Challenges And Implementation Of Universal Health Coverage Program In Indonesia

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Abstract.
The existence of Universal Health Coverage (UHC) implementation means that everyone in Indonesia will have access to the health services they need, when and where they need it, without financial hardship. It covers a wide range of essential health services, from health promotion to prevention, treatment, rehabilitation and miscellaneous care. Many countries are already making progress towards UHC, although the ubiquity of the global covid-19 pandemic is impacting the availability of health systems' ability to provide undamaged healthcare. All countries can take action to move more quickly towards UHC despite the setbacks caused by the pandemic, or to maintain the gains they have made. Indonesia continues to strive to realize Universal Health Coverage (UHC) through the implementation of the National Health Insurance-Healthy Indonesia Card (JKN-KIS) program whose program has been implemented by the government since 2014. Since the enactment of the policy on providing health services for the community through the National Health Insurance and the Healthy Indonesia card (JKN-KIS) by the Government, there have been more than 40 million people who have not been registered as participants in the National Health Insurance-Healthy Indonesia Card (JKN-KIS) program. This study uses a qualitative method by making a literature review with the aim of making it affordable for those whose health has not been protected through JKN-KIS services. As a recommendation in efforts to accelerate the achievement of UHC, the government must be committed to reducing the level of inequality between provinces and regions as well as regions in Indonesia, by building better health infrastructure and facilities, including a more even distribution of health workers in provinces with a UHC service coverage index that is still low.

Keywords: *Health insurance, health coverage, JKN-KIS, universal health coverage (UHC).*

I. INTRODUCTION

The state gains authority and legitimacy from society to maintain harmony, protect private and community rights and realize shared happiness or often call as *bonum comune*. In the practice of the state, state administrators have an obligation to fulfill all basic human needs in accordance with the essence of a complete human being, namely the entire human person consisting of body and soul. Aristotle stated about the obligations of this state in his writings known as the Nicomachean Ethics[1].The implementing universal health coverage (UHC) for all Indonesians in the health sector, the state is the only foundation and hope for the community during the covid-19 pandemic which has claimed many lives at this time. As the purpose of the formation of the state, individuals and communities have the right to obtain security guarantees, safety of life and property from natural threats and opponents who come from outside their community. In the modern life system, the state must fully guarantee the rights to individual and community freedom of citizens (civil society), the safety and security of property, as well as body and soul. These rights are known as basic rights that are given, which in the context of the development of a modern state are then referred to as fundamental rights or human rights[2][3]. Likewise, during the covid-19 pandemic that hit almost all countries in the world today, health is a primary need for every individual and society. The state as the person in charge of the safety of all its citizens is required to ensure and protect the health of the body and soul of all citizens and residents in its territory. The government as the executor of the responsibilities, functions and duties of the state in the implementation of public services must work hard to overcome the pandemic outbreak.

In the practice of living as a state in Indonesia, service facilities and financial support for the fulfillment of guarantees for the implementation of public health are one of the responsibilities of the state in realizing general welfare. As a means of supporting the fulfillment of public health, the Government has established the National Social Security System-Healthy Indonesia Card (SJSN-KIS) with the Social

Security Administering Body (BPJS), as the institution that manages the implementation of health insurance and services for the community[4].The Social Security Administering Body (BPJS) was formed by the Government, as a transformation of PT Askes (Persero). This started in 2004, when the Government issued Law Number 40 of 2004 concerning the National Social Security System (SJSN). As a follow-up, in 2011, the Government enacted Law Number 24 of 2011 concerning the Social Security Administering Body (BPJS), and appointed PT Askes (Persero) as the organizer of the social security program in the health sector, so that later PT Askes (Persero) changed its status to BPJS Health[5].Through the National Health Insurance Program-Healthy Indonesia Card (JKNKIS) organized by BPJS Kesehatan, the state is here to ensure that all Indonesians are protected by comprehensive, fair and equitable health insurance. Since the implementation of the policy for providing health services for the community through the National Health Insurance and Healthy Indonesia Card (JKN-KIS) by the Government, it has been recorded that around 40 million people have not been registered as participants in the National Health Insurance-Healthy Indonesia Card (JKN-KIS) program. That means, their health has not been protected through the JKN-KIS service. Therefore, Universal Health Coverage (UHC) must be the goal of providing public health services[6].Universal Health Coverage is a health insurance system that ensures that every citizen in the population has equitable access to promotive, preventive, curative and rehabilitative health services, of good quality at affordable costs.

UHC contains two core elements, namely: Access to fair and quality health services for every citizen, and protection of financial risks when citizens use health services. The definition of UHC above is the embodiment of three interrelated things, namely: 1). Equal access to health services, everyone in need will get health services, not only for those who can afford it, 2). The quality of health services is good and continues to increase for participants who receive services and 3). Ensure that the cost of health services used does not make the community in financial / financial loss. The government as the executor of public health services has an obligation to implement the goals of UHC, namely: access to comprehensive health services for all citizens. In the Universal Health Coverage (UHC) system, the Government has the obligations, responsibilities and duties of the government to realize the implementation of health services for the entire community in a fair and equitable manner. Communities in all corners of the region have the same rights to be able to access health care insurance by the state[7][8].WHO has agreed to achieve Universal Health Coverage (UHC), which is an important issue for developed and developing countries today, so it is important for a country to develop a health financing system with the aim of ensuring health for all people in the world. This provision is important to ensure equitable access for all citizens, to preventive, promotive, curative and rehabilitative health services at affordable costs[9]. Universal Health Coverage (UHC) is a crucial issue in many countries, especially with the covid-19 pandemic which has brought disruption to various sectors, one of which is the health insurance system. The most important key in realizing UHC is the government's commitment to protect all residents through health insurance, including Foreign Citizens (WNA) who work for a minimum of six months in Indonesia[10][11].

Currently JKN-KIS participants have reached 226.7 million people or about 83% of the total population of Indonesia. In addition to government support through regulations that require all residents to be registered in the JKN-KIS Program, BPJS Health is also proactively advocating for residents from various segments to become JKN-KIS participants. Synergy between institutions is also strengthened to enforce compliance, especially from the formal sector. In the Extending Social Health Protection in the Asia-Pacific Region towards Universal Health Coverage[12]. In years, UHC means that everyone can access the quality health services they need without financial difficulties. Based on this definition, the challenges faced by various countries in the world today are how social health insurance can cover the entire population in a country, how to ensure population access to social health insurance, and how to provide quality service guarantees[13]. Another major challenge is how to maintain the sustainability of the health insurance program. Poverty and social food challenges us to ascertain whether social health insurance covers all the population. Affordable health insurance or government-funded health services, is very important to protect the public. This issue is also a concern in the United Nations' 2030 agenda for Sustainable

Development[14].Since 2004, the Indonesian government has been trying to establish a health insurance system that covers all Indonesians. One of the efforts taken is to promote the JKN program which is managed by BPJS. The achievement of UHC through the social insurance mechanism is so that health financing can be controlled so that health financing guarantees are certain and continuously available which in the end achieves social justice for all Indonesian people[15].

II. METHODS

This research is a literature study which is part of a qualitative research related to the research subject. The research is descriptive of social phenomena in detail. Based on this research, the research objective is to describe the development of health insurance and health services for UHC implementation in Indonesia. The data collection technique used by researchers in collecting data and information is to take secondary data whose information comes from the official website of the Ministry of Health of the Republic of Indonesia, government regulations, and the internet data studies[16]. As well as other supporting data obtained by in-depth interviews with experts to confirm the completeness of the policies or related data involved in this research. The method used in this study with journals literature reviews, which aims to describe the impact of the existence of UHC and JKN-KIS on insurance company in Indonesia. The data collection technique used is to collect data and information, namely by secondary data collection techniques where the information comes from internet, government officially websites, and also related scientific journals[17].

III. RESULT AND DISCUSSION

In Indonesia, the philosophy and foundation of the state, Pancasila, especially the 5th precept, recognizes the human rights of citizens to health. This right is also enshrined in the 1945 Indonesia Constitution (UUD) article 28H and article 34. It is even clearer in Law No.39/1999 which emphasizes that everyone has the same rights in obtaining access to resources in the agricultural sector. health and obtain health services that are safe, quality, and affordable[18]. On the other hand, everyone also has the obligation to participate in the social health insurance program. The cost of dependents for health is very unpredictable both in amount and when the cost is needed, therefore a guarantee in the form of health insurance is needed where participants pay premiums at a fixed amount. The fixed premiums collected in mutual cooperation will later be used to cover health costs for participants in need so that they do not burden individuals. To ensure sustainability related to efforts to guarantee and protect all citizens, participation is mandatory for all Indonesian citizens[19].

3.1 Definition of JKN in Indonesia

The National Health Insurance or commonly abbreviated as JKN is part of the National Social Security System (SJSN) which is implemented using a mandatory health insurance mechanism or must be followed by all Indonesian citizens to meet the basic needs of public health properly given to every citizen. have paid premiums/contributions or for residents who cannot afford the premiums will be paid by the Government. There are at least 5 components in SJSN[20], including:

a. Health insurance
b. Accident insurance
c. Pension plan
d. Pension guarantee
e. Life insurance

3.2 Definition of BPJS

BPJS is an acronym for Social Security Administering Body. If we look closely at the name, we will immediately understand that BPJS is an entity[21][22]. BPJS is a legal entity or company that is responsible for administering social security. Most people will immediately associate BPJS with health services or hospitals. However, as explained in Law No. 24 of 2011 concerning BJPS, there are two types of BPJS, namely BPJS Health and BPJS Employment. As a company BPJS health comes from the ASKES company structure, while BPJS Employment comes from Jamsostek, Taspen, and Asabri which are merged. If BPJS

Kesehatan has changed its name and started operating on January 1, 2014, BPJS for Employment will only be fully operational from July 1, 2015. BPJS Health membership consists of two groups, namely the able and the poor[23]. The able-bodied group will pay the premium according to what is determined every month and for the poor group the premium will be paid by the state and is called the Contribution Assistance Recipient (PBI).

3.3 Definition of KIS

KIS or Healthy Indonesia Card is an identity card for BPJS Health membership. There are still many who think that KIS is only intended for poor people so that they can access health services for free. But actually, since March 1 2015, all Indonesian citizens will have a KIS as a form of identity for BPJS Health membership[4][24]. It's easier like this, JKN is the name of the program, BPJS is the name that organizes the program and KIS is the name of the membership card.

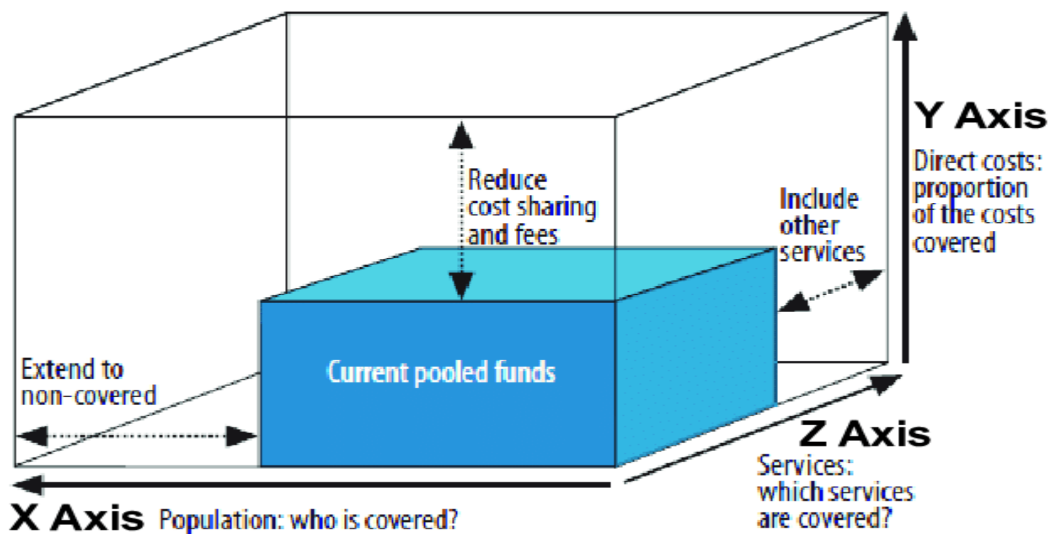

Fig 1. The Three Dimensions of WHO UHC Cube.

Abbreviations: WHO, World Health Organization; Universal Health Coverage

Through the provisions of the Articles above Law No. 24 of 2011 concerning the Social Security Administering Body indirectly, it does not provide a choice for consumers to choose the insurance product they want. When compared with the provisions of Article 14 to Article 17 of Law No. 24 of 2011 concerning Social Security Administering Bodies, this law is imperative (coercive) without giving consumers a choice, it is feared that this will have an impact on the abuse of the dominant position as regulated in Article 25 of Law No. 5 of 1999 concerning Prohibition of Monopolistic Practices and Unfair Business Competition due to the granting of monopoly rights granted by the government to BPJS. In the future, the products of private insurance companies will still be in demand by the public. What's more, the products offered are of a higher grade than BPJS health, the existence of BPJS health is not a concern for private insurance companies in Indonesia.

3.4 Definition of Universal Health Insurance Coverage (UHC)

The term universal coverage comes from WHO (World Health Organization), more precisely universal health coverage. Universal coverage can be interpreted as comprehensive coverage. The term is actually a continuation of the previous jargon, namely health for all. WHO formulates three dimensions in achieving universal coverage which are depicted by cubes (Figure1). The three dimensions of universal coverage according to WHO are (1) how large the percentage of the population is guaranteed; (2) how complete is the guaranteed service, and (3) how big is the proportion of direct costs that are still borne by the population. The first dimension is the guaranteed population. The second dimension is guaranteed health services, for example whether only services in hospitals or including outpatient services. The third dimension is the proportion of guaranteed health costs. The more funds available, the more people are served, the more comprehensive the service package and the smaller the proportion of costs that must be borne by the

population[7]

The limited allocation or collection of funds affects whether or not the guaranteed services are comprehensive and the proportion of guaranteed medical/care costs. The UK for example guarantees comprehensive health services, including organ transplantation, for the entire population (not just citizens, but residents legally living in the UK). Malaysia guarantees that all its residents receive treatment and treatment in hospitals, only that resident have to pay 3 RM (approximately Rp. 9,000) per day of treatment. Thailand has guaranteed its entire population (dimension I), for all diseases (dimension II) at no cost to the population (dimension III) and services are provided in public health facilities as well as in private health facilities[25].

The achievement of universal coverage with these three dimensions varies between countries, depending on the political will and financial capacity of the country concerned. The richer a country is, the more capable it is of guaranteeing the entire population to all health services[26]. The period of time required to achieve universal coverage through social health insurance also varies from country to country. Austria, for example, achieved universal coverage within 79 years of the first law on health insurance. Belgium achieved universal coverage in 118 years, Costa Rica (20 years), Germany (127 years), Japan (36 years), South Korea (26 years) and Luxembourg (72 years).

The speed at which universal coverage is achieved through social health insurance is influenced by several factors. There are five factors that affect the speed at which a country can achieve universal coverage. First, the income level of the population. The higher the income level of the population, the higher the ability of the population and employers to pay contributions (premiums). The more stable the economic growth, the higher the capacity of the country to provide social health insurance. Second, the economic structure of the country is mainly related to the large proportion of the formal and informal sectors[15][27].

The economies of developing countries are generally still dependent on the agricultural, trade and service sectors, most of which are informal workers. This condition makes it difficult to collect contributions because workers do not receive formal salaries. Third, the distribution of the country's population. The wide distribution of the population to various regions results in higher administrative costs than if the population is concentrated in certain areas. Managing social health insurance in urban areas with a high population density tends to be easier than if managing it in rural areas where the population is widely spread to outlying areas that are difficult to reach. Fourth, the state's ability to manage social health insurance. The implementation of health insurance requires adequate skilled resources.

Therefore, the implementation of social health insurance must be supported by skilled workers who understand various aspects of the implementation of health insurance. Fifth, the level of social solidarity in society. This level of solidarity is necessary because the social health insurance system is built on the principle of gotong royong, namely the rich help the poor, the healthy help the sick, the productive help the unproductive or unproductive[28]. These five factors need to be considered by the government in making guidelines and rules (stewardship) in achieving universal health coverage through social health insurance.

3.5 Relationship to Universal Health Coverage

UHC stands for Universal Health Coverage or after being translated by the Indonesian Ministry of Health in the 2015-2019 Indonesia Ministry of Health (MOH) Strategic Plan to become “Universal Health Insurance” and has been implemented in Indonesia since the JKN program was implemented in January 2014. In general, UHC is a health system that ensures every citizen has fair access to quality promotive, preventive, curative and rehabilitative health services at affordable costs[19]. There are two core elements in UHC, namely access to fair and quality health services for every citizen, and protection of financial risks when residents use health services. By definition, there are three objectives of UHC, among others:

1. Equality in accessing health services, everyone will get the services they need, not only limited to those who can pay for these services,
2. The quality of health services provided must be good enough so that the health conditions of service recipients will get better,
3. The community is protected from financial risk, ensuring that the costs incurred will not have a significant impact on the financial condition of the service recipients.

Based on data obtained from the Indonesia BPJS Health website, December 2017, the number of JKN participants had reached 187,982,949, which means that the number of Indonesian citizens who had become JKN participants reached 72.9% of the total population in Indonesia. This means that there are still 27.1% that have not been registered as JKN participants, so that to achieve UHC's goals, in addition to improving the quality of services in health services, it is also by expanding the coverage of participation by ensuring that all Indonesian citizens become participants in the JKN program[29].

IV. CONCLUSION

The data research that has been done it can be concluded that Universal Health Coverage can be interpreted as comprehensive coverage. The term universal coverage comes from the World Health Organization, more precisely universal health coverage, which means that all individuals and communities receive the health services they need without experiencing financial difficulties. It covers the full spectrum of essential and quality healthcare services, from health promotion to prevention, treatment, rehabilitation and palliative care throughout the life course. The delivery of these services requires adequate and competent health and care personnel with an optimal mix of skills at the facility, outreach and community levels, and who are equitably distributed, adequately supported and enjoy decent work. The UHC strategy enables everyone to access services that best match the causes of significant illness and death and ensures that the quality of those services is good enough to improve the health of those who receive them[13].WHO formulates three dimensions in achieving universal coverage which are depicted by cubes (Figure1). The three dimensions of universal coverage according to WHO are (1) how large the percentage of the population is guaranteed; (2) how complete is the guaranteed service, and (3) how big is the proportion of direct costs that are still borne by the population. The first dimension is the guaranteed population. The second dimension is guaranteed health services, for example whether only services in hospitals or including outpatient services. The third dimension is the proportion of guaranteed health costs. The more funds available, the more people are served, the more comprehensive the service package and the smaller the proportion of costs that must be borne by the population. The limited allocation or collection of funds affects the comprehensiveness of the guaranteed services and the proportion of guaranteed medical/care costs[17].

The achievement of universal coverage with these three dimensions varies between countries, depending on the political will and financial capacity of the country concerned. The richer a country is, the more capable it is of guaranteeing the entire population to all health services. The period of time required to achieve universal coverage through social health insurance also varies from country to country. The speed with which universal coverage is achieved through social health insurance is influenced by several factors. There are five factors that affect the speed at which a country reaches universal coverage[30].

First, the income level of the population. The higher the income level of the population, the higher the ability of the population and employers to pay contributions (premiums). The more stable the economic growth, the higher the capacity of the country to provide social health insurance. Second, the economic structure of the country is mainly related to the large proportion of the formal and informal sectors. The economies of developing countries are generally still dependent on the agricultural, trade and service sectors, most of which are informal workers. This condition makes it difficult to collect contributions because workers do not receive formal salaries. Third, the distribution of the country's population. The wide distribution of the population to various regions results in higher administrative costs than if the population is concentrated in certain areas. Managing social health insurance in urban areas with a high population density tends to be easier than if managing it in rural areas where the population is widely spread to outlying areas that are difficult to reach[31].

Fourth, the state's ability to manage social health insurance. The implementation of health insurance requires adequate skilled resources. Therefore, the implementation of social health insurance must be supported by skilled workers who understand various aspects of the implementation of insurance health. Fifth, the level of social solidarity in society. This level of solidarity is necessary because the social health insurance system is built on the principle of “gotong royong”, namely the rich help the poor in Indonesia. The concept of the healthy help the sick, the productive help the unproductive or unproductive. These five factors need to be considered by the government in making guidelines and rules (stewardship) in achieving universal health coverage through social health insurance (SHI).

There are some important notes that deserve attention and followed up in order to find a better solution related to UHC in the JKN Program. The JKN program which is a mandate The SJSN Law and BPJS Law have been in effect since 2014 (about five years), but until now the program has not been fully

able to achieve UHC nationally as targeted. Still need to follow up to achieve the real UHC. It takes hard work to reach UHC at all costs and the consequences. The UHC target in Indonesia is a reference for implementation of the JKN program and BPJS Health need to continue to improve expected health services. With the achievement of UHC, it is hoped that all Indonesian people have health insurance reliable. If this condition is met, then it is expected that social welfare will follow. In addition to the membership number, what is more important in the JKN Program is a public health service.

The achievement of the UHC number is not will be meaningful if the community does not get services good health, namely services that can meet needs basic public health according to medical indications professional. Utilization of health services in the JKN Program will be one of the benchmarks for the success of the JKN Program, where when people feel helped & facilitated in service, then the JKN program can be called successful. Recommendations put forward for improvement of implementation the JKN programs are:

1. BPJS health needs to continue to strive complete the JKN program participation numbers up to UHC 100%. This effort needs to be supported by all relevant institutions from central to regional level;
2. BPJS health with partners work needs to continue to improve the quality and quantity of service health so that the community can take full advantage of the JKN Program optimal;
3. The DPR of Republic Indonesia, needs to continue to carry out its duties and functions (legislation, oversight, and budget) in order to oversee the sustainability of the JKN Program, in order to create a system national social security that is able to protect and guarantee public health in Indonesia.

V. ACKNOWLEDGMENTS

The authors are grateful to the best research team support and for the invaluable advices from the university.

REFERENCES

[1] R. Agustina *et al.*, “Universal health coverage in Indonesia: concept, progress, and challenges,” *The Lancet*. 2019, doi: 10.1016/S0140-6736(18)31647-7.

[2] H. T. Indra Rachmad Darmawan, “Refleksi Implementasi Jaminan Kesehatan Nasional pada Pelayanan Kedokteran Gigi di Fasilitas Kesehatan Tingkat Pertama Kota Tangerang Tahun 2017,” ***Jurnal Kebijakan Kesehatan Indonesia :*** *JKKI*. 2017.

[3] E. P. Mahadewi, “Faktor-Faktor yang Mempengaruhi Pemberian ASI Ekslusif di Puskesmas Kecamatan Grogol Petamburan, Jakarta Barat Tahun 2016,” *Kesehat. Masy.*, 2016.

[4] A. D. Intiasari, J. Hendrartini, and L. Trisnantoro, “Analisis pola pemanfaatan jaminan pembiayaan kesehatan era Jaminan Kesehatan Nasional pada peserta non PBI mandiri di wilayah perdesaan Kabupaten Banyumas,” ***Jkki,*** 2016.

[5] BPJS Kesehatan, “PANDUAN PRAKTIS TENTANG KEPESERTAAN DAN PELAYANAN KESEHATAN YANG DISELENGGARAKAN OLEH BPJS KESEHATAN BERDASARKAN REGULASI YANG SUDAH TERBIT,” ***J. Vis. Lang. Comput.***, 2015.

[6] BPJS, “BPJS Kesehatan,” *Badan Penyelenggara Jaminan Sosial*, 2017. .

[7] M. Lagarde, “Health Care Financing: Provider Payments,” in *Introduction to health economics.*, 2011.

[8] R. Town and S. Liu, “The Welfare Impact of Medicare HMOs,” ***RAND J. Econ.***, 2003, doi: 10.2307/1593785.

[9] C. F. Hofacker, E. C. Malthouse, and F. Sultan, “Big Data and consumer behavior: imminent opportunities,” ***J. Consum. Mark.,*** 2016, doi: 10.1108/JCM-04-2015-1399.

[10] F. B. . Anderson GF, “Health Spending In OECD Countries : Obtaining Value Per Dollar . Health Affairs 2008 ; 27 (6): 1718-1727 .,” *Health Aff. (Millwood).*, 2008.

[11] E. P. Mahadewi, A. Heryana, and S. Kuswanti, “Kepuasan Layanan Pasien Jkn Berhubungan Dengan Kinerja Petugas Kesehatan,” ***J. Bunga Rampai,*** 2019.

[12] F. Di Gennaro *et al.*, “Coronavirus diseases (COVID-19) current status and future perspectives: A narrative review,” ***International Journal of Environmental Research and Public Health.*** 2020, doi: 10.3390/ijerph17082690.

[13] E. P. Mahadewi, A. Heryana, Y. Kurniawati, and I. Ayuba, “Analisis Waktu Tunggu Pelayanan Poliklinik Paru di Rumah Sakit Umum Daerah (RSUD) Tangerang,” ***Gorontalo J. Public Heal.***, 2019, doi: 10.32662/gjph.v2i1.463.

[14] H. Thabrany, “Politics of National Health Insurance of Indonesia : A New Era of Universal Coverage,” *7th Eur. Conf. Heal. Econ.*, 2008.

[15] E. Mahadewi, A. Heryana, . Herwanto, R. Astini, and N. Surip, “Marketing Mix Study using Social Media in Hospital,” 2020, doi: 10.5220/0009826004060413.

[16] A. Jenis, D. Penelitian, and J. Penelitian, “BAB III METODE PENELITIAN A. Jenis dan Desain Penelitian 1. Jenis Penelitian,” pp. 52–77, 2007.

[17] W. Quentin *et al.*, “Paying hospital specialists: Experiences and lessons from eight high-income countries,” *Health Policy (New. York).*, 2018, doi: 10.1016/j.healthpol.2018.03.005.

[18] W. Quentin, D. Scheller-Kreinsen, M. Blümel, A. Geissler, and R. Busse, “Hospital payment based on diagnosis-related groups differs in Europe and holds lessons for the united states,” *Health Aff.*, 2013, doi: 10.1377/hlthaff.2012.0876.

[19] D. C. Hsia and C. A. Ahern, “Good quality care increases hospital profits under prospective payment,” *Health Care Financ. Rev.*, 1992.

[20] L. Trisnantoro, “Trend pembiayaan kesehatan di berbagai negara,” *Modul 6 Trend Pembiayaan Kesehat.*, 2007.

[21] E. P. Mahadewi and A. Heryana, “Analisis Perilaku Pemberian ASI Eksklusif Di Puskesmas Bekasi,” ***Gorontalo J. Public Heal.***, 2020, doi: 10.32662/gjph.v3i1.850.

[22] E. Puspitaloka Mahadewi, I. Putri Yanuarti, A. Heryana, and R. Kusumapradja, “The Effect of Exclusive Breastfeeding in Grogol Petamburan Health Center,” 2020, doi: 10.5220/0009950026572662.

[23] B. Murti, “Asuransi Kesehatan Berpola Jaminan Pemeliharaan Kesehatan Masyarakat di Era Desentralisasi Menuju Cakupan Semesta,” *Inst. Heal. Econ. Policy Stud. (IHEPS). Univ. Sebel. Maret*, 2011.

[24] F. Tania and H. Thabrany, “Biaya dan Outcome Hemodialisis di Rumah Sakit Kelas B dan C,” ***J. Ekon. Kesehat. Indones.*,** 2017, doi: 10.7454/eki.v1i1.1763.

[25] The Joint Commission, “National Patient Safety Goals Effective January 1, 2016. Hospital Accreditation Program.,” ***Jt. Comm.***, 2016.

[26] Joint Commission International, “JCI Accreditation Standards for Hospitals,” ***Jt. Comm. Int. Accredit. Stand. Hosp.***, 2015.

[27] WHO, “Together on the road to universal health coverage: A call to action,” *World Heal. Organ.*, 2017.

[28] Marhaeni, Z. Fanani, B. Hartono, and B. A. Nugroho, “The influence of the marketing mix (Product, price, promotion, place, process, entrepreneurs and physical evidence) to customer satisfaction and loyalty in buying shredded beef in Palu City, Indonesia,” ***Int. J. Econ. Res.*,** 2015.

[29] A. Ambarriani, “Hospital Financial Performance In the Indonesian National Health Insurance Era,” *McKinsey Q.*, 2014.

[30] T. Şahin, S. Ocak, and M. Top, “Analytic hierarchy process for hospital site selection,” *Heal. Policy Technol.*, 2019, doi: 10.1016/j.hlpt.2019.02.005.

[31] H. Li and P. Hilsenrath, “Organization and finance of China’s health sector: Historical antecedents for macroeconomic structural adjustment,” *Inq. (United States)*, 2016, doi: 10.1177/0046958015620175.