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OPTIMIZATION OF PRIMARY HEALTH CARE TO IMPROVE HEALTH SERVICES FOR PARTICIPANTS OF SOCIAL INSURANCE ADMINISTERING AGENCY OF HEALTH IN INDONESIA

M. Hadi Shubhan[1], Rr Herini Siti Aisyah[2], L. Budi Kagramanto[3], Urip Santoso[4], Siswanto[5]

Universitas Airlangga, Surabaya Indonesia
Corespondent: herini@fh.unair.ac.id

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ABSTRACT. The Healthy Indonesia Program is one of the fifth agenda of Nawa Cita. It is Improving the Quality of Life of Indonesian People with the aim of increasing the degree of health and nutritional status of the community through some health efforts and community empowerment supported by the financial protection and equitable distribution of health services. This Program is implemented by upholding three main pillars, namely: the adoption of a healthy paradigm, strengthening health services, and implementing national health insurance (NHI). The implementation of NHI has shifted the paradigm of health care towards the quality of care. The communities can access the primary and secondary health services and begin to take into account the quality of the services they receive. The legal entity formed to organize National Health Insurance (NHI) program is the Social Insurance Administering Agency of Health (BPJS Kesehatan/SIAAH). For the first time, each participant is registered by SIAAH at a First Level of Health Facility (FLHF) determined by SIAAH after getting a recommendation from the local district/city health office. Primary Health Care (PHC) is one of the FLHF which prioritizes the fulfillment of community satisfaction through such qualified health services. Based on the standards of health service, one PHC serves thirty thousand (30,000) residents. Meanwhile, there are still some health facilities that are supported by only limited number of doctors and nurses, and even some do not have any pharmacists. There are many things to do to meet the standards. In fact, the existence of health services of non-local government hospitals is very vital, especially, since the launch of SIAAH program and considering the status of the PHC as FLHF of SIAAH services. Therefore, a study was conducted on the efforts to optimize the role of PHC as the health center to improve the health services, especially for SIAAH participants. The Socio Legal Research method was implemented in this study, the supporting legal materials were collected and the field research was conducted. The results of the research indicated that the renewal and improvement of PHC management through the formation of a Regional Public Service Agency (RPSA) made the PHC more developed since the fund or the financial support spent was according to the needs, and it was not dependent on the health department. All of these led to the operation of RPSA Primary Health Care was more flexible in managing the finance. Some of the benefits are as follows: safety and security at work, readiness of of givimg service at any time, anticipation of such conditions, and of unexpected costs, subsidies, income, accreditation, commercial, ease of reporting and flexibility.

KEYWORDS: Health, Primary, Social, Insurance

I. INTRODUCTION

The Healthy Indonesia Program is one of Nawa Cita programs - it is the fifth - namely Improving the Quality of Life of Indonesian Human. The program is planned for its achievement through the Strategic Plans of the Ministry of Health 2015-2019. The goal of the Healthy Indonesia Program is to increase the degree of health and nutritional status of the community through the health efforts and community empowerment supported by the financial protection and equitable health services. The Healthy Indonesia Program is implemented by upholding three main pillars: (1) the adoption of a healthy paradigm, (2) strengthening of health services, and (3) implementing national health insurance (NHI). The implementation of the healthy paradigm is carried out by carrying out the mainstreams of health strategies in the development, strengthening promotive and preventive efforts, and community empowerment. Strengthening health services is carried out with the strategies to optimize the referral system, improve the access to and the quality of health services by applying a continuum

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of care/sustainable care approach and health risk-based interventions. Meanwhile, the implementation of NHI was carried out through a strategy of expanding the targets and benefits, as well as the quality and cost control.

Primary Health Care (PHC) is one of the public sector services that prioritizes the fulfillment of community satisfaction through qualified health services. Based on the standards of health service, one PHC serves 30,000 residents. Meanwhile, the number of the medical personnels, such as doctors, nurses andpharmacist , to support the operation of the PHC is very limited to meet the standards. Even there are still many PHCs health facilities which do not have any pharmacists. In fact, the existence of health services of non-local government hospitals is very vital, especially, since the launch of SIAAH program and considering the status of the PHC as FLHF of SIAAH services. (Jawa Pos-Tuesday, February 9, 2016:33).

These things really hampered the service at the PHC and resulted in the long queues in the waiting rooms. The limited number of standby doctors, who were ready to provide some services at any time, and the limited time of the operational hours for inpatient admissions worsened the health service for the community. Improving the quality of PHC as a Primary Health Facility is very important in the era of the National Health Insurance (NHI) because more than 80% of health problems must be properly managed at the primary level of health facilities. The coverage of patients of the PHC referred to the hospitals was 21%. The referrals were due to the severe diseases of the patients that the PHC unable to deal with and the absence of laboratory facilities.

As a follow up to the Healthy Indonesia Program, the Regulation Number 39 of 2016 of the Minister of Health was issued and it concerns the Guidelines for Implementing the Healthy Indonesia Program with a Family Approach. The Healthy Indonesia Program with the Family Approach establishes 12 main indicators as the markers of the health status of a family. The twelve indicators of a healthy family are: Family joining the Family Planning program; Mothers deliver at health facilities; The baby gets the complete basic immunization; The baby gets exclusive breast milk (EBM); Toddlers get the growth monitoring; Patients with pulmonary tuberculosis receive treatment according to the standards; People with hypertension undergo the regular treatment; People with mental disorders get the treatment and are not neglected; No family members smoke; The family is already a member of the National Health Insurance (NHI); Families have the access to clean water facilities; and families use healthy latrines/water closets. The Healthy Indonesia Program with the Family Approach is implemented in stages with a target that by the end of 2019 the approach will have been applied by all PHCs in Indonesia. The number of PHC in Indonesia is 9,601 spreading across 34 Provinces with some different geographical conditions and people.

II. LITERATURE REVIEW

The management of facilities and human resources at the PHC and hospitals are still unable to meet the needs of the community for health referral services. Networking in the referral process is still done partially and there is no integrated communication network system for all PHCs and hospitals. There are five dimensions to evaluate the quality of health services, and they include physical evidence (tangible), responsiveness, reliability, empathy and assurance. Tangible or physical evidences are in the form of cleanliness of the room, exterior arrangement, neatness and cleanliness of officers, cleanliness and readiness of the equipment used. Responsiveness is in the form of staff readiness.

Reliability is in the form of service accuracy in accordance with the procedures and standardaized examination services. Empathy is in the form of special attentions from the officers to the clients/patients. Assurance is in the form of knowledge of the health workers related to the disease and the skilled workers in handling the complaints of the clients/patients. (Nizwardi Azkha, 2007: 71). One dimension with the highest minus score was responsiveness because there were complaints of many patients about the willingness of officers to give such quick services, especially, to SIAAH participants. (Retno Eka Pratiwi, 2013). In addition, the dimension of quality, especially, the tangible of FLHF is a matter that should be given some special attentions from the owners or managers of FLHF. Not only the technical criterion but also the patient satisfaction had to be met.

National Health Insurance (NHI) is regulated in the Presidential Regulation of the Republic of Indonesia Number 12 of 2013 concerning Health Insurance and Regulation of the Minister of Health of the Republic of Indonesia Number 71 of 2013 concerning Health Services on Health Insurance. Health Insurance is a guarantee in the form of health protection so that the participants get the benefits of health care and protection in meeting the needs of basic health provided to everyone who has already paid some contributions or the contributions are paid by the government. The regulation also regulates the Social Insurance Administering Agency (SIAA), Health Insurance Beneficiaries (HIB), Participants, Benefits, Health Facilities, First Level Health Care, First Level Outpatient, First Level Inpatient and Referral Health Services for Advabced or further level.

The participants of NHI program are all persons including foreigners who have already worked in Indonesia for a minimum of six months and have paid some contributions or paid by the government. There are two groups of NHI participants: the ones receiving health insurance contributions called the Health Insurance Beneficiaries (HIB) and the ones who do not receive the health insurance contributions called non-HIB participants. HIB Participants are the poor and disadvantaged people. Non- HIB participants are the workers earning some money (wage earners) and their family members, non-wage earners and their family members as well as non-

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workers and their family members. Health insurance contributions for participant workers receiving some wages are paid by the employer and the workers themselves while the independent participant contributions (non-wage workers and non-workers) are paid by the participants themselves to SIAAH according to the class of the care. In accordance with the 2012-1019 NHI roadmap, the World Health Organization (WHO) states that there are three dimensions that are absolutely noteworthy, and they include the percentage of the population is guaranteed; the completeness of the service guaranteed; and the proportion of the direct cost still borne by the population.

III. METHODOLOGY

The Socio Legal Research method was implemented in this study, the supporting legal materials were collected, and the field research was conducted. The legal materials were obtained through the study of literature, books, articles, legal journals, the internet, the results of seminars and others. Furthermore, the primary legal materials were used to explain the legal issues, and they were also the objects of discussion. They were deeply analized through the theories, concepts and principles of the law that form the basis of the research. The research materials already collected were studied carefully so that the essence contained in them could be obtained, either in the form of ideas, proposals, arguments, or related provisions.

The field research was carried out in Sidoarjo Regency, East Java, Indonesia. Some in-depth interviews and Focus Group Discussion (FGD) were conducted to support it. Sidoarjo Regency is a buffer zone of Surabaya City as the capital of East Java Province, The results of this study would obtain more factual information on the health service process in a small city that is relatively far away to get such complete and adequate health services. The results can also be used as a prototype in other areas.

The main sources of information in this study were the Sidoarjo Regency Health Office, the Manager of PHC, the Medical and administrative Personnel of PHC, SIAAH participants as patients of PHC, and SIAAH as the organizing body for public health insurance. The source of information would be determined by the snowball technique so that it resulted in complete and comprehensive information.

In-depth interview technique was conducted to the sources of information purposively determined. It was the sampling technique determining the samples taken by determining the specific characteristics that fit the research objectives in answering the research problems. The technique was used it was very appropriate for obtaining the data related to the organizational activities, motivations, feelings, attitudes and so on. In-depth interviews were conducted to get much deeper information and comprehensive data related to the factors that hampered the PHC in providing such services to the patients as SIAAH participants; the management of PHC; and the response of SIAAH participant as the patients to the services of the PHC where they were treated. Thus, the expected data relating to the capacity and performance of the PHC in providing services to SIAAH participants as the patients could be obtained.

The results of in-depth interviews were discussed in the Focus Group Discussion (FGD). This technique is suitable to get much deeper and comprehensive data from various perspectives and complementary and mutually correcting thoughts. In this study, FGD was used to collect some information from various parties who were directly involved in the role of the PHC, various laws and regulations, and any problems faced by each party to find some right solutions.

Furthermore, all research results obtained from the legal materials and field data were analyzed by using the framework of Mardiasmo (modification) which described the optimization of the role of the PHC Puskesmas. It is necessary to have some targets constructed so that it will be easier to analyze the problem and to find the solution.

IV. RESULTS

1.National Health System

The National Health System (NHI) is regulated in Presidential Regulation No. 72 of 2012 concerning the National Health System. NHI is a health management that is carried out by all components of the Indonesian people in an integrated and mutually supportive manner to ensure the highest possible level of public health. It is implemented by the government, regional government and/or the community in a sustainable, systematic, directed, integrated, comprehensive and responsive manner to any changes by maintaining the national progress, unity and resilience. Its implementation emphasizes on the improvement of community behavior and independence, professionalism of health human resources, promotive and preventive efforts, and compromising any curative and rehabilitative efforts. The professionalism of human resources in health fostered by the Minister is only for health workers and supporting health personnel involved and they work as well as dedicate themselves to the health management.

NHI implementation must pay attentions to: the coverage of qualified, fair and equitable health services; providing health services in favor of the people; public health policies to improve and protect the public health;

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leadership and professionalism in health development; ethical or technological innovations or breakthroughs proven to be useful in the implementation of broad health development, including the strengthening of referral systems; a global approach by considering the health policies that are systematic, sustainable, orderly, and responsive to gender and children's rights; family and population dynamics; people's wishes; disease epidemiology; ecological and environmental change; and globalization, democratization and decentralization in the spirit of national unity and cross-sectoral partnerships and cooperation.

The Social Insurance Administering Agency (SIAA) is a legal entity formed to organize a social security program. Social Security as a form of social protection to ensure that all people can fulfill their basic needs for a decent life. SIAA is regulated in Act Number 24 of 2011 concerning SIAA and Presidential Regulation of the Republic of Indonesia Number 12 of 2013 concerning Health Insurance. SIAA BPJS is divided into two types, and they are SIAA of Health and Employment. SIAAH is a legal entity formed to organize the Health Insurance program and has begun its operation in organizing a health insurance program on January 1, 2014.
Problems that often arise in the implementation of SIAAH are as follows: lack of transparency in the hospital management related to the distribution of packages from SIAAH for workers and for drugs; the absence of incentives for private hospitals from the government in connection with SIAA BPJS services; and the absence of mapping of densely-populated and rarely-populated regions. The dissatisfaction of health services of SIAA occured in: the implementation of health services for SIAAH patient in primary, secondary, and emergency health care facilities; and the disputes of SIAAH in the primary health services.

2. The Role of Primary Health Care in Improving Health Services

Primary Health Care (PHC) is a health service facility that organizes the public health efforts and first-level individual health efforts focusing on more priorities to some promotive and preventive efforts to achieve the highest level of public health in the working area. Health facilities are health service facilities that are used to carry out some promotive, preventive, curative and rehabilitative individual health care efforts done by the government or the community. A PHC is a health facility that organizes individual public health services for the purposes of observation, promotion, prevention, diagnosis, treatment or other health services. It is one of the public sector giving services that prioritizes the fulfillment of community satisfaction through the qualified health services. Indonesia still faces the problem of equity and affordability of health services, and it is estimated that only around 30% of the population use the health services of PHC.
The coverage of Services of PHC according to the Minister of Health Regulation of the Republic of Indonesia Number 99 of 2015 concerning amendments to the Minister of Health Regulation Number 71 of 2013 concerning Health Services on Health Insurance states that the First Level Health Services are non-specialistic health services which include: service of administration; promotive and preventive services; medical examination, medical treatment and consultation; medical and non-medical procedures for both operative and non-operative actions; service of medicines and consumable medical substances; primary laboratory diagnostic supporting examinations; First Level Inpatient admission in accordance with the medical indications; Inpatient treatment/treatment of cases that can be completely resolved in First Level Health Services; Non high risk of Vaginal delivery assistance; Delivery assistance with complications and neonatal with complications. Presidetial Decree No. 12 of 2013 states that within a period of at least three months NHI participants are entitled to choose the desired FLHF. The mutations of NHI participants often occur due to some dissatisfactions and it will have such an impact on the FLHF related to the amount of capitation and the number of participants served.
FLHF of NHI participants consists of Primary Health Care Puskesmas, doctors, dentists, first clinics and Primary D Class Hospitals in collaboration with SIAAH. Both general practitioners and dentists, including in the first-level health facilities of NHI program, can have some collaborations with SIAAH as long as they can meet the established requirements. Primary Health Care (PHC) is a health facility that organizes public health efforts and first-level individual health efforts, with more emphasis on the promotive and preventive efforts to achieve the highest degree of public health in the working area (Kemenkes RI, 2014c). Clinics are health facilities that carry out individual health services by serving basic and/or special medical services. Health services before the NHI era included some different health facilities. The Health facilities covered by the Community Health Insurance Program (JAMKESMAS) were Social Security for Workers (Jamsostek), Health Insurance (Askes) for civil servants, pension recipients, veterans, pioneers of independence with their families, and Regional Health Insurance Programs (JAMKESDA). They had different organizers. Health Service Provider (MPF) I Jamkesmas used the Primary Health Care Puskesmas and its networks. MPF I Jamsostek Social Insurance for workers cooperated with some private practitioners. MPF I for Askes Health Insurance worked with PHC and private practitioners, and Jamkesda Regional Health Insurance only used the government-owned Health Service Provider of MPF.

3.Changes in the Management of Primary Health Care

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Regional Public Service Agency (RPSA) is regulated in the Regulation of the Minister of Domestic Affairs No. 61 of 2007 concerning the Technical Guidelines for the Financial Management of Regional Public Service Agencies. RPSA is a Work Unit in a Regional Apparatus within a local government environment established to provide some services to the public in the form of the supply of goods and/or services sold without prioritizing looking for any profit, and in conducting its activities based on the principles of efficiency and productivity. Its Financial Management Pattern (FMP-RPSA) is a management pattern of finance that provides some flexibilities to implement the sound or healthy business practices to improve services to the community in order to advance the public welfare and the life of the nation, as an exception to the provisions of the regional financial management in general. Flexibility is the discretion to manage the finance/goods of RPSA in certain limits that can be excluded from the generally accepted provisions. The improvement of RPSA status is an increase in the status of the work units that gradually apply to fully apply FMP-RPSA. The substantive, technical and administrative requirements must be fullfilled in the application of FMP-RPSA to SKPD or Work Units. The substantive requirements are met if the duties and functions of the SKPD or Work Unit are operational in providing public services that produce quasipublic goods. These public services relate to: the provision of public goods and/or services to improve the quality and quantity of public services; the management of certain areas/regions for the purpose of improving the economy or public services for the community; and/or the management of special funds in the context of developing or improving the economy and/ or services to the community. The provision of public goods and/or services is prioritized for health services, but not applied to the public services under the authority of the local governments because their obligations are based on statutory regulations. The public services under the authority of the regional government include: servicesfor local tax collection, services for Identity Card, services for building permit.

The management of the RPSA funds is regulated in Presidential Decree Number 32 of 2014 regarding the Management and Utilization of the National Health Insurance Capitation Fund at the First Level Health Facilities of the Regional Government; and Regulation of the Minister of Health No. 19 of 2014 concerning the Use of the National Health Insurance Capitation Fund for Health Services and Supporting Operational Costs at the First Level Health Facilities of the Regional Government. Some appropriate competencies to manage their own funds are strongly needed, for example, treasurers must get some certain training related to the use of funds. The existence of RPSA results in the more developed Primary Health Care Puskesmas because the funds is properly allocated according to the needs, and it leads to the significantly reduced dependancy on the health department. The PHC of RPSA is more flexible in managing the finances.

This presidential regulation is intended for the First Level Health Facilities (FLHF) owned by the government that have not implemented the management pattern of RPSA finance. For budgeting, the head of the FLHF is asked to submit a plan for the income and expenditure of the current year of NHI capitation fund which refers to the number of participants registered at FLHF and the amount of NHI capitation to the head of the SKPD of the health department. Meanwhile, the regulation of the minister of health describes that capitation funds received by FLHF are entirely used for the payment of health services and support for operational costs of health services. The allocations for the payment to support the operational costs of health services are stipulated at least 60% of capitation funds, while the rest is used for medicines, medical devices and consumable medical materials, as well as other health service operational activities.

Some of the benefits of the PHC to become RPSA are as follows: safety and security at work, readiness of of givimg service at any time, anticipation of such conditions, and of unexpected costs, subsidies, income, accreditation, commercial, ease of reporting and flexibility.

(1) Safety and Security at work. The triggering factor of PHC to become RPSA is a policy for direct transfer of capitation funds to PHC by SIAA. SIAA thinks that this is the only way for PHC to improve the response and quality of service to patients. In fact, the PHC is a UPTD that is bound by the management pattern of the finance of the local government. In accordance with the Acts on State Finance No. 13/2003 and No. 1/2004 on state treasury it is stated that all non-tax state revenue must be deposited before it is used directly. The use of the funds must refer to the pattern of use of funds of the income and expenditure of local government budget. The only institution that can use funds directly, and is excluded from the above provisions, is the SKPD or UPTD who apply the Management Pattern of RPSA Finance. Thus, if the PHC does not become RPSA, there will be potential violations of Acts No. 13/2003 and No 1/2004. It is often said that currently there is a Presidential Regulation regulating the management of NHI funds, even though, according to the hierarchy, it is a temporary regulation, and the derivative rules after the law are the government regulations. Violating the provisions of the law leads to some problems which can be questioned.

(2) Readiness of givimg Service at any time. As a public service, especially in the health sector, the PHC must be ready to serve at any time, especially for the unforeseen or unpredictable events such as at the moment of new year or a long holiday when some accidents or natural disasters frequently occur. It sometimes causes some human victims so that first, immediate treatment by PHC is highly required, even more the location of the nearest hospital is far away.

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(3) Anticipation of such Conditions. If it turns out that the following year the number of sick people goes down, the costs incurred will be more efficient. This is a good indicator because it requires more appropriate management and measurement patterns.
(4) Anticipation of Unexpected Costs. Unpredictable costs for the unpredictable things such as leaking roof tiles, peeling of paint, leaking of ambulance tires, damage of tools, and some more often arise and they lead to some expenses to spend for the repair or the purchase of those things, es[ecially, when they require immediate treatment.
(5) Subsidies. Some officers of PHC are worried that if the PHC becomes RPSA, the subsidies will be revoked. It is not unreasonable to occur because the task of the local government is to provide the assurance or guarante of health service. The main existing problem at present is the imbalance in terms of service needs and the availability of personnel and facilities, and the regional government is seriously tasked with narrowing the gap. RPSA is a management pattern of finance to facilitate and secure, not for the purpose of seeking any profits. RPSA is not a regional government-owned company. Its main focus is improvement of the quality of service.. If the local government decides to reduce or revoke the subsidy, which is actually still lacking at the PHC, the quantity and quality of health services will certainly decrease. In the end, the regional government that will be in serious troubles such as demonstrations, and the dissatisfactions.
(6). Income. Some parties argue that PHC must provide some rooms for hospitalization/admission, or a certain amount of income to become RPSA. There is no legal basis about it. The first reason to make the PHC become RPSA is safety and security at work leading to no violations to the existing rules and regulations by the manager of PHC. The second one is the improvement of quality of health services. It doesn't matter, if, after becoming RPSA, the income of PHC does not increase, but the big problem is the improvement of service quality.
(7) Accreditation. Some parties argue that PHC must be accreditated first before becoming RPSA. It is a contradictory to what is actually going on. At the beginning, the PHC should become RPSA, and after that the accreditation is prepared. Accreditation really requires a lot of funds to support. Without any flexibility of using the budget, the PHC will find some difficulties resulting in failing to pass the accreditation. After becoming RPSA, the PHC will not find any problems related to an urgent situation to provide some tools, or some money for some immediate payments. In addition, by applying the RPSA pattern, the planning at the PHC level is forced to be good. These will be very important to answer the points of the accreditation assessment elements.
(8) Commercial. Some parties are worried that when the PHC becomes RPSA, it will be commercial and the prices to have some treatments go up. Actually increasing the price does not matter as long as it is proportional. If it is forced to provide lower tariffs far below the market price, and the local government also does not provide sufficient subsidies, there will be some disadvantaged parties such as doctors, nurses and administrative employees. In the long run, it will have an impact on the decreased motivation.
(9) Ease of Reporting. Some regional governments have some policies to make the PHC gradually becomes RPSA so that there will be no more difficulties for the small ones. However, if it really happens, the financial department of the Health Office will face some problems because they have to handle two different models of planning, administration and reporting.
(10) Flexibility. There is an impression that it will be difficult for PHC to become RPSA because they are not used to it. Being RPSA results in many conveniences or flexibilities such as to directly manage the income, to handle the procurement, to set the tariffs based on the regulations, and to recruit some non government employees and other

V.CONCLUSION

National Health System (NHI) regulated in Presidential Regulation of the Republic of Indonesia Number 72 of 2012 concerns the National Health System. In implementing NHI, a system of health protection of NHI was formed so that the participants can receive some health care benefits and protections to meet the basic health needs provided to everyone who has already paid some contributions or the contributions have been paid by the government. NHI is regulated in the Presidential Regulation of the Republic of Indonesia Number 12 of 2013 concerning Health Insurance and Regulation of the Minister of Health of the Republic of Indonesia Number 71 of 2013 concerning Health Services on Health Insurance. The regulation also regulates the Sosial Insurance Administering Agency (SIAA), Health Insurance Beneficiaries (HIB), Participants, Benefits, Health Facilities, First Level Health Care, First Level Outpatient, First Level Inpatient and Advanced level of Referral Health Services.
The renewal of the management of PHC is done through the formation of a Regional Public Service Agency (RPSA/BLUD). The PHC will be more developed because they can use some funds as it is needed and they are not dependent on the health department. The PHC of RPSA is more flexible in managing the finances. Some of the benefits of the PHC to become RPSA are as follows: safety and security at work, readiness of of givimg service at any time, anticipation of such conditions, and of unexpected costs, subsidies, income, accreditation, commercial, ease of reporting and flexibility. Regional Public Service Agency (RPSA) is regulated in the

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Regulation of the Minister of Domestic Affairs No. 61 of 2007 concerning Technical Guidelines for Financial Management of RPSA. RPSA is a Work Unit in a Regional Apparatus within a local government environment established to provide some services to the public in the form of the supply of goods and/or services sold without prioritizing looking for any profit, and in conducting its activities based on the principles of efficiency and productivity. The management of the RPSA funds is regulated in Presidential Regulation Number 32 of 2014 regarding the Management and Utilization of the National Health Insurance Capitation Fund at the First Level Health Facilities of the Regional Government; and Regulation of the Minister of Health No. 19 of 2014 concerning the Use of the National Health Insurance Capitation Fund for Health Services and Supporting Operational Costs at the First Level Health Facilities of the Regional Government.

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