Account and Financial Management Journal e-ISSN: 2456-3374
Volume 3 Issue 03 March- 2018, (Page No.-1437-1442)
DOI:10.18535/afmj/v3i3.11, I.F. - 4.614

The Role of Doctor in Accounting and Cost Containment Strategy in Public and Private Hospitals in Banda Aceh

Khairul Maghfira[1], Heru Fahlevi[2], Hasan Basri[3]

[1]Post Graduate Student for Accounting Master Degree at Syiah Kuala University, Banda Aceh
[2,3]Post Graduate Lecturer for Accounting Master Degree at Syiah Kuala University, Banda Aceh

Abstract: The purpose of this paper is to discuss the role of doctors in accounting and to analyze the cost containment strategy used in public and private hospital in Banda Aceh. In order to get a comprehensive understanding of the research, a qualitative approach is used as the research method. The object of the research is three public hospitals and three private hospitals in Banda Aceh. The questionnaires were given to sixty doctors and six head of finance department in hospitals. The findings indicate that accounting still plays a marginal role and only as a financial reporting tool rather than cost containment tool. Therefore both hospitals merely use cross subsidy method. Also, doctors within both hospitals play fewer roles in cost containment and separate from the managerial task. Therefore it could be concluded that the accounting must be used as cost containment and the doctor must be involved more in cost containment by giving them financial report and real cost the hospital spent to treat one patient.

Keywords: accounting management, role of doctor, cost containment, hospital strategies.

INTRODUCTION

The increasing of the hospital expenditure over the recent years has put some pressure on hospital management to reform the healthcare system. In INA/CBGs era hospital is paid using the same tariff. It is based on the doctor's diagnostic on the patient or per patient case. The hospital can experience large losses if the cost expended to treat patients is greater than the rate established by the government.

The application of this payment system is expected to provide positive impact on hospital financial performance. Assessment of profitability requires the availability of more detail accounting data and role of doctors as they play central role in patient treatment. But the fact indicates different things. Hospital management does not provide cost information that can be used as a tool to contain the cost (Fahlevi, 2004).

The role of doctors is very important in allocating hospital resources because they are the ones who have rights to treat the patients (Pettersen, 1995). Recent research suggest that cost consideration may have been accepted by doctors, yet the ethical obligation of doctors to consider cost remains murky and the logistic burden of such a requirement could be substantial (Shah, p.S19, 2013). Therefore the initiative to involve doctors and other medical staff in management accounting practice has been a very important step in cost containment.

This paper aims to observe doctor's role in using accounting data as useful information to contain patient cost treatment and to analyze the cost containment strategies used by public and private hospitals in Banda Aceh. This article organized as follows: the next section present a literature review interrelated to the role of doctors and hospital cost containment strategy. Section three present the research methods, followed by the section four that present a discussion on the findings against the role of the doctors in accounting also the hospital strategy in containing the cost.

LITERATURE REVIEW

In previous era, the medical profession preferred to add a nurse or a doctor to carry out the role of an accountant. The whole administration activities were to served doctors in treating their patients, as a result the accounting does not have a role in hospital daily activities (Alam and Lawrence, p.47, 1994). Accounting system in public sector was merely as a planning tool and prepared for the external users (Pettersen, 1994, Webster and Hoque, 2005). Hospitals were not demanded to provide accounting information because cost containment was relied on the hand of the government as the owner (Webster and Hoque, 2005).

Case mix payment system is a payment for Medicare packet or Medicare episode. In Indonesia, case based payment has run since 2008 as a payment method for jamkesmas. Furthermore, to contain the Medicare cost that keep increasing and to maintain the Medicare quality, various payment method was created and one of them is Diagnosis Related Groups also known as DRGs.

Doctors have vital role in allocating hospital resources because they are the ones who have rights to determine a treatment for a patient (Pettersen, 1995). Therefore, accounting intervention in medical treatment has become important thing for successful cost containment in

hospital (Kister, 2015). Doctors are the actors who decide how long a patient needs to be treated in hospital, this fact shows that there is a big power given to doctors to set the length of stay for a patient based on their professional judgment and their ethic code, sometimes all of these ignoring administration consideration and even the economic logic.

In addition, the physician is an important decision maker in the level of service, their behavior is influenced by economic interests and also other factors like the factor of personal and professional values and the hope of society. More doctors rarely taught how to consider the financial consequences in their medical school. So as a result, only a handful of doctors who understand that the decision they make may affect health costs (Shah, 2013).

Then, according to Riggs and DeCamp (2014) providing price information on physicians against medical intervention, medical tests, and treatment they ask can increase awareness of doctors against the cost-effectiveness, and high-value care. Doctors in performing their task have been to consider the costs but did not have enough knowledge.

It can be concluded that if hospitals want to control costs and accounting functions can run well so that the resource-limited resources can be managed properly so the doctors and medical staff should be involved in the responsibility Finance. Further, controlling costs means the necessity to evaluate cost against earnings (Hermawan, 2010). Therefore then the cost control is absolutely necessary for the survival of the Organization, including the Organization's health. Furthermore, Hermawan (2010) stated that control of costs is a must to evaluate cost against revenue.

Shadily (2003) gives the meaning of the word containment as detention (p. 142). When connected with cost containment, can be interpreted as an act or process of holding costs on predetermined limits. Cost control in implementation in hospitals there are several strategies that can be applied as in the review by NCSL which stands for the National Conference of State Legislatures (2011), namely: (1) Administrative Simplification in the system. health. According to the literature the administrative simplification can only be resolved by applying the standards of payment on other health insurance or the BPJS, standardization of patient registration (Cutler, Wikler, Basch, 2012). (2) global Payments on health care providers. (3) the Episode of care payments, namely the availability of a single payment for all the care of patients who have a specific disease, condition as the system contrary to the system of fee for service. (4) data collection i.e. whole health insurance companies have a shared data center, (5). Accountable Care Organizations (ACOs), a local organization that is comprised of healthcare providers who cooperate, (6). The use of generic prescription drugs, (7). An agreement granting a prescription drug and volume purchases, (8). Public Health and cost savings, there's a lot of evidence obtained from the research that the public health programs (such as health education, training, prevention of infectious diseases, etc.) are able to promote health and may reduce the cost of healthcare.

Meanwhile, according to Booz & Company (2011) in health Conference in Beirut about the strategy for controlling health costs give the following points as an activity that can be done to control hospital costs (1). Improve the efficiency of medical staff, (2). Using the power of the parties outside the hospital to exercise functions which are not the primary function of the hospital such as the cleanliness of hospitals, the provision of food for the patients, (3) Improve the performance of the services, (4). Adopt IT. With the adoption of technology some work during the time worked on by some of the officers of the hospital can be done only by a computer with an integrated system with a network with other computers.

RESEARCH METHOD

This research used the qualitative method, with exploratory as the purpose of the study (Sekaran, 2014). The data gained from the interview of semi-structured, the dissemination of questionnaires and documents. Exploratory research that aims to do in order to get a better understanding of the nature of the problem which caused the least amount of existing research regarding these problems (Sekaran, 2013).

The questionnaires distributed to each head of Finance of each hospital that became the object of research. To find out and get a clearer perspective on the role of the doctor in accounting researchers spread also questionnaire on ten doctors from every hospital that became the object of research. And also do some triangulation in the form of a semi-structure interviews at each of the doctors of the hospital was made the object of research. As for the hospital at being the object of the research: Dr. Zainal Abidin RSU (provincial government), RSU Meuraxa (Pemko), RS Jiwa of Aceh (the provincial government), Teuku Fakinah HOSPITAL (private), RS Mutia (private) and RSIA Cempaka Az Zahra (private).

FINDINGS AND DISCUSSION

Cost Containment Strategy

The level of implementation of the strategy of cost control at the hospital who examined can be analyzed by means of doing the calculation by using the method scoring the results of the questionnaire field. The interview was conducted by using the method of semi-structure interviews or a semi-structured interview. Likert scaling method using scoring. The strategy of cost control has some method, the following methods are put into the questionnaire along with the results of the questionnaire are obtained from the informant.

NO.	Methods Of Cost Containment Strategies	Public Hospital	Private Hospital
I	Administrative Simplification Strategies	2.3	2.0
II	Prescription drugs agreements and volume purchasing	1.7	2.0
III	Improve staff efficiency	3.3	4.0
IV	Outsource for non-core hospital function	2.7	2.7
V	Adopting more modern accounting system strategy such as ABC and Case Mix	3.0	2.1
VI	Profitability analysis on each type of service unit and compare it with the calculation of the cost of the system INA/CBGs	2.5	1.7
VII	Calculating the cost per patient strategy	2.3	2.0
VIII	Evaluation of the feasibility of INA/CBGs service per patient	2.0	1.6

Table 4.2 the results of assessment of strategy cost containment method

The assessment above is obtained by counting the results of the questionnaire then divided by the number of questions. Implementation of the first method is still less well. This is apparent from a score of government hospitals and private 2.3 2.0 in field observations and the results of Government and private hospitals, patient registration process still brings photocopies of references from the clinics, and photocopies of ID CARDS. The multiple layers of Administration make administrative service performance becomes less efficient as well as incurring a large expenditure. According to the scientific literature uses of computer technology can help simplify administration. at the beginning of the use of technology will require high costs at the beginning but the costs that would be saved is much larger (Chung, Joo, 2005, p. 55). The purpose of the simplification of the Administration is not only to save money but also to avoid any actions which are not efficient with regard to the complexity of the bureaucratic administration.

The next method is the selection of the use of drugs. The use of the newest drugs led to a rise in spending on hospitals. Government hospitals are very bad in the implementation of this strategy, it can be seen from the value of the cost control method of only 1.7. This is caused due to a government hospital gets a subsidy from the Government, so that the management of the hospital not responsive to government spending that comes from this method. This led to the increase of the debt of government hospitals toward drug providers. In private hospitals, the implementation of this strategy a little better, with a value of 2.0. Need to do a better analysis in comparing the effectiveness of drug benefits between brands with one other (Billa, et.al., 2014).

The next method is the increased efficiency of the staff. Government hospitals are good enough in carrying out the strategy of cost control this with a value of 3.3. It is difficult for the Government to implement the hospital staff efficiency because a large part of a worker's status as the civil servant (PNS), making it difficult to take action against CIVIL SERVANTS who are not efficient in work. Moreover, a government hospital is a place for political power holder (natural & Lawrence, 1994). Private hospitals have a higher score IE 4.0 in the implementation of this strategy. The use of good labor services both medical and nonmedical in excess of the required amount of financial burden is lighter for the hospital.

The outsourced service in the hospital is to work on a job which is not the core function of hospitals like hygiene activities (cleaning service) can reduce hospital costs. According to Jad (2011) labor is the largest component in the improvement of hospital expenditures. As for the suggested areas to outsource is part of security, ICT (with regard to technology), a janitor, a part of waste management, facilities management, and revenue cycle, and the potential benefit gained is reducing costs, improve service, increase efficiency, and improve quality. Good government hospitals as well as private hospitals in less good value in the implementation of the strategy of cost control. Seen from the average number of only 2.7.

The adoption of a more modern accounting system such as ABC, balanced scorecard, and case-mix is one of the most important strategies in the method of cost control. In this method of government hospitals have implemented accounting system is quite good (3.0) compared with private hospitals still use simple accounting system on the grounds that a more modern accounting systems are not yet required to This can be seen from the executed value of 2.1 as in speak by informants, "accounting that we use only for financial reporting to the owner, to more complex methods such as ABC does not use" (K02).

Analysis of the profitability of each type of service unit and compare it with the calculation of the cost of the system INA/CBGs both government hospitals and private alike are still weak. Government hospitals have a value of 2.5. And for private hospitals an average rating of 1.7 methods which means that the application of this strategy is very bad. The hospital did not do an analysis of the cost drivers, and not counting the cost of using accounting techniques are more advanced hospital management, therefore, cannot do the profitability analysis. The results of this research show that the hospital still prioritizes instrument compared to nonfinancial performance financial performance.

The application of strategies for calculating the cost per patient is still less well at the hospital which became the object of research. This hospital where both have a value of 2.3 and 2.0. Hospital response in the control of the cost after the application of INA-CBGs is still not visible because the hospital did not have the capacity to anticipate the potential deficits that can be experienced.

In a public hospital, this last strategy application is lesser with a value of 2.0 while private hospitals have a value of 1.6 which means the application of this strategy is very bad. Hospital management has no special strategy in controlling the costs of hospitals because the owner of the hospital i.e. the Government will underwrite the deficit and provide subsidies every year through GRANT and APBK. This is in accordance with the information obtained from a resource person who stated, the Government of Aceh as the owner does not want to know whether the hospital's profit or loss and always give subsidies every year (K01).

The same condition also experienced by private hospitals that became the object of research. Although the condition of the hospital suffered losses, the owner of the hospital retains its existence by taking the losses hospitals and consider it as a social activity. It is in accordance with the statement of the head of finance private hospital, which provided a resource person: the owner of the hospital not too questioned the losses and bear the losses because they consider it as a charity.

The management of both Government and private hospitals have acknowledged that they have no special strategy to anticipate the application of the system of the INA-CBGs. As a result of the system applied in the year 2014, both government hospitals, as well as private hospitals, suffered losses since the implementation of the payment system INA-CBGs. We have no special strategy for controlling costs. There is usually a rate higher than the BPJS rate hospitals and there are unisex tariffs lower BPJS from hospital rates. Therefore we do cross-subsidies to cope with losses resulting from this system (K03).

The Role of Doctors in the Implementation of Cost Containment Strategy

Based on observation, the management of government hospitals and private focus more on health care rather than on financial administration. The Administration still following medical services, so that more focus on quality rather than financial efficiency. It can be seen from the results of the assessment are listed in table 4.3 below:

NO.	Elements Of The Role Of The Doctor	Public Hospital	Private Hospital
I	Availability of financial report information	2.5	1.7
II	The role of cost in medical decision making	3.5	3.1
III	Access to accounting information costs	2.2	1.8
IV	Liability of doctors against the cost of hospitals to care for patients	3.6	2.6
V	The involvement of physicians in calculating the unit cost	2.0	1.6
VI	Doctor familiarity of INA/CBG system	3.0	3.5

Table 4.3 results of assessment of the elements of the role of physicians in the implementation of the strategy of cost control

The first assessment element is the availability of the information financial statements. Government hospitals have a value of 2.5, while private hospitals only 1.7. which means the role of doctors at private hospitals against the availability of very bad financial statement information. This is in regard to work as informants by the head of finance private hospital, "doctor structurally separate from the management. That decision cost and budget management. While the doctor (General) just as employees who work "(K03). So, on the one hand, the doctor didn't want to be involved with the Affairs of the cost control and management on the other hand lack financial accounting information.

The second element is the role of cost in medical decision making, a good doctor in a government hospital or private hospital did not include considerations against the cost in their medical decisions. This can be seen from the value in the Government hospitals and private hospitals 3.5 3.1. This happens because the price on the set by the BPJS was lower than the actual costs incurred by hospitals in treating patients, according to the informant who worked as a specialist in a government hospital:

It's hard to do savings in medical action. For example, there is a remedy of the BPJS not suitable for certain patients which concerned better suited with drugs that are not covered by the BPJS. So we can't impose it must wear a drug from the BPJS (dr01).

But if giving the priority to the interests of patients by providing the best service regardless of cost then this problem will trigger inflation of health care (Ubel, 1999, p. 1675) which this is a serious problem in the present. This is because the limited resources for health services makes it difficult for doctors to offer all existing technologies and all the convenience of medical services in all patients.

Access to information in accounting hospital cost results obtained unfavorable i.e. 2.2, so it can be seen from the results of this assessment that access to information fees accounting doctor. While at private hospitals the results obtained only 1.8 meaning not all doctors get access to accounting information. As a result, they have less chance to evaluate the cost of treatment per patient and comparing it

with the rates in force. Thus the doctors do not have enough information to control costs.

The fourth method is the value of 3.6 methods for government hospitals, which means the role of the doctor in the liability against the cost of hospitals to care for patients is good enough, but at the private hospital RS 2.6 only meaning that the role doctors in this method. When doctors do not care about the costs incurred by the hospital then the long-term financial health of hospitals in jeopardy. Weinstein (2001) reveals that the doctor should be responsible for setting priorities or carry out treatment and can involve side cost effectiveness with the help of accounting information in the implementation of these priorities. When doctors noticed it and carry it out then the doctor can be more responsible for the costs incurred by the hospital.

The next method on the results of the questionnaire shows hospitals don't involve physicians in calculating the unit cost. It can be seen from the low value on Government 2.0 on hospital private hospital 1.6 which means doctors are less or not involved at all in calculating the unit cost. In the research literature Taher, et.al. (2000) if the doctor should be held responsible for the total cost of care then they should have more role in strategic decision making.

The last method is the doctor's familiarity with the system INA-CBGs at government hospitals obtained average value score of 3.0 or less good. While in private hospital obtained a better RS 3.5 which means doctors better understand the private hospital system INA-CBGs and its impact on the finances of the hospital. A large part of doctors who practice in the private hospitals are experienced specialists and also serves or has served as head of SMF at government hospitals. Therefore they have to first get training on the coding of health insurance is concerned.

The condition confirmed research done by Doolin (1999) at a hospital in New Zealand. He found that a doctor at the Central Hospital of Health has a bad against the validity of case-mix and information showing interest for very little against the use of such information in the performance of their medical practices.

CONCLUSION AND SUGGESTION

The hospital examined did not adopt new accounting techniques as a means of cost control. The role of accounting in hospitals on the conscientious only used as a reporting tool. Then another cause is the financial protection (financial protection) from the owner of the hospital both Governments and individuals. For accounting is still a marginal role at the hospital then there has not been a good cost control.

Access information on physician fees and accounting as well as the involvement of physicians in cost control is still not optimally at a hospital in Banda Aceh. Not all of the doctors working at the hospital in Banda Aceh getting access to information fees. The main cause is the role of the accounting reporting tool rather than as a tool for decision making. To be able to implement cost control it would be nice if accounting does not only serve as a tool of financial reporting but also as a tool for controlling costs, besides the doctor and management can work together better to let cost control can be realized at the hospital in Banda Aceh.

BIBLIOGRAPHY

1. Alam, M. & Lawrence, S. (1994) A new era in costing and budgeting: Applications of health sector reform in New Zealand, *International Journal of Public Sector Management*, vol. 7, no. 6, pp. 41- 51.
2. Booz & Company. (2011, March). *Health Cost Containment Strategies*. Paper Presented at The Meeting of Containing Health Care Cost, Beirut
3. Broadbent, J. (1992). Change in Organisations: A Case Study of the Use of Accounting Information in the NHS. *British Accounting Review*, 24, 343-367.
4. Busse, R., et al. (2011). *Diagnosis Related Groups in Europe – Moving Towards Transparency, Efficiency and Quality in Hospitals*. New York: Open University Press, McGraw-Hill.
5. Coombs, R.M. (1987). Accounting For The Control of Doctors: Management Information Systems in Hospitals. *Journal of Accounting Organizations and Society*, Vol.12, No.4, pp. 389-404.
6. Creswell, J.W. (2014). Research Design (4th Ed.). Qualitative, Quantitative and Mixed Methods Approaches. California: SAGE Publications, Inc.
7. Doolin, B. (1999). Casemix Management in A New Zealand Hospital: Rationalisation and Resistance. *Journal of Financial Accountability & Management*, 15 (3) & (4).
8. Fahlevi, H. (2014). *The Innovation of the Role of Accounting In Public Hospitals – Lessons Learned from Hospital Financing Reforms In Indonesia and German*. Disertasi Doktor. German: German University of Administrative Sciences Speyer.
9. Fahlevi, H. (2016). Understanding Why the Role of Accounting is Unchanged in Indonesian Public Hospitals. *Journal of Accounting & Organizational Change*, Vol. 12 Iss: 2, pp.- 203-222.
10. Furrow R. B. (2012) The Ethics of Cost-Containment: Bureaucratic Medicine and the Doctor as Patient-Advocate. *Notre Dame Journal of Law, Ethics & Public Policy*, Vol.3.
11. Hansen, Don R & Mowen. (2000). *Manajemen Biaya: Akuntansi & Pengendalian Jilid 1 dan 2.* Jakarta: Penerbit Salemba Empat.
12. Healy, J, & McKee, M. (2001). Implementing Hospital Reform in Central and Eastern Europe. *Journal of Health Policy*, 61, 1-19.

13. Hermawan, B. (2010). Strategi Pengendalian Biaya Sebagai Alat Perencanaan Laba. *Jurnal Media Wisata*, Vol.4 No.1.
14. Hill, N. T. (2000). Adoption of costing systems in US hospitals: An event history analysis 1980-1990. *Journal of Accounting and Public Policy*, vol. 19, pp. 41-71.
15. Hoque, Z & Webster C. (2005). Cost Information in the New Public Sector. *Australian Accounting Review Vol.15, No.3*.3
16. Horngren, C.T., Datar, S.M., & Foster, G. (2008). *Akuntansi Biaya: Penekanan Manajerial* Jilid 1 dan 2. (P.A. Lestari, SE, Penerjemah). Jakarta: Penerbit Erlangga.
17. Jacobs, K., Marcon, G. And Witt, D. (2004). Cost and performance information for doctors: an international comparison. *Management Accounting Research*, vol. 15, pp. 337–354.
18. Jifri. (2017). *Inovasi Akuntansi Pada Rumah Sakit Setelah Penerapan Indonesia Case Based Groups (INA-CBGs) (Studi Pada Rumah Sakit di Kota Banda Aceh)*. Tesis Pascasarjana. Banda Aceh: Universitas Syiah Kuala Program Pascasarjana.
19. Lapsley, I & Arnaboldi, M. (2004). Modern Costing Innovations and Legitimation: A Health Care Study. *Abacus*, Vol.40, No.1, 2004.
20. Mathauer, I. & Wittenbecher, F. (2012). *DRG-based payment systems in low- and middleincome countries: Implementation experiences and challenges*, Discussion Paper, no.1 World Health Organization.
21. Pettersen, I.J. (1995). Budgetary Control of Hospitals – Ritual Rhetorics and Rationalized Myths?. *Financial Accountability & Management*, 11, 0267-4424.
22. Pettersen, I.J. (2004). From Bookkeeping to Strategic Tools? A Discussion of the Reforms in Nordic Hospital Sector. *Journal of Management Accounting Research*, 15, 319-335.
23. Riggs, Kevin R & DeCamp, M. (2014). Providing Price Displays for Physicians: Which Price is Right?. *JAMA 2014 October 22; 316 (16): 1631-1632.doi:10.1001/jama.2014.7105*.
24. Sekaran, U. (2003). *Research Methods for Business. A Skill Building Approach* (4th Ed.). Southern Illinois University: John Wiley & Sons, Inc.
25. Shadily, H & Echols, John M. (2003). An English – Indonesian Dictionary (27th Ed.). Cornell University Press. PT. Gramedia Pustaka Utama, Jakarta.
26. Shah, N.T. (2013). A Role for Physicians an Observation on Cost Containment. *American Journal of Preventive Medicine*. 44: S19-S21.
27. Weinstein, C Milton. (2001). Should Physicians Be Gatekeepers of Medical Resources? *Journal of Medical Ethics.* 27:268-274.

Appendix 1. Informant list

No.	Informant	Code
1	Doctor RSUDZA	(dr01)
2	Doctor RSUM	(dr02)
3	Head Of Finance RSJ	(K01)
4	Head Of Finance RSMH	(K02)
5	Head Of Finance RSZ	(K03)