INDONESIA'S HEALTH FINANCING POLICY AN EFFORT TO REALIZE UHC

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Abstract

The health financing system created by one country aims to improve its health status and relieve the burden of individual suffering and reduce the burden on the state. To realize the goal is not easy and many problems. The state of the budget, corruption, inconsistency between regulations and the system, the wrong choice in realizing health financing will certainly harm public health services and the realization of the UHC concept. The focus of this research is how the health financing policy in realizing UHC.

Methods: This study uses a normative and sociological juridical approach to study the condition of an object naturally through regulatory studies and mutually supportive empirical facts. This finding found that the health financing policy still had many obstacles, including the lack of funds for health services and drug standards. Many regulatory policies have not regulated an adequate service system.

Conclusion: This study recommends that the integration of regulations and an effective and efficient financing system can create an equitable distribution of health services to realize UHC.

Keywords: *Policy, Health financing, Universal Health Coverage*

1. Introduction

In fulfilling the basic rights mandated by the 1945 Constitution, currently, the health sector in Indonesia is facing increasingly complex challenges. Indonesia faces various challenges that have an impact on greater financing needs. The increasing population and the aging structure have led to an increase in high-cost chronic degenerative diseases. There are still many poor people and need subsidies[1]. Universal Health Insurance (UHC) is critical to global poverty alleviation and health equity. Many countries in the lower and middle stages have committed to UHC and are harmonizing for UHC.

The UHC concept is needed for the poor and meets the additional needs of the rich and the government budget (Asante et al., 2017). Therefore, increasing funding is an important issue in increasing the expansion of health coverage. Research in Cambodia found that high expenditures and low utilization rates hinder outreach and improve health outcomes, and for 20 years health financing has focused on addressing health care for the poor. Health financing policies are the basis for developing health (Ensor et al., 2017). Anticipation of future health expenditures and sources of funding are critical to effective health policy. With well-targeted spending forecasts, decision-makers can adjust long-term planning and processes. Investments can be made strategically to address shortfalls or increase growth in the years to come. Reliance on healthcare payments from OOP (Out Of Pocket) has been shown to reduce access to healthcare and increase medical impoverishment in some settings, understand how funds will be collected. (Falkingham, 2004; K. et al., 2007; Piette et al., 2004) Health funding sources often determine the types of services and supplies

[1]Universal health coverage in Indonesia: concept, progress, and challenges

obtained and how efficiently these resources are used. (Manning et al., 1987; Mwabu et al., 1993; Sahn et al., 2003). In some areas of small towns they choose not to participate in the health insurance program created by the government because they are unable to bear the burdens that must be borne in one family so that when one family is sick, they are forced to pay for it themselves.

Therefore we need a strong health system with sustainable financing that is strived to be able to help improve the health of its citizens. In general, there are several steps to assessing health financing that must be a concern and become a guide for several countries in determining health financing budgets, according to Chu there are 4 factors that must be met as shown in Figure 1 below. (Chu et al., 2019):

Figure 1. Steps to assess health financing

We all know that increasing health financing by studying and maximizing the use of health services is part of the health financing system as a step towards UHC as recommended by the United Nations.

Tax collection and salary deductions are the main factors in the management of health funds, in addition to the expansion of public services and policies and institutions assigned the task of coaching are also important factors and can protect and improve the health status of a country, especially the poor. (Mathauer & Carrin, 2011; Tangcharoensathien et al., 2011)

To achieve the SDGs there is a continuing need that requires a serious role from stakeholders. In addition, sustainable development (SDGs) is part of the Millennium Development goals, namely (Bennett et al., 2020):

i. Protecting and accessing health services through social protection systems
ii. Strengthening multisectoral collaboration for health
iii. Developing institutions that are more participative and accountable

Financial and health administration reform to realize UHC needs to be informed to all stakeholders so that there are no mistakes in its implementation because there are still some findings that the poor have not received justice, and the distribution of subsidies. (Guinness et al., 2018) Without careful planning, limited health resources can lead to inadequate access to health services and an over-reliance on direct payments. (J. Dieleman et al., 2017) The health financing transition illustrates how health financing changes, on average, as countries develop economically: per capita health spending increases, and spending alone makes up a smaller share of total health spending than before. (Fan & Savedoff, 2014).

Based on the background of all the descriptions above, this research focuses on the problem of how the Health Financing System efforts in realizing UHC?

2. Method

This study uses a normative and sociological juridical approach to describe and analyze phenomena, events, or social activities that take place in society either through a study of existing regulations and existing empirical facts. This method is used to examine the condition of natural or natural objects carried out directly by researchers(Creswell, 1994). A sampling of data sources was carried out by purposive and snowball methods, namely collection techniques with in-depth interviews and document studies.

This study uses primary and secondary data. Primary data was collected through in-depth interviews or Focus Group Discussions (FGD) with stakeholders. Stakeholders consisting of the Ministry of Health, Ministry of Finance (Fiscal Policy Agency), Social Security Administration Health Center. Secondary data consists of national and regional data collected for analysis purposes, in the form of State Revenue and Expenditure Budget/ Regional Revenue and Expenditure Budget documents, regulations, program reports, financial reports, and regional health profiles.

3. Results

Health Financing System in Indonesia

The health financing system is the management of various efforts to extract, allocate, and spend health funds to support the implementation of health development to achieve the highest degree of public health.

The health financing system must adapt to several regulations, which are related to health development, health development must also adapt to several strategic changes in the health sector. One of the changes that have influenced the direction and policies of health development in Indonesia is the national health insurance program.

The issue of transparency in health services is also an issue in society. The existence of the issue of patient refusal, if they want to go to the hospital, is evidence of the limited access for participants of the National Health Insurance. In addition to this, the quality of service facilities and infrastructure in each region which is still not evenly distributed is a problem that certainly has an impact on health development in the region. This illustrates that although the National Health Insurance program is important to carry out, how the community gets access to good health services, disease prevention efforts, and cross-sectoral coordination in health development is also important to consider in realizing fair, quality, and equitable health development.

The goal is the availability of health funds in sufficient quantities, allocated fairly, equitably, and utilized effectively and efficiently, distributed according to their designation.

The State Revenue and Expenditure Budget is allocated a minimum of 5% excluding salaries. State budget allocation is needed for:

- Health programs in the ministry of health and other state ministries/agencies.
- National Health Insurance Program
- Special allocation funds transferred to local governments

The Regional Revenue and Expenditure Budget is allocated a minimum of 10% excluding salaries. The Regional Revenue and Expenditure Budget allocation is intended for

promotive, preventive health programs from the provincial, district, or city health offices, and fee financing. Personal health or national health insurance premium payments, personal medicines are not covered by insurance. From the private sector through the National Health Insurance premium, Corporate social responsibility (CSR), private or independent insurance. Other sources of funding include donor assistance for special prioritized programs such as HIV/AIDS, Tuberculosis, and Malaria.

In the implementation of health services, a financing strategy is needed to meet fair and equitable health service standards. Funding for health is a shared responsibility of the government, the community, and the private sector. The allocation of funds from the government for health efforts is carried out through a program for preparing revenue and expenditure budgets, both central and regional, where financing for the poor and underprivileged is the responsibility of the government.

WHO recommendations in health financing

The World Health Organization (World Health Organization) itself provides a focus on health financing strategies that contain the main issues, challenges, main objectives of policies and programs of action that are generally in the following areas:[2]

1. Increase public investment and spending in the health sector
2. Strive to achieve universal participation and strengthen health care for the poor
3. Development of pre-employment financing schemes including social health insurance
4. Excavation of national and international support
5. Strengthening regulatory frameworks and functional interventions
6. Development of health financing policies based on scientific data and facts
7. Monitoring and evaluation

WHO defines 8 elements that must be included and determine the quality of health policies, namely: [3]

1. Holistic Approach →Physical, mental, social, and spiritual dimensions
2. Participatory →Community participation will increase the effectiveness and efficiency of policies
3. Healthy public policy →Conducive health development
4. Equity →Even distribution
5. Efficiency → Optimizing cost and technology
6. Quality→ Quality health care
7. Community Empowerment →especially in remote areas
8. Self-reliant →public confidence in health in their area.

The health system has at least 4 main functions, namely: health services, health financing, provision of resources, and stewardship/regulator. These functions will be represented in the form of subsystems in the health system, developed as needed. The Ministry of Health compiles a document on the health system in Indonesia. Then the Ministry of Health of the Republic of Indonesia in 2004 made an "adjustment" to the 1982 National Health System. The document states that the National Health System is defined as an arrangement that brings together the efforts of the Indonesian people in an integrated and mutually supportive

[2]The world health report 2000: health systems: improving performance
[3]The world health report 2000: health systems: improving performance

manner, to ensure the highest possible health status. as the embodiment of general welfare as referred to in the Preamble to the 1945 Constitution

Challenges of the Health Financing System in Indonesia

The health sector in Indonesia faces increasingly complex challenges. In addition to having to adapt to various regulations related to health development, at the same time it must also adapt to several strategic changes in the health sector and solve health problems in the era of decentralization. One of the changes in the national strategic environment that also influences the direction and policy of health development in Indonesia is the National Health Insurance program.

The three main areas of focus in national health insurance are:

- Production – ensuring there are sufficient quantities to meet the demands of universal health insurance
- Distribution – ensuring the availability of services in remote and rural areas; and
- Improving the quality and performance of health workers by ensuring schools meet Government standards and conducting routine competency training. The challenge of ensuring the availability of services in remote and rural areas is critical to achieving key health outcomes and this needs to be a major focus. Identifying and putting incentives in place is a key factor. Salary increases are also important, but other factors such as access to sending health workers to post-graduate education and formal rotation also have a role

One of the government's national strategic policies is to target all residents to be covered by the National health insurance program in 2019, although if you look at it until now, according to the President Director of Health Social Security Administration, Fachmi Idris, until April 30, 2020, National Health Insurance-Healthy Indonesia Card has only protected 222.9 million people. or 83.64%.

Health financing must be strong, stable, and always sustainable to ensure the implementation of adequacy, equity, efficiency, and effectiveness of health financing itself. The important thing in health financing is how to use these costs effectively and efficiently from the economic and social aspects and can be enjoyed by all people in need. Therefore, the main requirements in health financing must be mutually sustainable.

The health financing program certainly requires increasing access and quality of health services, both at the first level and advanced level health facilities, as well as improving the referral system for health services. However, since National health insurance was rolled out as a national program, there has always been a deficit. Apart from National health insurance, several government breakthroughs in the health sector are still said to be insufficient to improve access and quality of health services in Indonesia. The government continues to make various efforts, in addition to continuing to increase the number of National health insurance participants as an effort to realize Universal Health Coverage (UHC) and overcome the National health insurance budget deficit, various innovations are continuously promoted by the government.

In the context of the health system, health development in Indonesia has been regulated in Presidential Regulation no. 72 of 2012 concerning the National Health System. In Article 1 point 2 of the Presidential Regulation it is explained that National Health System is health management that is carried out by all components of the Indonesian nation in an

integrated and mutually supportive manner to ensure the achievement of the highest degree of public health. National Health System becomes a reference in the preparation and implementation of health development starting from planning activities to monitoring and evaluation activities.

Article 2 paragraph (2) of Presidential Regulation No. 72 of 2012, mandates that health development must be carried out in stages, both at the center and in the regions by taking into account regional autonomy and functional autonomy in the health sector. The article juridically has two meanings. Development is still uneven and Java-centric, with a high level of referrals. Most of these high referrals still go through the "bypass" phenomenon and mostly aim at government-owned hospitals. To achieve the goals and targets of health development, the health development strategies for 2005-2025 are:

1) Health-oriented national development
2) Community and regional empowerment
3) Development of health efforts and financing
4) Development and empowerment of health human resources
5) Handling of health emergencies.

There are at least 6 obstacles that need to be addressed and addressed as soon as possible because they can disrupt and even hinder healthy development and also the health financing system in Indonesia (Universal health coverage in Indonesia: concept, progress, and challenges) :

1. Connectivity. Connectivity constraints are the main reason why the digital health system (E-Health) in Indonesia does not develop, especially in remote areas that should need the same access to health as urban communities. If connectivity is evenly distributed throughout Indonesia, people can certainly get access to good health because they can consult with doctors even though they are far apart.
2. Regulatory Clarity. According to a survey from Deloitte Indonesia, Bahar, and Chapter, 15.6 percent of users are still dissatisfied with digital health services. This dissatisfaction occurs because users are worried about the security of the data inputted into the digital health service. In addition to data security, the main problem in the development of this digital service is, among others, the occurrence of poor communication between doctors and patients with diseases because they do not check for diseases directly.
3. Demographic Bonus Indonesia's population is the 4th largest population in the world, which is dominated by young people and the middle-class economy. This demographic bonus is a strength for Indonesia to compete in the global arena. Unfortunately, this demographic bonus is not accompanied by good health services. Young people and the community who are considered capable of advancing Indonesia are not protected because there is no good health service.
4. Archipelagic State Being an archipelagic country, is indeed very influential on the export potential of Indonesia's Natural Resources (SDA). Indonesia is famous for its variety of natural resources and natural beauty that can attract tourists to visit. On the other hand, the distribution of food and health distribution is hampered because it cannot be reached only by land.

5. Low Service. The level of hospital service in Indonesia is relatively low. This is reflected in the community's obstacles in obtaining health services in several hospitals. Patients who suffer from serious illnesses are asked to wait for services for up to 1 month at home as a result, many people in the Medan area finally choose Penang, Malaysia, for treatment rather than in Indonesia.
6. Technology Not Used Well. Existing technology is not used properly for health services. Internet users in Indonesia are the highest compared to other countries. We also found weaknesses in the use of technology applications in health services, especially in First Level Health Facilities.

So if you look at the above, the three main challenges in the Indonesian health system today are still in the scope of access, effectiveness, and efficiency. There needs to be a mental revolution in improving the quality and also managing health data. Although nationally the quality of health has improved, disparities between regions, between economic levels and between urban and rural areas are still quite high.

The availability of manpower supply and health service facilities in Indonesia shows the gap between districts and cities. The distribution of doctors, both in terms of number and ratio, is still higher in cities, however, the distribution of the number and ratio of midwives is higher in districts than in cities. The availability of health facilities in cities is much better than in districts in indicators of the number of hospitals (government and private), the total available beds, and the ratio of beds compared to the population.

Infrastructure plays a role as one of the main physical components for border areas considering that systematic, targeted, and consistent infrastructure development can lead to improving the welfare of people in border areas. The availability of health services and supporting facilities is still low because their distribution is less evenly distributed compared to the City.

The reform of the social security program in the health sector is quite important because the implementing regulations that apply are still partial and overlapping, the benefits of the program are not optimal, and the reach of the program is limited and only felt by a small part of the community. Reforms are carried out not only in the financing aspect but also in the health service aspect

Another challenge faced by the government is the integration of regional health insurance programs managed by local governments into the national health insurance program. The implementation of regional health insurance itself varies greatly in terms of management patterns, payment methods, the number of contributions, benefits packages, and especially the participants who are covered. Most of the regional health insurance programs cover participants who are not included in the community health insurance program, while a small portion covers the entire population in the area. Regional health insurance participation data is often unclear and not based on name and address. Most regional health insurance programs also have membership in the national health insurance. Accurate population data is needed to involve health insurance participation. So far, health insurance participation data has not been integrated with population and employment data. As a result, until now the exact number of people who do not have health insurance is not known. The various types of existing health insurance/insurance programs are estimated to have covered about half of Indonesia's population.

In the future some several challenges and problems need attention and solutions for their solutions:

1. National Health Insurance Sustainability Strategy
2. A new source of income for the health sector: creating a fiscal capacity
3. Membership Expansion
4. Supply Side Readiness
5. Pharmaceutical Policy in the Social Health Insurance System

The National Health System is health management organized by all components of the Indonesian nation in an integrated and mutually supportive manner to ensure the achievement of the highest degree of public health. To achieve the goals of health development, health management is carried out through a health sub-system which is divided into several parts, namely health efforts, health research and development, health financing, health human resources, pharmaceutical preparations, medical devices, and food, management, information and health regulation, community empowerment. The health system of a country is strongly influenced by health policies set by policy makers, both government and private. Health policy itself is influenced by the policy triangle, namely context (economic, socio-cultural, political factors), content, policy-making processes, and actors who play a role (policy elites). National Health System Indonesia has 3 foundations including the ideal foundation, namely Pancasila, the constitutional basis, namely the Republic of Indonesia Constitution, especially articles 28 and 34, and the operational basis, namely Law Number 36 the Year 2009 concerning Health. The World Health Report 2000 entitled Health System: Improving Performance sets the normative goals of the health service system, namely (Siswanto, 2010):

a. Improved health status
b. Improving the quality of health services (responsiveness)
c. Improved equity in health financing

The Urgency of Universal Health Coverage

Universal Health Coverage (universal coverage) is a health system that aims for the community to gain access to quality health services according to community needs and at affordable costs by the community, including promotive, preventive, curative, and rehabilitative health services. Universal coverage is divided into two elements, namely access to fair and quality health services and protection of financial risks. While the universal coverage related to the financing system is divided into 3 categories, namely single payment (single-payer), double payment (two-tier, dual health care system), and insurance mandate system.

One of the positive impacts of universal health insurance is an increase in service utilization, but it is suspected that it will result in moral hazard and a decrease in motivation on the part of service providers. The main problem encountered is usually the sustainability of the free medical treatment system due to the lack of consideration of budget requirements and weak cost control mechanisms. The policy of free medical treatment is even considered only a political policy to fulfill the 'election promise' which harms the health system. The purpose of planning and managing adequate health financing can help mobilize health financing sources, allocate them rationally and can be used effectively and efficiently.

Health financing has a policy that prioritizes equity and focuses on the poor (equitable and pro-poor health policy) that can help achieve universal health access.

The Challenge of Realizing UHC

Problems arising from health financing include a lack of funds and an increase in funds. Lack of funds occurs due to inefficiency in financing management and the wrong allocation of funds. Meanwhile, what is meant by increased costs is the trend of increasing medical technology as a diagnosis base (evidence bases) which causes cost consequences, as well as the trend of supply-induced demand which is currently widespread. In addition, the dominance of financing with a fee for service mechanism, and the lack of allocating resources and services themselves (poor management of Resources and services).

The health system in Indonesia is now heading in a better direction, although there are still many kinds of obstacles. This can be seen from the improvement in the health status of the community. However, despite the improvement in public health status, efforts are still needed to accelerate the achievement of health indicators to catch up with other countries, so that the National Health System still needs to continue to be evaluated and improved. Access to fair health services uses the principle of vertical justice. The principle of vertical justice emphasizes that the contribution of citizens in health financing is determined based on the ability to pay, not based on a person's health/illness condition. With vertical equity, lower-income people pay lower costs than higher-income people for health services of the same quality. In other words, cost should not be a barrier to getting the health services needed (needed care, necessary care).

The development of the financing model and system in the National Health Insurance program run by the Health Social Security Administration is considered to require regulatory support. The reason is that this step is considered to be an alternative to overcome the challenges of mismatch or deficit management of social security funds. Its implementation is stated in a cooperation contract with health facilities which are expected to provide more effective and efficient services with quality that is maintained. The development of models and systems for financing health facilities is also part of the effort to implement the policy mix strategy to control the deficit of the National Health Insurance. However, to implement it requires supporting regulations.

One of the challenges in implementing the current National Health Insurance – Healthy Indonesia Card program is how to align the limited budget or costs with the high number of health service delivery. Therefore, the development of financing models and systems is an alternative to overcome these challenges.

Currently, the financing methods used by the Social Security Administration are capitation and INA CBG's. However, the Social Security Administration is currently developing more effective financing models, including service commitment-based capitation, hospital-value base, and global budget. service commitment-based capitation is a capitation payment system to First Level Health Facilities based on the fulfillment or achievement of four indicators, namely the number of contacts, the ratio of outpatient referrals for non-specialist cases, the ratio of regular visits to participants in the chronic disease management program or Polaris. In this way, the service quality of participants at the First Level Health Facility can be improved.

The problems that occur in health financing are:

1. Lack of available funds
   The cost of medical services is much higher than the cost of public health services. Even though all parties already know that medical services are seen as less effective than public health services
2. Inappropriate distribution of funds.
   The main reason is that the management is not perfect, which is related not only to the limited knowledge and skills but also to the mental attitude of the managers.
3. Improper use of funds.
   the cost of medical services is much higher than the cost of public health services. Even though all parties already know that medical services are seen as less effective than public health services
4. Improper fund management.
   The main reason is that the management is not perfect, which is related not only to the limited knowledge and skills but also to the mental attitude of the managers.
5. Increasing health financing.
   The causes of increased health costs are inflation rates, demand levels, advances in science and technology, changes in disease patterns, changes in community service patterns, changes in the pattern of doctor-patient relationships, Weak Cost Control/Control Mechanisms, Misuse of Health Insurance

The process of health services cannot be separated from health financing. Health costs are the number of funds that must be provided to organize and or utilize various health efforts needed by individuals, families, groups, and communities.:

1. Health Service Provider, is the number of funds that must be provided to be able to carry out health efforts, so it is seen from this understanding that health costs from the point of view of service providers are the main problem for the government and/or private parties, namely those who will carry out efforts health. The amount of funds for health service providers refers to all investment costs and all operational costs.
2. Service User (Health Consumer), is the number of funds that must be provided to be able to take advantage of the service. In this case, health costs are the main problem for service users, but within certain limits, the government also participates, namely to ensure the fulfillment of health service needs for people who need it. The amount of funds for service users refers more to the amount of money that must be spent (out of pocket) to be able to take advantage of a health effort.

Strong, stable, and sustainable health financing plays a very vital role in the implementation of health services to achieve various important goals of health development in a country, including equal distribution of health services and access (equitable access to health care) and quality services. Therefore, health policy reforms in a country should give an important focus to health financing policies to ensure the implementation of adequacy, equity, efficiency, and effectiveness of health financing itself.

Planning and arranging adequate health care financing will help the government in a country to be able to mobilize health financing resources, allocate them rationally and use them efficiently and effectively. Health financing policies that prioritize equity and pro-poor health (equitable and pro-poor health policy) will encourage the achievement of universal

access. In a broader aspect, it is believed that health financing has a contribution to social and economic development.

The health service itself has recently become very expensive in both developed and developing countries. Excessive use of health services with high technology is one of the main causes. Another cause is the dominance of health care financing with a cash payment mechanism (service fee) and the weak ability to manage resources and services themselves (poor management of resources and services).(Departemen Kesehatan, 2015) Health services have several characteristics that do not allow each individual to bear the cost of health services when needed:

1. The need for health services appears sporadically and is unpredictable, so it is not easy to ensure that every individual has enough money when they need health services.
2. The cost of health services under certain conditions is also very expensive, for example, services in hospitals and advanced health services (operations and other special measures), emergency conditions, and long-term illness that the general public cannot afford to pay for.
3. The poor are not only more difficult to access health services, but also need more health services because they are vulnerable to various health problems due to poor nutrition and housing conditions.
4. If the individual suffers from the illness, it can affect the ability to function, including work, thereby reducing the ability to finance.

Based on these characteristics, a health care financing system should aim to:

1. Risk spreading, health financing must be able to even out the number of risk costs over time so that the amount can be reached by every household. This means that a financing system must be able to predict the risk of individual illness and the amount of financing within a certain period (eg one year). Then the amount is averaged or distributed every month so that it becomes an affordable monthly premium (contribution, savings).
2. Risk pooling, some types of health services (although the risk is low and uneven) can be very expensive for example hemodialysis, specialist surgery (coronary heart) which cannot be covered by individual savings (risk spreading). The financing system must be able to calculate by accumulating the risk of an expensive illness between individuals in a community so that community groups with low levels of need (not infected with the illness, do not need health services) can subsidize community groups that need health services. In simple terms, a financing system will calculate the risk of expensive health problems in a community, and calculate the amount of these costs and then divide it among each member of the community. So that following the principle of solidarity, the cost of expensive health services is not borne by individual savings but is shared by the community.
3. The connection between ill-health and poverty, because of the link between poverty and health, a financing system must also be able to ensure that the poor are also able to provide adequate health services according to standards and needs so that they do not have to spend disproportionately with their income. In general, in poor and developing countries this often happens. The poor have to pay for health services that are not affordable by their income and also receive substandard health services.

4. The fundamental importance of health, health is a basic need where individuals cannot enjoy life without good health status.

The World Health Organization (WHO) itself focuses on a health financing strategy that contains the main issues, challenges, main objectives of the policy and program of action, generally in the following areas::

1. Increase public investment and spending in health
2. Strive to achieve universal participation and strengthen health care for the poor
3. Development of pre-employment financing schemes including social health insurance
4. Excavation of national and international support
5. Strengthening regulatory frameworks and functional interventions
6. Development of health financing policies based on scientific data and facts.
7. Monitoring and evaluation.

The high cost of healthcare is caused by several things, some of the most important of which are as follows:

1. Inflation rate If there is an increase in prices in the community, then automatically the investment costs and also the operational costs of health services will also increase, which of course will be borne by service users.
2. Demand level In the health sector, the level of demand is influenced by at least two factors, namely the increase in the quantity of the population requiring health services, which due to the increase in number or increase in number, the costs that must be provided also increase. The second factor is the increasing quality of the population. With a better level of education and income, they will demand the provision of good health services as well and this requires better and higher health care costs.
3. Advances in science and technology. In line with the progress of science and technology in the provision of health services (the use of modern and sophisticated medical equipment) has its consequences, namely the high costs that must be incurred in investing. This has resulted in the imposition of investment and operational costs on health service users.
4. Changes in Disease Patterns The increase in health costs is also influenced by changes in disease patterns, which shift from acute diseases to chronic diseases. Compared to various acute diseases, the treatment of chronic diseases is much longer. As a result, the costs incurred for the treatment and cure of this disease will be greater. This will greatly affect the high health costs.
5. Changes in the pattern of health services This change in the pattern of health services occurs due to scientific developments in the medical field so that specializations and sub-specialties are formed which cause health services to become fragmented health services and seem unrelated to each other. As a result, there is often overlapping or repetition of the same examination method and the administration of drugs to a patient, which of course has an impact on the increasing burden of costs that must be borne by patients as users of these health services. In addition, with the division of specializations and sub-specialties of health care workers, the number of days of care will also increase.
6. Changes in the Pattern of Doctor-Patient Relationships The family system that used to underlie the doctor-patient relationship seems to have disappeared. With the development of specializations and sub-specialties as well as the use of various

equipment supported by advances in science and technology, resulting in increased costs to be incurred by patients, this of course makes patients demand certainty of treatment and healing from their illness. This is exacerbated by the increasing level of education of patients as users of health services, which encourages their critical thinking and knowledge about health problems. The foregoing encourages doctors to often carry out excessive examinations (over utilization), for the sake of certainty of their actions in carrying out treatment and care, and also to reduce the possibility of errors made in diagnosing the disease suffered by their patients. The consequences that occur are the higher costs required by patients to obtain health services.

7. Weak cost control mechanisms Lack of legislation that is set to regulate and limit the use of health care costs causes their use to be often uncontrolled, which in turn will burden the insurer (company) and the community as a whole.

Misuse of health insurance is a mechanism for controlling health costs, following the recommendations implemented by the government. However, if it is applied incorrectly as is commonly found in conventional forms (third party systems) with a reimbursement system, it will push up health costs. There are many kinds of health costs because they all depend on the type and complexity of the health services provided and/or utilized. It's just that according to the distribution of health services, the health costs can be divided into two types, namely:

1) Medical service fee The intended cost is what is needed to organize and or utilize the service

medicine, which is primarily aimed at treating disease and restoring the patient's health.

2) The cost of public health services The costs in question are those required to organize and or utilize public health services, namely those whose main objectives are to maintain and improve health and to prevent disease. As with overall health costs, each of these health costs can also be viewed from two angles, namely from the point of view of the health provider and from the point of view of the service user (health consumer).

The strategy for achieving UHC is to ensure that all residents have access to quality health care. Health financing is a challenge for low and middle-income countries (LMIC) in realizing UHC. Budget allocations are highly dependent on macro-fiscal policies, sustainable economic growth, and high-income mobilization, and social factors resulting from the recession. So that a good macro-fiscal policy will increase the financing of health sector development. then obtaining health-specific income and efficient use of the budget will accelerate UHC.(Behera & Dash, 2019; Fullman et al., 2018)

A fair financing system is the certainty of payment for health services that follows the ability to pay and benefit from expenditures based on needs, but in practice social, political, and economic conditions greatly affect the way to achieve it. In addition, the selection of characteristics is a very useful tool for policy making and assessing the progress of equitable health financing. (Asante et al., 2019; Ataguba, 2016) Therefore, low- and middle-income countries introduce the concept of state-funded health that always puts the poor first to realize Universal UHC health insurance. (Virk & Atun, 2015) Therefore, to achieve UHC, a financing system is needed that provides prepaid resources collected for primary health services without burdening the poor. Then an assessment is made of how funding sources are used, the types of services purchased, and the health development assistance provided will be in

line with economic developments. (J. Dieleman et al., 2017; J. L. Dieleman et al., 2018) In addition, comprehensive and comparable estimates of health expenditures in each country are a key input for health policy and planning to achieve UHC. (Chang et al., 2019) Prepaid resources available for health can affect access to health care and health outcomes Estimating future expenditures can be useful to policymakers and planners and can identify financing gaps. (J. L. Dieleman et al., 2017)

The research found several challenges that must be faced in various countries, including (Chu et al., 2019):

1. The challenge of expanding health financing mechanisms in a fair and efficient manner
2. Increase surveillance
3. Accountability, strengthen the transition to domestic financing
4. Enabling evidence-based prioritization and benefit design processes.

In Bangladesh, there are still many obstacles in the health system, weak governance, and high mortality rates, as well as limited capacity, so these factors are a serious concern if you are to achieve UHC. (Islam et al., 2018) Micro Health Insurance or also known as CBHI is community-based health insurance that is often applied in poor and developing countries, especially in rural areas. Because without subsidized income, usually, expenses cannot exceed their premiums. On the other hand, Willingness-To-Pay (WTP) which is the ability to pay is not easy to use because it requires sufficient research to determine the amount of the specified ability. (Binnendijk et al., 2013)

The results of the study found several frameworks as variables in determining the criteria for payment of health financing to support UHC, namely (Vilcu & Mathauer, 2016) :

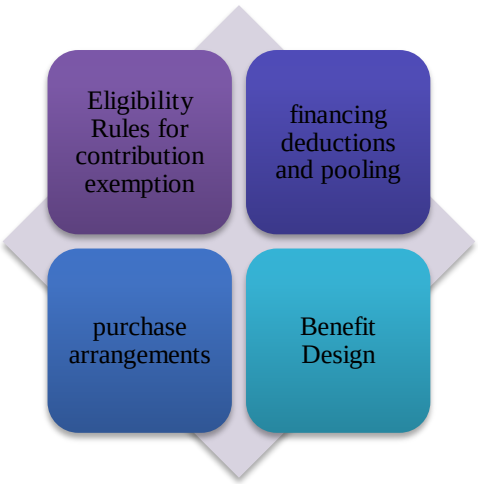

Figure 2. Criteria for payment of health financing to support UHC

In Thailand there are 2 tax-funded health financing schemes, namely the Universal Coverage Scheme (UCS) and the Civil Servant Medical Benefit Scheme (CMBS), the Ministry of Finance's General Financial Supervisory Department (CGD) manages CSMBS as a civil servant welfare program. Meanwhile, the Office of National Health Security (NHSO) manages the purchasing of UCS, which carries out various strategic purchasing actions, closes provider payments, promotes primary health care gatekeeper functions, exercises collective purchasing

power, and engages member views in decision making. everything goes towards realizing UHC. (Patcharanarumol et al., 2018)

The movement towards UHC is certainly a difficult problem for low-income countries to place macro and fiscal economy as a financing sub-sector, but this condition is not easy, policies have not been implemented so that the health sector is considered unimportant. (Cashin, 2016) Gaining an understanding of public finance for health in a macroeconomic environment is extremely difficult. (Barroy et al., 2017)

Financial resources are used for strategic purchases and optimally to achieve health system goals. This requires an adequate policy, legal and regulatory framework that integrates the implementation of strategic purchasing. In addition, the Ministry of Foreign Affairs responsible for finance and health must establish an effective, consistent, and harmonious coordination structure between buyers and service providers in the health system. (Munge et al., 2019)

Research has found that future health policies will be advantageous if their design is an integrated integration of all targeted and structured actions within a single organization from the governing body of the financing system. (Akhnif et al., 2019). In addition, to achieve UHC health coverage, countries must develop and review and evaluate the health system that has been created. Furthermore, from several studies, 9 principles must be considered in achieving UHC, namely: supervision, methods of increasing income and contributions, combining risk and financial protection, allocation of purchasing resources, human resources, policy makers, policy content, policy context, and policies. process. (Alipouri Sakha et al., 2016)

The role of health financing management institutions or institutions supported by appropriate laws and regulations is very important in increasing the success of the health financing system. (Mathauer & Carrin, 2011) Various reforms in the field of health financing and provisions to realize UHC has been carried out by several countries. These reforms greatly affected the ministry of health as the department responsible for public health and the national health care system. The results of the study found that 4 capabilities of the Ministry of Health changed organizations. (Berman et al., 2019)

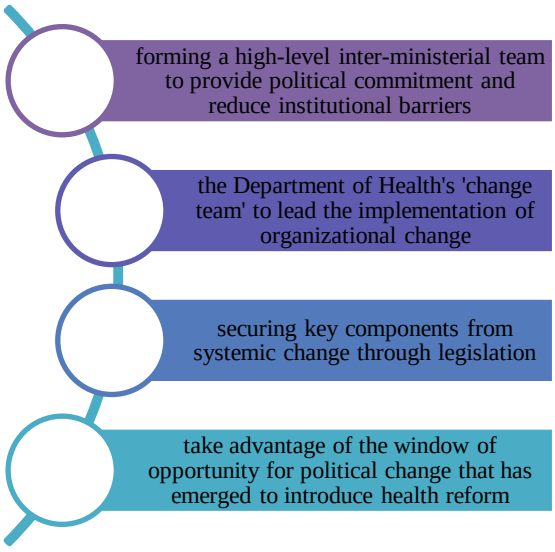

Figure 3. There are 4 capabilities of the Ministry of Health in changing the organization

In addition, technical cooperation from various countries is also needed to make health planning and financing a core area to realize UHC. (Robert et al., 2019)

At the practical level, it is not easy, for example, the salaries of the administrators of the Social Security Administration are said to be too high. Citing the 2019 Annual Budget Work Plan, the Health Social Security Administration has budgeted the incentive burden for directors of Rp 32.88 billion. If the board of directors is divided into eight, each member of the board of directors will get an incentive of Rp 4.11 billion per person. This means that all directors will receive an incentive of Rp 342.56 million per month.

Meanwhile, the cost of the supervisory incentives for the Health Social Security Administration is budgeted at IDR 17.73 billion per year. If divided into seven supervisory boards, each leader gets an incentive of Rp 2.55 billion. If it is averaged for 12 months, the incentive received by the supervisory board is IDR 211.14 million per month.

4. Discussion

The main driver of future overall health spending and by the source is economic development, which is often measured by GDP per capita. This technique is more reflective of the fact that health spending by the government is limited by the size of the government. These two stages of government spending modeling capture direct competition for scarce government resources between sectors. The potential for low- and middle-income countries to increase the amount spent on health by increasing the share of GDP spent by the government, increasing the share of the government budget spent on health, or both. This exploration of fiscal space to increase health spending was not completed earlier and is undertaken empirically by adjusting the frontier to the observed spending patterns at each level of development. (J. L. Dieleman et al., 2017) The results show that state revenues (direct taxes and indirect taxes) and central transfers (tax devolution) are the main providers of health care financing so that improvements to revenue collection that will effectively and efficiently finance health services are the focus that must be done. for the country. Low maintenance is a wonderful addition to health care. (Behera & Dash, 2018b) In addition, the combined mechanism is positively influenced by the fiscal size, so that health financing will increase if fiscal capacity and public finance policies improve. (Behera & Dash, 2018a)

In Indonesia, with conditions that are very turbulent in various ways at the moment, as well as with limited existing resources, the managed care system is the right choice in overcoming the problem of health financing. Managed care is considered appropriate for conditions in Indonesia, possibly because the managed care financing system is managed in an integrated manner with the financing system, with managed care meaning that the fund management agency (insurance company) does not only act as a payee, as applies to traditional insurance but also plays a role in two important things, namely service quality control (quality control) and cost control (cost containment). One of the elements of managed care is that services are provided by certain providers, namely those that meet the specified criteria covering aspects of administration, facilities, infrastructure, procedures, and work processes or in other terms covering business processes, production processes, facilities, products, and services. In this way, the fund manager (insurance) participates in controlling

the quality of services provided to its participants. The efforts to solve the problem of health financing are:

1. Efforts to increase funding sources, how:
   a. Government: increase the allocation of health costs in the State budget.
   b. For other agencies outside the government, it is collecting funds from community sources as well as from foreign aid sources.
2. Efforts to improve the distribution, utilization, and management of funds, essentially:
   a. Improvement of the service system.
   b. Improve the knowledge and skills of the workforce.
3. Efforts to control health costs (cost containment), al :
   a. Treating the certificate of need laws.
   b. Treat the feasibility study regulations (feasibility study).
   c. Treat development plan laws.
   d. Establishing health service standards (professional medical standards).
   e. Organizing a quality assurance program Implementing a rate regulation.
   f. Health insurance

At the practical level, the implementation of the national social security system organized by the Social Security Administering Body has different impacts on the stakeholders. Some parties feel benefited by this system, but some parties feel disadvantaged. The party who benefits the most is, of course, the poor who receive the contribution payment facility from the central government or local government. Then some feel disadvantaged.

As for the parties who feel aggrieved by the implementation of the paid health insurance financing system so that it does not fulfill a sense of justice for the community, including:

1. With the transfer of state responsibility to individuals or the people through contributions paid directly, or through employers for private employees, or by the state for civil servants. Then as a patchwork, the state pays contributions to the social security program for the poor. The transfer of state responsibility to individuals in social security matters can also be seen from the explanation of the Law on the principle of cooperation, namely: Participants who can (help) to participants who are less fortunate in the form of compulsory participation for all people; low-risk participants assist high-risk participants, and healthy participants help sick participants. So it is clear that this law wants to release the state's responsibility for social security or health.
2. The quality of service obtained for health insurance participants is not good paid in getting their rights so that they feel they do not fulfill a sense of justice, including:
   a. Difficulty getting an inpatient room because the rooms for health insurance participants are often full
   b. There are types of diseases and medicines that are not covered by the Social Security Administering Body so that the health insurance participants must bear it themselves
   c. Even though it should be free as long as it is following the class, participants sometimes still have to pay the excess ceiling

The National Health Insurance currently implemented in Indonesia is a social

insurance system. Health insurance is a social instrument to ensure that a person (member) can meet the needs of health care without considering the person's economic condition at the time the need for health services occurs. In countries that can provide health services for the entire population, health insurance is not needed at all. Health insurance is needed if the state does not provide the health services needed by its population or the state is only able to provide part of the health care needs. Indonesia is a developing country that does not provide all the fulfillment of health care needs but also does not give it to the community at all.

The application of social insurance in Indonesia has not yet reached the root of the problem because administrative problems in Indonesia are still very chaotic. The recording of population data related to social data is still far from accurate. So there are still many people who are not reached by population data, which in terms of social conditions is very worrying. As a result, when the community wants to obtain health services, administrative problems will form such as the absence of an Identity Card, clarity on the status of the Health Social Security Administering Body card or the Healthy Indonesia Card, and so on. So the affordability aspect is still a problem.

Then, related to services received by the community, there are still problems with premiums that should be borne by the government but are not recorded. This resulted in the non-active of the community guarantee. From the service side, there are still differences in the services obtained, including differences between treatment rooms for classes I, II, III, and rooms above class I. Class III treatment rooms, especially in the government, are still identical with treatment for community groups receiving contribution assistance (PBI). or those categorized as poor people, while the treatment rooms above have differences. This difference will also be seen in government and private hospitals. This is because the hospital certainly does not provide certainty of proper payment for these caregiving professionals, which has an impact on the quality of service received by the community. Financing should reach certainty to the comfort of professionals to provide the best service.

As for the mandatory membership health insurance, it is regulated in Article 6 paragraph (1) of Presidential Regulation Number 111 of 2013 that: "Health Insurance participation is mandatory and covers the entire population of Indonesia". Based on the description above, it can be seen that the right to health is a basic social right that will be realized through the Health Insurance Program, meanwhile, every person and every company, both private and public, without exception is obliged to become a participant in the national health insurance program. Therefore, it is interesting to study what if the obligation of a company or corporation to realize the right to health is related to the provisions on corporate social and environmental responsibility or Corporate Social Responsibility (CSR), which is also a mandatory provision, as regulated in Article 74 of the Law. Law Number 40 of 2007 concerning Limited Liability Companies

The types of health financing are seen from the distribution of separate health services on:

1. Medical service costs are costs for administering and/or utilizing medical services whose main purpose is to lead to treatment and recovery with funding sources from the government and private sectors.
2. The cost of public health services is the cost to organize and/or utilize public health

services whose main objective is to improve health and prevention with funding sources mainly from the government sector.

The outcome of the National Health Insurance Program is the tangible result of the output of an activity and is a measure of the performance of a program in meeting its targets. The outcome is a measure of performance based on the level of success to be achieved based on the objectives of the program or activity that has been implemented.

Law No. 40 of 2004 concerning the national social security system, article 6 states that "for the implementation of the national social security system, a national social security council shall be established with this law." While Article 7 of Law no. 40 of 2004 on the national social security system. Article 19 of the Law on the National Social Security System states that the principles of social insurance are as follows:

1. Cooperation between the rich and poor, the healthy and sick, the old and young, and the high and low risk.
2. Participation is mandatory and non-selective.
3. Contribution based on the percentage of wages/income.
4. Non-profit. The equity principle in question is equality in obtaining services following medical needs related to the number of contributions that have been paid.

The commonality of access to services is the similarity of financial reach to health services. The service costs covered by the Health Social Security Administration at the first level facilities are the maximum capitation costs at the Puskesmas based on the available capitation norms.

From the findings above, it can be concluded that coordination and integration of all elements in the health financing system are needed. The same thing can be explained that there needs to be a strengthening of state regulations and coordination as well as a strong role of state finances and political and technical support to realize UHC. (Gautier & Ridde, 2017) In addition, health financing is a measure of the extent to which the collection and flow of funds determine the right to health services, and this is where donors become a determining part of the health system going forward.(Bertone et al., 2018; Kiendrébéogo & Meessen, 2019) Recent findings have found that low- and middle-income countries do not find it easy to meet international targets set by UHC, even though their health systems are efficient, so developed country standards remain unless there is a strong and fundamental policy from the authorities. (J. L. Dieleman et al., 2016) Inadequate and inefficient public health services will also have an impact on the shortage of health workers and of course, will also have an impact on a large disease burden, both due to pandemics and weather changes. (Hassan et al., 2016)

To address this gap, Italy tries to focus on promotive and rehabilitative concepts. The findings of the application of a combination of a healthy lifestyle and a universal health system, both of these are important concerns, a healthy lifestyle in guiding many citizens will burden public health financing. (Monasta et al., 2019) The problem of listening time and the availability of expensive drugs for chronic diseases are often problems and the victims are patients, so a comprehensive management and financing system is a way out if you want to achieve justice for the poor. (Vijayasingham et al., 2019) Social health insurance as the key to universal care and financial protection for the poor still bears the burden of disease and enormous costs. Various facilities and systems were created to implement the social health insurance system, some of which are examples(Fenny et al., 2018):

Tabel 1. Population coverage rates

Country	(Social) health insurance enrolment rate of the total population	Population groups among which some individuals are more likely not to be enrolled	Exempted as a share of			Year
			Total population	Insured population	Eligible population	
Croatia	98.4 %	n/a	64%b	65%b	n/a	2008
Czech Republic	99.9%	Individuals from the Roma ethnic group	58%	58%	100%	2011
Estonia	93.9%	Long-term unemployed	4,9% b (2011)	5,3%b	n/a	2014
		Men that do not belong to the economically active population between 30 and 50 years				
Hungary	96.0%	Individuals from the Roma ethnic group	n/a	n/a	n/a	2013
Poland	91.6%	Poor	n/a	n/a	n/a	2013
		Homeless				
		Children of uninsured parents				
		Youngsters kept in holding facilities				
Slovakia	94.6%	Individuals from the Roma ethnic group	61.5%b (2011)	63.5%	n/a	2013
Slovenia	100%	n/a	n/a	n/a	n/a	2013

[a]data are taken from OECD, if not otherwise indicated
[b]Authors' calculations based on data from countries' Statistical Office or Health Insurance Fund report

Good management arrangements and financing systems are the state's obligation to realize sustainable health needs for its citizens. (Bello et al., 2018) These recommendations require new alternatives that need to be considered in the study of the health system by paying attention to the health promotion system as an example of the concept in Italy. On this basis, equitable health financing is very important in realizing UHC and the SDGs' sustainable development goals. Several low-income countries (LMICs) are undertaking various UHC reforms.(Asante et al., 2019; Fenny et al., 2018) Many Asian countries use prepaid financing mechanisms with government subsidies to reduce out-of-pocket payments, but on the other hand, this condition presents many challenges in its implementation, both at the implementation stage and in the management and expansion of social health insurance. In addition, stagnant economic growth becomes a problem when the government continues to be burdened by high costs so that limited, efficient, and effective elections become a determining factor in policymaking in the field of health spending. In addition, an accountable monitoring and maintenance mechanism is also an important factor in realizing a fair financing system. (Chu et al., 2019) With a commitment to expanding universal health coverage, dimensions identified from the literature can help policymakers to prioritize competing demands, make rational choices, and adapt their approaches. Transferring policies and adapting them to local conditions helps governments make better policy decisions, and proceeds wisely in the face of challenges that countries must face if they are to achieve UHC. (Alipouri Sakha et al., 2016) To accelerate UHC, public finance should be central to research, tracking budget allocations from domestic sources, and relative and absolute measures for appropriate health spending. (Barroy et al., 2017)

5. Conclusion

From the results of the overall discussion, it can be concluded that; health financing policy turns out that there are still many obstacles including the lack of funds for health services and standard medicines. Thus, these conditions reduce the quality of health services to the community or patients. In addition, many regulatory policies are not able to regulate an adequate service system. Therefore, in this study, researchers provide policy recommendations and an integrated financing system that aims to create an effective and efficient financing system to create an equitable distribution of health services to realize UHC.

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