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The Role Of The Local Government In Realizing The Universal Health Coverage For The Community

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Abstract – In order to improve the development of the welfare of the Indonesian citizens, the government is gradually determined to improve the lives and social security in accordance with the mandate of the 1945 Indonesian Constitution Article 28 H Paragraph (1) which states: "Every person has the right to live in prosperity, physically and mentally, to live, and to have a good and healthy living environment and the right to obtain health services Article 34 paragraph (3) states: "The state is responsible for the provision of good health facilities and public service facilities", but in fact, Indonesia still faced the problem of low public access to quality of health services. Implementation of the health service is unable to answer the complexity of the organization and financing of health care, which is really dependent on expensive health technologies. WHO has agreed to achieve Universal Health Coverage.

Keywords – Government, Role, Universal Health Coverage.

I. INTRODUCTION

Since the enactment of Law Number 40 of 2004 on National Social Security System (SJSN), Indonesian government then organized National Health Insurance Program or called JKN. The JKN program isthe government program that aims to ensure comprehensive health insurance for all Indonesian citizen to be able to live healthy, prosperous and productive.

In Accordance with the mandate of Law Number 40 of 2004, SJSN then organized with socil helath insurance system wchich iscompulsory, where each participant is required to pay dues to provide protection against socio-economic risks that befallparticipants and/or their family. In managing the system, the organizer of this health insurance system in accordance with the mandate of Law number 40 of 2004 andLaw Number 24 of 2011 is the Social Security Administering Body or called BPJS.

The last data of JKN participants (JKN- KIS) after 4 years of implementation per 31 December 0f 2017 reach 187.982.949 participants or 72,9% of Indonesian citizen, it means that there still 27.1% of Indonesians who are not joined JKN-KIS. It is targeted that in 2019 JKN-KIS membership can reach 95% of Indonesia's population, it is certainly in line with government policies in the 2019 NationalMedium-Term Development Plan (RPJMN).In Law Number 36 of 2009 on Health, stated that health services are listed in Article 52 paragrapgh (1) stated that: "Health services consist of: a. individual health services, b. public health services"and in paragraph (2) : "healths services asreferred in paragraph (1) include promotive, preventive, curative, and rehabilitativeapproach". Article 53 paragraph (1) thenstated: "individual health services are aimedat curing diseases and restoring of individual and family health", and in paragraph (2): "public health services are aimed to maintain and improving health and prevent diseases of a group or society".

1945 Indonesian Constitution (UUD 1945) affirm that citizen has the right to access health careand the state is responsiblefor providing health care for all citizens. In Article 19 paragraph (1) of Law Number 40 of 2004 on National Social Seurity System, stated “health insurance is provided nationally from the government based on the principle of social insurance andequity”. Through social health insurance,which is mandatory for participation, it can collect sources of funds from the public as health financing capital. As well as to reducethe out of pocket payment system and improve the pre-paid system, to realize the Universal Health Coverage.

Souce of funds from central or local government (province and district/city)collects from taxes (general and sales), financial deficits (foreign loans) and social insurance. While, funds from private sectors comes from company, private health insurance, social contributions and household expenses.

In terms of management, at the end of 2011 has been signed Law Number 24 of 2011 on Social Security Administration (UUBPJS) to carry out the constitutional mandate of Law Number 40 of 2004 on the National Social Security System (SJSN). The implementation of National Health Insurance runs by as mandated in Article 1 paragrapgh (1) of UU BPJS which states that BPJS is a legl entityestablish to administer social security programs. According to Article 2 of UU BPJS, the dutyof BPJS is to administering the National Social Security System based on humanity, benefits, and social justice principle. It isclear that all forms of National Social Security System administration are carried out in terms of national by BPJS. In this caseit is clear that all forms of the implementation of the National Social Security System are held nationally by BPJS, including health insurance in it. This is reinforced by Article 6 of the BPJS Law which states that BPJS health organizes health insurance programs.

In some *focus group discussion* ofstakeholders carried out by the Ministry of Health, various substantive materials neededcan not only be stated in regulations but must integrate various patterns of health insurance that have been running in the region. The focus of the preparation of the national social security system (SJSN) currently is for the implementation of the Social Security Administering Body (BPJS) in 2014. BPJS will focus on the authority to finance health as mandated by law. Therefore, to prevent overlapping between the central, regional and BPJS, health insurance financing must be integrated first, so that there is no gap in the authority and responsibility of the government.

Dimensional accuracy and dimensional policy formulation of policy recommendations are used to assess alternative management scheme Jamkesda today, especially in terms of management, benefits and tuition assistance package alongwith the problems and tantangannya.Selainit also used to assess *alternative best practices* management scheme Jamkesdathathave been run and according to the pattern of the strategic plan for the management of Jamkesda based on the local government perspective (district/city and province) as well as based on the central perspective.

The number of theories that underlie the determination of the right policy will result in a large selection of alternative strategies, this requires the accuracy of policy makers in choosing the best strategy. According to Abidin (Abidin, 2004), there are several criteria commonly used in measuring the accuracy of a public policy formulation, including: political feasibility, economic feasibility, financial/cost feasibility, administrative feasibility, technological feasibility, socio-cultural feasibility, and other feasibility. according tospecially created criteria.

Health problems cannot be solved properly without adequate financial support. Health financing is a factor that significantlyaffects the quality of a country. Indonesia is categorized as a country with low health financing with an average of around 2.2% ofgross domestic product (GDP) and 87$ per capita, a value that is far from the WHO recommendation, at least 5% of GDP peryear.

Policy evaluation should be carried out more focused on the purpose of the policy, namely serving the people and society. Surveys on services and financing of government-owned hospitals also need to be carried out by hospitals as service providers and other policy-making parties such as the health department. That way, the problem can be used as an agenda for determining further policies for the main purpose of improving health services to the people.

II. Research Objectives

Based on the background, the formulation ofthe problem is as follows:

1. What is the role of local governments inrealizing universal health coverage.

2. How to implement regional healthinsurance to national health insurance.

III. Research Method

This research is a mixed research, and also uses normative legal research. The data used is secondary data consisting of primary legal materials in the form oflegislation and secondary law, namely booksand journals. Data collection is done throughliterature and studies conducted by theliterature study. Data analysis was carriedout using conceptual approach and the statutory approach. The theory used in this study is the stakeholder theory of modern corporation.

IV. Discussion

Policy should be carried out more focused on the purpose of the policy, namelyserving the people and society. Surveys on services and financing of government-owned hospitals also need to be carried out both by hospitals as service providers and by other policy-making parties such as the health department. that way, the problem can be used as an agenda for determining further policies for the main purpose of improving health services to the people.

The Universal Health Coverage(UHC) program is a universal health insurance program which is a health system that ensures every citizen in the population has equitable access to quality promotive,preventive, curative and rehabilitative health services at affordable costs. At the end of 2017 alone, there were 3 provinces (Aceh, DKI Jakarta, Gorontalo) which had reached 95% participation, 67 regencies and 24 citieshad *Universal Health Coverage* (UHC), the plan is to have 3 provinces (Jambi, WestJava and Central Java).), 59 Regencies and 15 Cities that are committed to achievingUniversal Health Coverage (UHC) in 2018.

This is in line with the opinion of Murti (Murti, 2010) which describes that theimplementation of a universal health caresystem varies in various countries,depending on the extent of government involvement in providing health services and health insurance. This is in accordance with the reality that is happening in Indonesia, namely the effect of decentralization is very visible in health financing, as evidenced by the variety of Jamkesda management models that exist in Indonesia.

Looking at the pattern of financing management implemented in six provinces, which uses a cost-sharing financing pattern that has been determined between the provincial government and district/citygovernments, namely the Province of West Sumatra and the Riau Islands.implementation in regencies/cities in the region (top-down approach) targeting peoplewho do not have health insurance and the poor. In addition to looking at the management pattern that occurs in the regions, it is also necessary to review the management pattern carried out by theUnited States through Obama Care (the Affordable). Act).

In the context of the management pattern of the Obama Care financing organization, there are two things that must be noted, namely: 1) Transferring the authority to manage financing to the center based on regional wishes, this is similar to the effort to integrate Jamkesda into JKN in Indonesia, and 2) management refers to the stock exchange system. insurance is not managed directly by the center, this is different from Indonesia which manages it directly through BPJS.

This shows that Obama Care's policyis to centralize financing, but it does noteliminate equal opportunity and even opens new preferences for the community. This principle should be a reference for Indonesia, because the Jamkesda integration process must continue to run and be centralized. This shows the substance of Obama Care's policy. is the centralization of financing, but it does not eliminate equalopportunity and even opens new preferencesfor the community. This principle should be a reference for Indonesia, because the integration process of Jamkesda must continue to run and be centralized. However,the government must be able to open uppreference options for regions to adjust theirregional conditions to the standardconditions expected by the central government.

Regional health insurance (Jamkesda) is a complementary health insurance, especially to public health insurance (Jamkesmas). This means that Jamkesda is only a complement to Jamkesmas.

Jamkesda generally has similaritieswith the benefit packages offered by Jamkesmas, with adjustments to each area complete for the regions, then the pattern of benefit packages offered by Jamkesda often refers to and even directly implements the pattern of benefit packages offered by Jamkesmas. This then becomes an imbalance because the benefit packages offered between Jamkesmas and Jamkesda do not have any differences. The difference in health insurance is ultimately only different in terms of financing and contributions issued.

Another difference that occurs between regions in the provision of benefit packages is the existence of promotive and preventive services in the Jamkesda benefit package. In some areas promotive andpreventive services receive less attention. the community so that curative actions can be reduced and have an impact on more efficient health financing analysis district health account that has been carried out in many districts/cities shows that thefinancing for public health programs is very insufficient (Gani, 2010)

Universal Helath Coverage inIndonesia was actually carried out much earlier than the United States, namely through the SJSN Law. However, the UnitedStates' readiness to implement *Universal Health Coverage* in its health system is basically better prepared and morecomprehensive. Readiness is not only in terms of the health facilities system and its financing system but also their readiness to provide a preventive promotive system that involves the participation of the community as a whole. Likewise, the involvement of jobproviders into the financing system. Likewise for budget readiness.

Even though the Obama Care systeminvolves a very large amount of state funding, the effectiveness of its use is also highly considered, especially in terms of financing accuracy and preparation of a competitive insurance industry, so that in the end the benefits obtained by the community will be even greater. This illustrates that*universal health coverage*can be realizedif on the other hand the pattern of *good governance* is implemented as a whole.

By applying the principles of *good governance* in the management of health services, a large state budget burden will receive high compensation benefits in the form of creating a truly healthy and highly productive society, so that it has a positive impact on the development of a country. In addition to good governance, Obama Care isvery concerned about the issue of health decentralization, in this case Indonesia is also facing a similar situation in the context of Jamkesda which is currently running in various regions with their respective systems. In this case, decentralization considerations, including in determining the pattern of organization, benefit packages andparticipant coverage, should be applied in the implementation of *universal health coverage* in Indonesia in the future so that the benefits obtained by the community will be maximized and sustainable.

In the context of the pattern of organizational management management, there are 2 things that must be noted: 1) The United States transfers the authority tomanage financing to the center based on regional wishes, this is similar to the effortto integrate Jamkesda into JKN in Indonesia

2) management refers to the insuranceexchange system, not managed directly by the center, this is different because Indonesia manages it directly through theBPJS institution. In the context of thebenefit package, the United States federalgovernment provides flexibility for each state or health insurance provider in determining the benefit package, but the benefit package must include 10 essential benefits that must be present in all financing schemes without limitations on time and amount. In the context of the pattern of contribution recipients, the determination of the recipients of contribution assistance in Obama Care is based on benchmarks approaching the federal poverty line, but also takes into account regional characteristics so that the number can exceed national standards depending on individual conditions and needs. Jamkesda integration into JKN.

Comparison of the Philippines' health insurance system with Indonesia's UHC formulation in the Philippines began in 1994, approximately ten years earlier than in Indonesia, with initial reforms in 2005-2006 to prepare for reforms in 2014. Faster implementation boosts the health system. The Philippines is considered more advanced when compared to 9 billion pesos or equivalent to 2.4 trillion rupiah for Indonesia. From a financial perspective, the Philippines has budgeted for this insurance. The existence of a decentralized health system in the Philippines is quite similar to the Jamkesda system in Indonesia, although basically it is more integrated and formulated.

V. Conclusion

In order to achieve 95% participants of national health insurance (JKN-KIS), there are various efforts and strategies are carried out by BPJS, one of which is to invite local governments to expand the coverage of national health insurance participation (JKN-KIS) in the region.

In order to realize *Universal Health Coverage* in 2019, the role and support of the local government (local government) is very strategic and decisive in optimizing the JKN-KIS program, there are 3 important roles for the Regional Government in encouraging *Universal Health Coverage* (UHC). Namely, by expanding the scope of participation, improving service quality, and increasing compliance. One of the local government's efforts to expand the coverage of participation is to integrate the

Regional Health Insurance (Jamkesda) program into the JKN-KIS program. Jamkesda integration is a synergy in the implementation of health insurance for residents registered by the local government with the JKN-KIS scheme which is managed by BPJS Health.

The JKN-KIS program in an effort to achieve UHC is certainly very strategic, "Currently the role of the Regional Government is very good, especially in terms of commitment in registering itscitizens to become JKN-KIS participants through the integration of the Jamkesda program. BPJS would like to thank the Regional Government for encouraging UHC in the regions. and it is hoped that all regional governments can do the same, support and realize the national strategic plan as well as the mandate of Law Number 40 of 2004."

There are three target patterns in the implementation of Jamkesda in Indonesia,namely the use of a certificate of incapacity (SKTM) as a way to access Jamkesda services; targeting the poor and disadvantaged who are not covered byJamkesmas; and comprehensive targeting (*broad targeting*) or *universal healthcoverage* by targeting all communities in an area regardless of economic and socialbackground. The results of the analysis emphasize several things. First, that poverty is not a static thing and is not vulnerable to change. Accuracy, validity, and updating of data then becomes very crucial. Second, is the portability factor, which is an obstacleon Jamkesda implementation. This has the potential to cause data overlap if the Government is not able to integrate data between regions properly.

The role of the central government isto be able to collect data under one institutional umbrella, so that the principle of portability in JKN can run optimally. Increasing the allocation of Jamkesda funds from year to year in regions that fully guarantee social security services with a benefit package through the APBD. The use of*floating*without strict control over claims, as happened in NTT, resulted in leaks ofclaims for Jamkesda bailouts which in turn led to debts that had to be borne, thus disrupting the APBD and even development in other sectors.

In the context of the pattern of organizational management, there are 2things that must be noted: 1) the United States transfers the authority to manage financing to the center based on regional wishes, this is similar to the effort to integrate Jamkesda into JKN in Indonesia 2)management refers to the insurance exchange system, not directly managed by the center, this is different because Indonesia manages it directly through the BPJS institution. The recipients of national contribution assistance are not necessarily inaccordance with the needs at the regionallevel. This happens in Obama Care, which isin fact in many states, citizens who needassistance actually exceed the established criteria, this occurs mainly due to theemergence of non-financial criteria. This problem was then addressed by the US Government by providing a way out in the form of flexibility for states to apply for an official expansion of coverage beyond federal standards with a strictly defined mechanism.

The Philippines is considered more advanced when compared to 9 billion pesos or equivalent to 2.4 trillion rupiah for Indonesia. From a financial perspective, the Philippines has budgeted for this insurance. The decentralization of the health system in the Philippines is quite similar to the Jamkesda system in Indonesia, although basically more integrated and formulated.

Policy implementation is carried out with a top-down approach, namely policyformulation is carried out at the central government level, while the regions are obliged to implement it. Policies are generally set at a macro scale which results in socio-economic changes. Policy evaluation policy makers say that evaluations have been carried out regularly. However, the results of the evaluation ofservices by patients show that there are still many shortcomings that must be corrected, such as doctors not providing explanations, delayed drug administration time, cleanliness, and patient perceptions of differences in doctor communication based on inpatient classes.

To realize the integration of Jamkesda into the National Health Insurance in a comprehensive manner that is centralized but still provides space for the regions, from the results of this study, an integration policy formulation in the form ofa Dynamically Centralized Policy Formulation is formulated, which is a policyformulation in the National Health Insurance System which is centralized but dynamically still provides opportunities within the framework of decentralization to the government area.

VI. Suggestion

The central government must be able to bridge the differences in the understanding of regional policy makers, especially regional heads in the effort to integrate Jamkesda into JKN. this means that the government must also be able to

reduce the opportunities for political dynamics in the regions that arise due todifferences in interests and political commitments. To formulate an appropriate management policy, it can be overcome through the establishment of a *result-based financing*. This pattern helps bridge the gap between existing systems andsimultaneously improves the supply and demand side performance of the health insurance system.

Policy actors at the central level mustbe able to equalize the perception and understanding of policy actors below themin understanding the policy steps that will betaken. In integrating regional policies intocentral policies, the concept of integration policy formulation must provide greaterflexibility for regions in the centralization ofJamkesda integration policies. This is a form of effort to meet the criteria for regional interests so that policy formulation will be more dynamic and participatory.

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