ANALYSIS OF THE DISTRIBUTION OF HEALTH SERVICES FOR THE AVAILABILITY OF HEALTH FACILITIES IN THE IMPLEMENTATION OF HEALTHCARE *BPJS* IN SPECIAL REGION OF YOGYAKARTA

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In 2014, the commencement of the National Health Insurance was carried out in stages towards Universal Health Coverage, in which the public can easily access health services and obtain quality health care insurance. As time goes by, problems arises from various lines, such as, limited health care providers, widespread population distribution and limited access, causing lack of supply (service provision) by the government and other parties, resulting in difficulties to access health facilities. The availability of health services depends on the infrastructure in the community. Without any improvement in the infrastructure, the distribution of health services is difficult and the implementation of health insurance for the community is not real. The policy for implementing the National Health Insurance by Healthcare and Social Security Agency (BPJS) has not been able to improve access to health services and guarantee quality health services to all Indonesians with the principle of justice.

Keywords: health facilities, equity, health services, healthcare *BPJS* implementation.

INTRODUCTION

Health services for Indonesian community are regulated in Article 28 H paragraph (1) of the 1945 Constitution of the Republic of Indonesia which stipulates that the right of citizens is to obtain health services. Provision of health services is related to the values that uphold the dignity of Indonesian people, while the determination of the right to obtain health services is an embodiment of the principle of social justice that embodies equity.[1] Health services is one of the efforts that can be carried out to improve health standard for both individual and groups, or community as overall.[2] Based on Law number 36 of 2009 concerning Health in Article 52 paragraph (1), health services generally consist of two forms[3]:

a. Individual health services. Health services organized by individuals independently and families that aim to heal and restore health. The service efforts are carried out at health care institutions called hospitals, maternity clinics, independent doctor practices.
b. Community health services. Health services organized by groups and community that aim to maintain and improve health referring to promotive and preventive actions. The service efforts are carried out at Community Health Centre *(Puskesmas)*.

Organizing health services is the responsibility of the government and local government carried out evenly and non-discriminatively. One of the responsibilities of the government is to provide health insurance for all people in the health insurance system so that people as health insurance participants can fulfill basic health needs. In organizing health services, the government establishes a public legal entity that is directly responsible to the President who is has a role to organize national health insurance for all Indonesian people called Healthcare and Social Security Agency *(BPJS)*.

Healthcare and Social Security Agency *(BPJS)* as the organizer of the National Health Insurance *(JKN)* was started in 2014, which so far has been carried out by many providers of health insurance. Gradually, *JKN* goes to Universal Health Coverage in accordance with the 2019 Roadmap to Health Insurance. In 2019, the roadmap stipulates that there are eight targets, namely:

1) Healthcare *BPJS* has received full trust by the community;[4]
2) All population (estimated at 257.5 million) have guaranteed health;
3) The package of medical and non-medical benefits is the same for all Health Insurance participants;
4) Health facilities have been spread evenly and adequately;
5) Laws and regulations are adjusted to meet needs;
6) At least 85% of participants are satisfied with the health services received from health facilities and Healthcare *BPJS*;
7) At least 80% of health facilities are satisfied with health services received from Healthcare *BPJS*;
8) Financial management of Healthcare *BPJS* has reached an optimal level of transparency, efficiency and accountability.

The purpose of the National Health Insurance in general is to ease the community to access the health services and obtain the quality health services. Changing financing towards Universal Coverage is a good thing, but it has side effects and risks. The inequality of the availability of health facilities, health workers and geographical conditions, raises new problems in the form of injustice between provinces, regencies/cities and sub-districts in Indonesia. Limited health service providers, wide population

[1] A.Heuken SJ (1973), *Ensiklopedi Politik Pembangunan Pancasila*, Yayasan Cipta Loka Caraka,Jakarta, hal. 218.
[2] Widodo Tresno Novianto (2017), *Hukum Dalam Pelayanan Kesehatan,* Surakarta ,UNS Press, hal.13
[3] Isharyanto (2016), *Hukum Kesehatan Suatu Pengantar,*Pustakapedia, Tangerang Selatan, hal.52
[4] GTZ,AUSAID (2012), *Peta jalan menuju jaminan kesehatan nasional 2012-2019,*Jakarta.

distribution and limited access, lead to lack of supply (service provision) by the government and other parties so that difficulties will arise to access health facilities.

Special Region of Yogyakarta is one of 34 provinces in Indonesia and located on the island of Central Java, which has an area of approximately 3,185.80 km² or with a percentage of 0.17% of the total area of Indonesia, reaching 1,860,359.67 km². Based on the data from the Population Section of the Governance Bureau of Regional Secretary of Special Region of Yogyakarta, the population of the Province of Special Region of Yogyakarta in 2017 was 3,762,167.[5]

The distribution of health services for the availability of health facilities is often debated because the ratio of health facilities, health workers or beds to the population does indeed vary between regions. This equity is blamed as the cause of injustice, inequality in national health insurance. The ratio of the population as participants of Healthcare *BPJS* and the condition of the region or its geographical location to the availability of health facilities is very unbalanced. There are many complaints or news about long queues, lack of beds and inadequate health facilities in certain areas.[6]

However, people in remote areas do not have many options for the treatment. On the other hand, the urban areas provide many service providers so that the use will be more frequent with an unlimited benefit package in which the payments are made based on the availability of the use of health facilities. In certain and remote areas where the first level service facilities and referrals are limited, the participants cannot use the health facilities. The increased supply in certain and remote areas is very absolute so that the funds of Healthcare *BPJS* can be absorbed. If there is no addition, the funds of Healthcare *BPJS* will be sucked into urban areas that have many health facilities. The provision of health services depends on the infrastructure in the community. Without any improvement in the infrastructure, the distribution of health services is difficult and health insurance for the community is not real. The overall health financing is related to financing policy strategies that are not through the scheme of Healthcare *BPJS*. In this case, the investment financing and various health actions have not been covered by Healthcare *BPJS*. In addition, it is necessary to discuss the role of the local governments in providing health financing.[7]

PROBLEM STATEMENT

Based on the background above, the problem that arose was How was the distribution of health services for the availability of health facilities in Yogyakarta in the implementation of Healthcare *BPJS*?

RESEARCH OBJECTIVE

This study aimed to analyze the distribution of health services for the availability of health facilities and government efforts of Special Region of Yogyakarta in the implementation of Healthcare and Social Security Agency.

RESEARCH METHOD

In this study, the researchers used empirical research method by systematically analyzing and compiling the data obtained from interviews, collection of data/notes in a related institution like at the branch office of Healthcare *BPJS* of Special Region of Yogyakarta, the First Level Health Care Provider *(PPK1)* Cendrawasih of Adisutjipto Airport Yogyakarta and other materials implemented and developed in the community to produce an improvement and change. According to Hilman Hadikusumo, the empirical research method is exploratory, descriptive and explanatory.[8] The type of approach used was quantitative and qualitative approaches. The collected quantitative data sources were obtained from the branch office of Healthcare *BPJS* of Special Region of Yogyakarta in the form of the Profile of Provincial Health Office of Special Region of Yogyakarta of 2017 and other documents used to determine the availability and coverage of health services between regencies/cities of Yogyakarta in the implementation of Healthcare *BPJS*. On the other hand, the qualitative data sources were obtained from the interview with the Head of the branch office of Healthcare *BPJS* of Special Region of Yogyakarta and the Head of *PPK1* Cendrawasih of Adisutjipto Airport Yogyakarta as the baseline of health care facilities that cooperated with Healthcare *BPJS* used to obtain analysis of health services providers, the implementation of health insurance, and influencing barriers and factors found in the implementation of Healthcare *BPJS*.

RESULT AND DISCUSSION

It must be acknowledged that in the present conditions, equity and quality of health services with the availability of health facilities have not fulfilled the expectations of many parties. This is affected because the distribution of health workers is uneven, health facilities and quality of services are inadequate. The equity of health services is needed by the involvement of the city/regency and private governments in developing health facilities that are in good quality and evenly distributed in the first and advanced level health facilities.[9]

Distribution and Availability of Health Services at the First Level Health Facilities

[5] Profil Dinas kesehatan Provinsi D.I Yogyakarta Tahun 2017, hal. 5.
[6] Hasbullah Thabrany (2016), *Jaminan Kesehatan Nasional,*Jakarta: PT. Rajagrafindo Persada, hal. 278
[7] Firginia L.B.Putri, Xaverius B.N.Najoan, Yaulie D.Y.Rindengan (2017), *Sistem informasi pemetaan fasilitas kesehatan Badan Penyelenggara Jaminan Sosial berbasis android di Kota Bitung,* E-Journal teknik Informatika, Vol. 11, Nomor 1 tahun 2017.
[8] Istanto, F. Sugeng (2007), *Penelitian hukum*, Yogyakarta,hal. 56
[9] GTZ,AUSAID (2012), *Opcit,* hal. 98-100

The number of the First Level Health Facilities in the collaboration with Healthcare *BPJS* in Yogyakarta has 121 units of Public *Puskesmas* and 319 units of Auxiliary *Puskesmas* with a total room availability of 44 rooms and 496 beds for inpatients in each regency. The following table contains the overall *Puskesmas* in each regency and city of Yogyakarta and their capacity:[10]

Table 1: Number of *Puskesmas* in the Regency/City of Special Region of Yogyakarta in 2017

Regency/City	*Puskesmas*			
	General	Room	Bed	Assistant
Kulon progo	21	6	93	63
Bantul	27	16	155	67
Sleman	25	5	71	70
Gunung Kidul	30	14	152	110
Yogyakarta	18	3	25	9
D.I Yogyakarta	**121**	**44**	**496**	**319**

Based on the data from the Bureau of Governance of Special Region of Yogyakarta, the population of the Province of Special Region of Yogyakarta in 2017 was 3,762,167. Based on the division of percentages, male sex was 49.65% and female sex was 50.35%. The comparison was relatively balanced by showing the number of the female population which was slightly larger than the male population.[11]

Table 2: Population in Regency/City of Special Region of Yogyakarta in 2017

Regency/City	Population		
	Male	Female	Male+Female
Kulon progo	234,641	237,494	472,135
Bantul	478,281	477,236	955,517
Sleman	555,931	550,120	1,106,051
Gunung Kidul	393,295	395,998	789,293
Yogyakarta	214,573	224,598	493,171
Total	**1,876,721**	**1,885,446**	**3,762,167**

The Republic of Indonesia Minister of Health Regulation No. 69 of 2013 concerning Health Service Rates Standards at the First Level Health Facilities and Advanced Health Facilities in the Implementation of Health Insurance Programs establishes capitation for *Puskesmas* or facilities that are equal and large capitation of Rp 3,000.00 to Rp 6,000.00. On the other hand, Pratama Hospital, Pratama Clinic, Medical Practice, or Health Facilities have the same capitation from Rp 8,000.00 to Rp 10,000.00.[12] Based on the agreement of the Clinical Association and the Yogyakarta Primary Indonesian Health Service Facility and Regional Division III of PT. *Asuransi Kesehatan* on December 23, 2013, service rates are set for complete clinical standards with 2 general practitioners, 1 dentist, midwife/nurse/dental nurse, drug and laboratory services with capitation of Rp 10,000.00. The capitation value is reduced if the type and number of energy and services are incomplete. The Collaboration of The Head of the Health Office with *BPJS* stipulates *Puskesmas* with 2 general practitioners, 1 dentist, and the capitation network of Rp 6,000.00. The capitation value is reduced if the type and number of energy and network are incomplete. The amount of collaboration between the Regency/City Health Office and *BPJS* for one year did not reach the maximum value because the type, number of staffs and network services were not enough.[13]

The First Level Health Facilities in Yogyakarta are still lacking when being compared to the ratio of general practitioners of 33.34, compared to 100,000 or 1 to 3000 people. This ratio becomes the achievement of the National Health Insurance in 2019. Curative health services are the same as the number of general practitioners so that the lack of primary care facilities must be added with a doctor's practice or *pratama* clinic. Addition of primary services like clinics requires investment and operational costs. Private primary services can serve 3000 people with full capitation of Rp 10,000.00 so that the total capitation is Rp 30,000,000.00 per month. The use of outpatient health services in the Province of Special Region of Yogyakarta is 16.34%. If it is calculated on the average in the city of Yogyakarta multiplied by 3000 people, the number of visits of 489 per month x Rp 60,000.00 for each total visit for curative services will be Rp 29,340,000.00. Thus, the remaining capitation is Rp 10,000.00 x 3000 people = Rp 30,000,000.00 – Rp 29,340,000.00 = Rp 660,000.00 that is very little for clinic operations. The little operational remaining is difficult to develop *pratama* clinic to meet the shortage of primary health facilities.[14]

Lack of general practitioners and dentists to meet the needs at *Puskesmas* in accordance with the standards set by the Yogyakarta Regency/City Health Office and the Clinical Association and the Indonesian Primary Health Care Facilities in Yogyakarta for the primary care facilities of two general practitioners and one dentist. The Yogyakarta Government needs to appoint general practitioners and dentists as Civil Servants in *Puskesmas*. If it takes contract health workers, it will require substantial funds

[10] Ibid, hal. 13
[11] Ibid,hal. 7
[12] Peraturan Menteri Kesehatan Republik Indonesia Nomor 69 Tahun 2013 tentang *Standar tarif pelayanan pada fasilitas kesehatan tingkat pertama dan fasilitas kesehatan tingkat lanjut dalam penyelenggaraan program jaminan kesehatan.*
[13] Profil Dinas Kesehatan D.I Yogyakarta, hal. 99
[14] Ibid, hal. 107

which are not in accordance with the lack of capitation amount obtained by *Puskesmas*. Contract health workers like general practitioners are equated with non-permanent employee *(PTT)* doctors at remote areas of Rp 5,000,000.00 per month. In Yogyakarta, a budget of Rp 1.2 billion must be spent to meet the shortage of 20 general practitioners in *Puskesmas*. On the other hand, the monthly contract dentists are equated with non-permanent employee *(PTT)* doctors at remote areas of Rp 5,000,000.00. The Regional Government must spend a budget of Rp 1,260,000,000.00 to fulfill the shortage of 21 dentists in *Puskesmas*.[15]

The collaboration between the Special Region of Yogyakarta Health Office and Healthcare *BPJS* stipulates a *Puskesmas* with 2 general practitioners, 1 dentist, nurse/midwife, drug services and a capitation network of Rp 6,000.00. The capitation value is reduced if the type and number of energy and network are incomplete. The total cooperation between the Special Region of Yogyakarta Health Office and Healthcare *BPJS* for one year did not reach the maximum value because the type, number of staffs and network services were not enough.[16]

Based on the Presidential Regulation of the Republic of Indonesia Number 82 of 2018 concerning Health Insurance in Article 31 paragraph (1), if Health Facilities are not eligible to meet the medical needs of a number of participants in a region, Healthcare *BPJS* must provide compensation. In paragraph (2), Compensation as referred to in paragraph (1) can be in the form of:[17]
a. Replacement of cash;
b. Delivery of health workers; or
c. Provision of certain Health Facilities.

Healthcare and Social Security Agency *(BPJS)* is obliged to compensate for reimbursement or send practitioners and dentists to meet the needs of general practitioners and dentists in primary health services.

Based on the Republic of Indonesia Minister of Health Regulation Number 71 of 2013 concerning Health Services at the National Health Insurance in Article 30 paragraph (4), compensation in the form of cash replacement in the form of compensation of health care costs provided by Health Facilities does not cooperate with Healthcare *BPJS*. In paragraph (5), it is stated that the amount of the compensation for health care costs is equal to the rate of Health Facilities in the nearest area by paying attention to the health workers and the type of services provided. The Regency Health Office and Healthcare *BPJS* need to establish a verification team for remote communities to use health facilities that do not cooperate with Healthcare *BPJS*.[18]

In the 2010 World Health Report[19], three dimensions were included in achieving coverage, namely:
1) All population become participants of health insurance;
2) Benefit package of health services includes comprehensive services (preventive, promotive, curative and rehabilitative). The services must be provided by health facilities of the government, such as, *puskesmas*, clinics, practitioner practices and hospitals;
3) Financing for the recipients of the contribution assistance is paid by the government, the people who are able to pay premiums.

Distribution of the availability of the first level health facilities/primary health services will affect the service package provided by Healthcare *BPJS* to the participants. This condition needs to be supported by a policy so that Healthcare *BPJS* compensates money for contracting health workers or sending health workers or providing health facilities in the form of *pratama* clinics/practitioner practices. So, the community can easily get access to health services. Healthcare *BPJS* is obliged to compensate in an effort to realize the roadmap to the 2012-2019 health insurance to point (3) the package of medical and non-medical benefits is the same for all the participants, and (4) health facilities have been spread adequately. The population participating in the *BPJS* is not only the number calculated to achieve the overall coverage, but also the locations of the population settlements that are spread out and geographically large areas and many mountains. It is an irreversible natural condition so that the fulfillment of health care facilities cannot be calculated by ratio only.[20]

The First Level Health Facilities *(FKTP),* such as, *puskesmas*, practitioner practices, *pratama* clinics that function as gate keepers by controlling the use and referral of Healthcare *BPJS* participants. The government as a duty bearers is obliged to provide health facilities like *puskesmas* throughout Indonesia. *Puskesmas* has a strategic role and excellence in supporting the implementation of the National Health Insurance compared to practitioner practices and private clinics. This is because *puskesmas* serves as the driving center for health-minded development, community empowerment center and the first strata health service center. *Puskesmas* that is responsible for organizing the first-level health efforts for individuals and communities has mandatory health efforts and development health efforts.[21] The use of capitation funds at the first level health facilities of the Regional Government like *puskesmas* is divided into 60% services and the rest is to support the operational costs of health services. Services include individual health services carried out by health and non-health workers, while operational costs include the costs of medicines, medical devices, medical consumables, and supports for other operational costs of health

[15] Ibid, hal.108
[16] Ibid, hal 100
[17] Peraturan Presiden Republik Indonesia Nomor 82 Tahun 2018 tentang Jaminan Kesehatan.
[18] Peraturan Menteri Kesehatan Republik Indonesia Nomor 71 Tahun 2013 Tentang Pelayanan kesehatan pada jaminan kesehatan
[19] WHO (2010), World Health Report 2010: *Health system financing the path to universal coverage,*Geneva.
[20] GTZ,AUSAID, *Opcit*, hal.33
[21] Badan Litangkes Kementerian Kesehatan (2013), *Riset kesehatan dasar*, Jakarta.

services. The role of *puskesmas* as a primary care provider that is comprehensive in providing promotive and preventive services can use the other operational costs of health services in accordance with the Republic of Indonesia Minister of Health Regulation No. 19 of 2014 concerning the Use of Capitation Funds of the National Health Insurance for Health Services and Support for Operational Costs at the First Level Health Facilities of the Regional Government in Article 5 paragraph (3) stating that Support for other health care operational activities includes[22]:

a. Individual health efforts in the form of promotive, preventive, curative, and other rehabilitative activities;
b. Home visits in the context of individual health efforts;
c. Operations for mobile *puskesmas*.

Distribution of Health Services and Availability of the Advanced Level Health Facilities

At the advanced level health facilities, namely the Hospitals, there are 74 Hospital units in Special Region of Yogyakarta owned by both the government and private sectors with the availability of bed capacity of 6,259. The distribution of beds in Bantul and Gunung Kidul Regency is uneven so that the rejection of providing health services to the participants of Healthcare *BPJS* who receive referrals to the advanced level health facilities in certain areas often occurs. The following table is the number of hospitals in regency/city of Special Region of Yogyakarta[23]:

Table 3: The number of accredited hospitals in Special Region of Yogyakarta in 2017

Regency/City	Hospital		Bed Capacity	
	Government	Private	Government	Private
Kulon Progo	1	7	290	319
Bantul	2	11	526	552
Sleman	7	20	1,404	1,059
Gunung Kidul	1	4	156	151
Yogyakarta	2	18	307	1,597
D.I Yogyakarta	**14**	**60**	**2,595**	**3,664**

This is to meet the planned targets of the National Health Insurance in 2019 in health services at the advanced level for the area of Yogyakarta city in the normal category. However, overall the number of existing beds is not optimal yet, especially in Gunung Kidul and Bantul regency and still needs additional health facilities, especially beds and other health facilities. A specific policy is needed from the regency/city government of Special Region of Yogyakarta and Healthcare *BPJS* as the social security provider to develop the hospitals of type D into type C so that health services will be evenly distributed. The development of health services includes the addition of health facilities, health workers, health equipment and infrastructure as well as the strengthening of the referral system that are evenly distributed by the Ministry of Health so that the availability of health facilities can be fulfilled.

The implementation of Healthcare *BPJS* in Special Region of Yogyakarta for the participants of Healthcare *BPJS* beyond insurance or Premium Assistance Beneficiaries *(PBI)* is organized by Healthcare *BPJS* which is the Technical Implementation Unit *(UPT)* of Health Office as the implementer of health financing for poor people in Special Region of Yogyakarta cooperating through health care providers of Special Region of Yogyakarta.[24]

The following table is a number of Healthcare *BPJS* participants who have been covered or who have not received health services in Special Region of Yogyakarta[25]:

Table 4: Number of population who have been covered and have not received Health Services in Special Region of Yogyakarta in 2017

No	Reg./City	Number of Participants of Healthcare *BPJS*	Total of the covered	% The covered	Total of not covered yet	% not covered yet	% not covered yet	
							% well not covered yet	% poor not covered yet
1	Bantul	931,356	775,616	83.3%	155,740	16.7%	14.5%	2.2%
2	Gunung	755,977	614,725	81.3%	141,252	18.7%	16.2%	2.4%

[22] Saefudin, F.Ilyas Y (2004), *Managed care mengintegrasikan penyelenggaraan dan pembiayaan pelayanan kesehatan bagian A*, Jakarta, Pusat Kajian Ekonomi Kesehatan FKM UI dan PT Asuransi Kesehatan, hal. 23.

[23] Profil Dinas Kesehatan Provinsi DI Yogyakarta, hal.109

[24] Peraturan Gubernur Daerah Istimewa Yogyakarta Nomor 57 Tahun 2015 tentang *Rincian Tugas dan Fungsi Dinas Kesehatan*, Pasal 3 ayat (2) huruf g, yang menyebutkan bahwa : "Untuk melaksanakan tugas urusan pemerintah daerah di bidang kesehatan dan kewenangan dekonsentrasi serta tugas pembantuan yang diberikan oleh Pemerintah, Dinas Kesehatan mempunyai fungsi pengelolaan pembiayaan dan jaminan kesehatan".

[25] Ibid, hal. 111

3	Kidul Yogyakarta City	410,262	394,143	96.1%	16,119	3.9%	3.4%	0.5%
4	Kulon Progo	445,655	338,127	75.9%	107,528	24.1%	21%	3.2%
5	Sleman	1,062,861	910,002	85.6%	152,859	14.4%	12.5%	1.9%
Total DIY		**3,606,111**	**3,032,613**	**84.1%**	**573,498**	**15.9%**	**13.8%**	**2.1%**

The national target in achieving Universal Health Coverage in the implementation of health services distribution is expected to be achieved in 2019 at least 95% of Healthcare *BPJS* participants can receive health services for the availability of health facilities. However, the data at the end of 2017 shows that there were still 15.9% of Healthcare *BPJS* participants who have not been covered in health services. The percentage of Healthcare *BPJS* participants who have not been covered in health services still looked high in Kulon Progo Regency and Gunung Kidul Regency, while the lowest was in Yogyakarta City. This proves that the distribution of health services in the implementation of Healthcare *BPJS* was not optimal yet.

The main goal of the National Social Security System is to improve, restore and maintain health. The implementation of the national health insurance must improve service distribution by increasing the number of the first level health care facilities and referrals in Special Region of Yogyakarta. The improvement of health care facilities can be carried out in the collaboration between Healthcare *BPJS,* the Regional and Provincial Government, and Ministry of Health.[26]

In accordance with the Presidential Regulation No. 72 of 2012 concerning the National Health System of Point A No. 151, the Government is obliged to provide fair and equal health care facilities to meet the needs of the community in the health sector throughout the areas of the Republic of Indonesia *(NKRI)* and overseas in certain conditions, and based on the concept of the 2009 WHO, the building blocks of the health system are Service delivery and Health workforce.[27]

Planning of National Health Insurance Policy in the Effort of the Distribution of Health Services for the Availability of Health Facilities

Planning of National Health Insurance policy is not an activity to make an alternative, but rather for the understanding that the government prepares itself to make a strategic decision to deal with the various possibilities that will occur in the future.[28]Health facilities of the government and private sectors that have been recognized and have permits from the government agencies which are responsible for the health sector are permitted by the National Health Insurance to cooperate with Healthcare *BPJS* to serve the participants of Healthcare *BPJS*. With the limited availability of health facilities at the first level and referral or further, Healthcare *BPJS* must make a specific policy to improve the number of health facilities to be able to go to Universal Health Coverage. Without the addition of health facilities by Healthcare *BPJS* and the regency/city government of Special Region of Yogyakarta along with the Ministry of Health, the participants of Healthcare *BPJS* will still find it difficult to access health facilities because of the geographical conditions that cause injustice among the participants of Healthcare *BPJS* to be able to obtain health services. The implementation of the policy is inseparable from the readiness of the health system and health financing. The provision of health services that are evenly distributed will affect the quality of services, the fairness of the provision of health services, the distribution of health workers, service efficiency, and transparency as well as accountability.[29]

The planning of the national health insurance policy in the effort of the distribution of health services for the availability of health facilities in the implementation of Healthcare *BPJS* must be associated with the geographical location of an area. The addition of the First Level Health Facilities *(FKTP)* and the Advance Level Health Facilities *(FKTL)* in Special Region of Yogyakarta also needs to consider the population distribution which is uneven. In the fulfillment of health facilities, the government and Healthcare *BPJS* provide the policy to the separated participants of Healthcare *BPJS* because of the geographical location at the regencies in Special Region of Yogyakarta by providing compensation for service fees for the participants of Healthcare *BPJS* who use the nearest health facility that does not cooperate with Healthcare *BPJS*.

Closing

The national health insurance requires hospitals and the First Level Health Facilities owned by both the government and private sectors to serve the patients to all the Healthcare *BPJS* participants with the aim of realizing the distribution of health services for health facilities in the implementation of Healthcare *BPJS*. The limitation of the first level service facilities and referrals requires Healthcare *BPJS* to make specific policies to increase the number of health care facilities. Without the additional availability of health facilities by Healthcare *BPJS*, the government of Special Region of Yogyakarta, and the Ministry of Health, Healthcare *BPJS* participants will get difficulties to access health care facilities because the geographical conditions cause injustice among the Healthcare *BPJS* participants to be able to get services. The fulfillment of the first level facilities requires control to monitor and regulate financing changes and ensure the development in a more effective and sustainable direction. The *JKN* implementation is inseparable from the readiness of the health system and the current health financing system in the effort to optimize the implementation of the National Health Insurance organized by Healthcare *BPJS*. The regulations regarding the

[26] Mailinda Eka Yuniza (2013), *Pengaturan pelayanan kesehatan di Kota Yogyakarta setelah penerapan otonomi luas*, Mimbar Hukum, Vol. 25 Nomor 3, tanggal 3 Oktober 2013.
[27] Peraturan Presiden Nomor 72 Tahun 2012 tentang Sistem Jaminan Kesehatan Nasional.
[28] GTZ,AUSAID, *Opcit*, hal. 100
[29] *Ibid*, hal. 95

provision of health services will affect the quality of services, fairness of the use and the distribution of human resources, service efficiency, and transparency and accountability in the distribution of health services.

CONCLUSION AND SUGGESTION

The most important thing in relation to health services is the need to provide evenly distributed health facilities that enable all participants of Healthcare *BPJS* in Special Region of Yogyakarta to access the necessary health facilities. No matter how good the management of health insurance, without being supported by the availability of adequate health facilities that can provide quality health services, it will not give negative impacts in improving the health standard of the community in Special Region of Yogyakarta. Therefore, with the planning of the health insurance policy, the policy will be in line with improving the management of the health insurance by increasing the number and quality of evenly distributed health facilities which can reach all participants of Healthcare *BPJS* in Special Region of Yogyakarta. The efforts in providing equitable and quality health facilities need to be carried out by the regency/city government of Special Region of Yogyakarta and the private sectors in collaboration with Healthcare *BPJS* and the Ministry of Health. Universal coverage in the term of overall participation must be followed by universal coverage in the understanding of the access of the *BPJS* participants to health services for the availability of health facilities in *FKTP* and *FKTL* in the implementation of Healthcare *BPJS*.

Therefore, Healthcare *BPJS* with the Ministry of Health need to compile policy regarding the development of health services including the plans of the development of health facilities, health workers, health equipment and infrastructure, as well as the strengthening of the referral system that are evenly and gradually distributed to universal health coverage.

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