were Rp 2,500,000 (medium) and Rp 5,500,000 (major). According to sensitivity analysis there was inefficiency in both types of surgery. There should be increasing number of surgical operations in order that unit cost could be minimized. Hospital Management Information system should be established in order that comprehensive and accurate data were available. Efficiency should be enforced by managing non value added activities.

**Keywords:** hospital tariff, unit cost, ability to pay, willingness to pay