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Basic Health Policy in The Context of Minimum Service Standards at Aruk Border Indonesia's Sambas District

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Abstract

The study aims to figure out how basic health policies are linked to Health Minimum Service Standards (HMSS) on the boundary of Aruk, Sambas Regency, West Kalimantan in the implementation context of the Law no. 23 of 2014 about regional autonomy. The study uses two methods of descriptive qualitative approach and strengthens it with action research by involving informants through the Focus Group Discussion (FGD). Research has concluded that political decentralization is a choice of citizens of the Republic of Indonesia to return to era-centralization. Health sectors in the republic of Indonesia still use market-based or other-language systems to obtain quality goods or services at their own expense. Furthermore, putting the boundary into Gate Keepers has become a national obligation in the primary health policy service that is the right of every Indonesian citizen not to distinguish where they live. According to the finding of this research, Researchers have given recommendations that should be reevaluated for the division of both central and local affairs and the boundary health care mechanism need to be reconsidered and require a simplification of health regulations.

1. Introduction

Health is something that every individual needs. Each individual will not be able to meet the needs of his life if he is in an unhealthy condition. Health is everyone's capital to continue their individual life well. The health sector is part of the economy, according to (Massie, 2012). Health is

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one of the essential things, and everyone has a responsibility in meeting the needs of himself and others. Environment, so health is the need and commitment of everyone. Starting from the reform era, several central government affairs were gradually handed over to the Regional Government. This policy is based on what is stated in Article 18 paragraph (6) of the 1945 amendments to the 1945 Constitution, which explains that Regional Governments carry out the broadest possible autonomy. The regulations governing the division of affairs between the Central Government and Regional Governments are contained in Law Number 23 of 2014, a replacement for Law Number 32 of 2004. What is stated in Law Number 23 of 2014 concerning Regional Government is that health is one of the government affairs related to essential services. To realize this commitment, the government is responsible for the implementation of public health insurance through the National Health Insurance (Karim et al., 2018).

As we know today, (Saimima, 2021) the ability of each local government is certainly not the same; therefore, the implementation of public service affairs is regulated by Minimum Service Standards (SPM) to ensure the availability of these services for the entire community; this is the government's obligation to fulfil the rights of the government. Each community is at a minimum. SPM is a benchmark for the quality of hospital services in providing services to the community. Every citizen's needs for health goods and services are fundamental and have unique and complex health goods/services. In the health sector, we provide health goods and services for middle to lower economies to meet their needs (Kuzairi et al., 2017).

Health is a human right and also one of the elements of welfare which of course must be realized in accordance with the ideals of the Indonesian people which have been stipulated in the Republic of Indonesia Law Number 36 of 2009 article 14 concerning Health, "The government is responsible for planning, organizing, organizing, fostering, and supervising the implementation of health efforts that are just and accessible to the community. However, in its performance, the distribution of health efforts in Indonesia has not been fully implemented optimally due to several obstacles, including geographical and social problems, namely those who live in underdeveloped and border areas. According to (Efendi & K., 2013), the crisis of health workers is increasingly felt in underdeveloped areas so that it has an impact on hampering Indonesia's development as a whole.

Indonesia's strategic geography in the form of islands makes Indonesia a beautiful country and rich in natural resources (Fahmi et al., 2022). But in management, it becomes a problem that has an impact on the level of welfare of the community, which is still relatively low; the same is felt by the people in the border areas of the Republic of Indonesia. An evident impact on health, access and rather long distances, so that the effect on health costs in the form of goods and services becomes more expensive. The community expects Pusat Kesehatan Masyarakat (PUSKESMAS) health workers to provide medical services at home or in a place close to where they live (Suharmiati et al., 2013). There are three levels of government involved in providing primary health service needs at the border, namely, following minimum service standards (SPM). The urgency of this research is to build a direct health policy model in the context of minimal service. This is based on the reformation until now. Health problems at the border are still an expensive item.

The breadth and length of Indonesia's borders, including those in West Kalimantan along the 987 km line, places different difficulties in providing standardized services to border communities. Limited health facilities and infrastructure this has an impact on community access to health service facilities below. In addition, the lack of interest from health workers who want to be allocated in the border areas of the Republic of Indonesia so that public health in border areas is still relatively low. Another problem is the uneven distribution of health efforts caused by social problems, namely, the community's economy is still down, so, it cannot reach the cost of health services. This is the face of health services at the border

2. Materials and Methods

The research was conducted on the Aruk border between Sarawak Malaysia and Sambas Indonesia. The reason for the research in choosing the research location is that Sambas is located on the border between Indonesia and Malaysia. This research was conducted from August to November 2021. This study uses qualitative descriptive methods, observes and describes health policies describes the health policies that have been carried out by the government in providing essential health services with the concept of Minimum Service Standards at the Aruk border. The author's data retrieval technique is carried out by in-person or face-to-face interviews to the community in Sajingan Besar district of Sambas regency, the head of the health center and health workers in Puskesmas Sajingan Besar, head of the Sambas Regency health office, regent of Sambas and community leaders at the Aruk border. The author chose the people of Sajingan Besar subdistrict because those who get health services at the border of Aruk and this region is the closest area to East Malaysia (Serawak). This data collection uses in-depth interviews, observation and documentation. In addition, the author and related stakeholders held a Focus Group Discussion (FGD). Research instruments in the form of interview guidelines or question lists, document formats, observation guidelines, photos and results of FGD meetings.

3. Results and Discussions

Health policy is defined as one of the actions that influence the institutions, health services, organizations, and finances of the health system (G, 1994). In Health policy, a network of related decisions is also considered an effort to care for health services in the community. The purpose of policy analysis in the field of Health in the book (Dachi, 2017) is to guide or guide in addressing problems that arise in the health sector. There are several accurate dimensions that have been classified, which are used to support formulating health policies. In social, political and cultural contexts(Kusnanto, 2011). A network of interrelated decisions and their fieldwork prioritizes concern for health services in the community space which can be seen in health policy according to (Grenn & Thorogood, 1998). Therefore, that health policies are implemented by hospitals, one of which is contained in the Minimum Service Standards (Saimima, 2021).

In achieving the Minimum Service Standards (SPM) indicators, health workers are required to optimize understanding in the achievement of SPM indicators so that people get services that meet expectations to avoid complaints and patient dissatisfaction with these health services. SPM is useful as a benchmark in providing services to the community. Government regulation regulated in the law on Minimum Service Standards Number 2 of 2018 identifies that SPM is a reference in the community's type and quality of service. Every citizen has the right to get it. Adjustment of service compliance with service standards is one way to meet SPM. Health service standards are made with the aim of providing references within an organization in planning, implementing, and supervising, as well as being responsible for health services (Kuzairi et al., 2017; Margiluruswati & Irmawati, 2017; Purnomo, 2016; Vermasari et al., 2019).

The empowerment of health workers is strongly influenced by policies originating from the supporting sector, including education, finance, and staffing (Rawung, 2019). According to (Aprilla, 2020), The application of SPM in essential health cannot be separated from implementing the Jaminan Kesehatan Nasional (JKN) program. SPM is determined to be a must for cities/districts to be implemented, and a minimum analysis is carried out for health services within the district/city (Hendarwan et al., 2016). Several factors have been classified by (Farida & W, 2021) that are used to achieve the MSS target, including adequate health facilities, fulfilled supporting facilities, and fulfilled

puskesmas resources. The amount of SPM can be obtained from inputs, results, processes, and benefits from health services (Jaswin et al., 2019).

The health sector in the Unitary States of the Republic of Indonesia is currently facing increasingly complex challenges. Not only have to adapt to several policies related to the health sector. However, at the same time, it can adapt to the strategic changes that occur in the health sector and the problems that arise in the era of decentralization. One of the changes visible in the national strategic environment and affecting the regulation of health sector development in the Republic of Indonesia is the National Health Insurance (JKN) program.

One of the government's national strategic policies is to target the entire population in the National Health Insurance program in 2019. This certainly deserves appreciation. The National Health Insurance Program is expected to provide increased access and quality of services in the health sector, both at the first level and at the advanced level, and the need for improvements in the referral system for health services. However, since the National Health Insurance program was launched as a national program, there has always been a deficit; in 2014, the deficit figure reached Rupiah 8-9 trillion. Of course, the current state of affairs must be of particular concern to the central and local governments. In addition to the National Health Insurance (JKN) program, JKN is an effort by the government to finance health for the people in Indonesia in an affordable, quality, and inexpensive way through a referral system that runs well according to research conducted by (Primasari, 2015) there are several government innovations in the health sector.

However, it can still be said that it has not fulfilled the need to improve access and quality of health services in Indonesia. The government has carried out various efforts in recent years. In addition to increasing the number of participants for the National Health Insurance (JKN) to Realize Universal Health Coverage and overcome the National Health Insurance budget deficit (JKN), the government has carried various breakthroughs. The Primary Service Doctor Program (DLP) is intended to improve the quality of health services in Indonesia, prevent disease and ensure the sustainability of health services at the primary level. Then, to solve the problem of health workers who are still not evenly distributed, the government sends health workers through the Healthy Nusantara program to underdeveloped border areas and islands, better known as the Daerah Tertinggal Perbatasan dan Kepulauan (DPTK) P and Daerah Bermasalah Kesehatan (DBK).

Several efforts have been made to improve services in the health sector in border areas, including 1) Planning that focuses on producing services in the health sector that can act as a "gatekeeper". Health referrals and health service show windows by building responsive and competitive health service units for health services in border areas; gatekeeper theory; 2) Building cooperative relationships with neighbouring countries in case of emergency referrals; 3) The need for coordination of services in the health sector between the Regional Government, Health Office and health offices in border areas; 4) The need for medical radio availability. Apart from that, there are also particular policies in the border, underdeveloped and the archipelagic regions, including the movement and empowerment of the population; increasing population access to quality health services; improving the budget for the health sector in border areas; empowering and developing Human Resources (HR) in the health sector; increase the availability of drugs and medical devices; developing a surveillance money system and Health Information System (SIK), and develop and improve health management.

In implementing public health management that will be carried out in the future, it is necessary to start mapping the problems and the available health potentials first. The need for local government support in the implementation of development that prioritizes the health sector and increases support in the form of costs from the central government, which is more oriented to the needs and special conditions of the region (not top-down). The state is a public organization to be realized, and

the state has problems that must be overcome, reduced or prevented. The problems faced by the state can come from the citizens themselves but can also come from the impact caused by the policies taken by the government itself. The government must address problems that include public problems, values, needs, or unrealized opportunities, which, although identifiable, can only be achieved through public action. According to (Engkus et al., 2019), every general problem requires action from the public through national and global contexts, which are generally adopted from practices from different contexts (benchmarking) in other countries. The characteristics of public problems that must be overcome are interdependence and dynamic. Solutions to overcome them require a holistic approach, which is an approach that views the problem as an unbroken unit because of issues of authority, for example.

3.1. The Achievements Of The Sambas District Basic Health Policy

As explained above, in the context of Standar Pelayanan Minimal (SPM) related to essential health, this research was conducted in the border area of Sambas district in Sajingan Besar sub-district, Kaliau village. Kaliau village is the boundary between the territory in Indonesia and the Biawak, which is the territory of Malaysia where the border with Malaysia is in Aruk. It is essential to research our walls as the development paradigm changes from inward-looking to outward-looking.

The achievement of primary health policy outputs in border areas is significant. Sambas district as an area directly adjacent to neighbouring countries, in implementing basic health policies, it can be said that it has not shown significant changes compared to the achievements of districts/cities in the province of West Kalimantan, let alone nationally in the same year and before.

Human development can be defined as expanding choices for the population. The Human Development Index (HDI) explains how people can access development results in obtaining income, health, education, etc. The United Nations Development Program (UNDP) introduced the human development index in 1990 and is published regularly in the annual Human Development Report (HDR).

Community/human welfare is measured by looking at the Human Development Index (IPM). The Human Development Index (HDI) is formed by 3 (three) basic dimensions, namely: a) long life and healthy life; b) knowledge, and c) a decent standard of living. The Human Development Index (HDI) is an essential parameter in measuring the success rate of efforts to build the quality of human life (citizens). The Human Development Index (HDI) can determine the ranking or level of development of a region/country. For Indonesia, the Human Development Index (IPM) is strategic data because apart from being a measure of government performance, the Human Development Index (IPM) is also used as one of the allocators for determining the General Allocation Fund (DAU). Based on the calculation of the Human Development Index in 2015, the highest Human Development Index was DKI Jakarta Province with a figure (IPM) of 78.99, followed by DIY Province with a figure of 77.59, which occupied the second position and East Kalimantan in the third position with a figure of 74.17. At the same time, the Human Development Index (IPM) of West Kalimantan Province is 65.59.

Based on the ranking of the province of West Kalimantan, it is in the order of 29. In general, the development of the Human Development Index (IPM) in Sambas Regency continues to experience an increase in the component of the Human Development Index (IPM). In West Kalimantan Province, the highest Indeks Pembangunan Manusia (IPM) was Pontianak City with a figure of 77.52, then Singkawang City with a figure of 70.03, followed by Kubu Raya Regency with a figure of 65.02. Sambas Regency is ranked 6th out of 14 regencies/cities in West Kalimantan Province (Badan Perencanaan Pembangunan Daerah Kabupaten Sambas, 2021).

3.2. Policy Process Analysis

The process leads to how the policy is initiated, developed, drafted, negotiated, communicated, implemented, and evaluated. The easiest way to reveal how the process through which the Basic Health Policy (KKD) is made both on a national and regional scale. There are many regulations governing health policies; one example is the Law of the Republic of Indonesia Number 36 of 2009 concerning Health. Regent Regulation No. 7 of 2021 regulates the implementation of public health centres in Sambas Regency at the regional level.

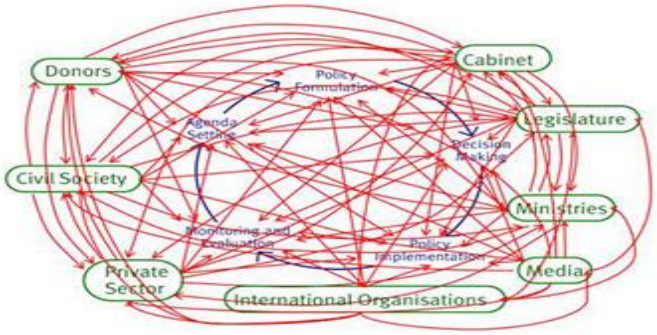


Figure 1. Basic Health Policy Process in Indonesia
Source: https://kebijakankesehatanindonesia.net/component/content/article/2496

In this aspect of the process, basic Health Policy (KKD) cannot be interpreted linearly; there is no policy process. Not all regulations undergo a rational approach. In reality, the regulatory process is a complicated and complex process due to the influence of tug-of-war between stakeholders (stakeholders). Besides that, background experience is one of the factors influencing the implementation of policies related to previous approaches, directed by various voices of interest groups, and usually enter the realm of politics of interest.

3.3. Policy Content Analysis

The implementation of a decentralized system in the health sector based on Law RI No. 1999, which was amended by Law No. 32 of 2004, intends to give local governments the authority to carry out development in the health sector with the hope of improving the quality of health services. The decentralization of the health sector has been going on for more than ten years. However, it is still experiencing problems in its implementation, one of which is Government Regulation Number 38 of 2007 concerning the Division of Government Affairs between the Provincial Government and City District Governments. The division of affairs or authority places the province in only managing two matters related to essential health policies, namely: sector services, paragraph 1) services in the health sector are provided for people affected by health crises due to extraordinary events (KLB) such as disasters and/or potential provincial disasters; 2) Services in the health sector for the community in the case of a Kejadian Luar Biasa (KLB); 3) Health sector services for pregnant women, health sector for mothers; 4) Maternity services for newborn health services; 5) Health sector services for primary education age.

From this, it can be said that the division of authority or affairs between the provincial government and the government under it, in this case, Sambas Regency, is very disproportionate, where we know that the completeness of health infrastructure is very inadequate. The availability of doctors as the main element in basic health policies are also minimal, only doctors general. The

central government launched the *Nusantara Sehat*[3] policy to address the distribution of health services by deploying or appointing doctors to become State Civil Apparatus (ASN); however, this has not answered the community's need to obtain essential health services. Usually, after being appointed as ASN the doctor applies for a specialist school and rarely returns to the area where they were assigned. This is also the case at the study site.

In the era of decentralisation, health parameters in the community have not changed too much. For example, the maternal mortality rate is 307 / 100,000 due to births that occurred in 2000, and the change in the number is not too far away and seems to be still high at a high rate of 228 / 100 000 births that occurred in 2009. The same thing also happened to the maternal mortality rate. Infant mortality only decreased from 37/1000 births to around 26.9/1000 births over 9 years. What happened in the Eastern Province of Indonesia had a higher infant mortality rate. In Sambas district, which is the research area, in 2015, the maternal mortality rate increased by 40.9%. In the implementation of decentralization of the health sector, especially in the financing, the distribution of funds from the central government is still not following the decentralization law, in Law Number 33 of 2004, which stipulates that funds for the implementation of deconcentration and co-administration tasks that should be transferred slowly to DAK (included as Regional Revenue and Expenditure Budget). However, the performance of assistance tasks continues to grow, including Health Operational Assistance (BOK) funds. In a situation where the State Revenue and Expenditure Budget (APBN) funds are getting bigger, the central government officials are very busy. While the authority of the Provincial Government and the City/Regency Government is increasingly at risk of being neglected. On the other hand, the Regional Revenue and Expenditure Budget (APBN) for the health sector in several regions has not increased except for Jamkes. 60% of income as PAD in the research area comes from BPJS payments, in this case, is the Health Insurance Policy.

Problems in managing funds from the central government to the regions (e.g. Puskesmas) are one source of the Ministry of Health's disclaimer. This is a vital issue when there is pressure to increase the budget for the Ministry of Health, which is already close to 5% of the State Budget (APBN). In this case, various regulations from the central government that are good, such as Health Operational Assistance (BOK) and maternity insurance, are less effective. This is due to problems related to the decentralized system. With the funding for the procurement of medical devices, it is reported that there has been a mismatch, resulting in a buildup of unneeded medical devices.

The even distribution of Health Workers is also still an obstacle. General doctors, specialist doctors, midwives, and nurses prefer to work or open valuable services, and live in big cities, so inequality occurs in Eastern Indonesia, even though regional heads are willing to provide additional funds. Having more power in determining health officials in the area is one proof of political intervention from regional leaders in determining structural positions in the health sector. This causes the assignment by the regional head to be unobjective, in other words, without looking at the appropriate competence. In addition, regional directors are given the authority to assign their supporters to be Head of Health Offices or leaders at Regional General Hospitals (RSUD) and not elect those competent in the health sector but do not support regional head elections. Regulation of the Minister of Health Number 971 of 2009 concerning the competence of structural health personnel which is still not a reference.

Handling disasters and Extraordinary Events (KLB) that occur between regions. Natural and non-natural disasters and Extraordinary Events (KLB) do not know geographical boundaries. As a result, the need for medical devices and drugs that must be immediately procured is hampered. This

[3] Nusantara Sehat is an integrated health effort covering preventive, promotive and curative aspects through the special assignment of team-based health workers with a certain number and type to increase access and quality of health services at Health Service Facilities in Disadvantaged, Border and Islands areas as well as areas with Health Problems

is due to the lack of approval from the level 1 local government, in this case, the provincial government. In managing and administering health insurance. In managing Jamkes, local governments provide several variations of the Jamkes benefit package. Central government attention, especially at the ministry of health level, is still lacking. Various policies are expected to lead to government regulations in the decentralization policy.

3.4. Policy Context Analysis

The analysis of the health policy context consists of several supporting factors, such as; situational factors, structural factors, cultural factors, and international factors. Situational Factors; Health services in the Republic of Indonesia still use a market-based system or in other languages to obtain quality health goods or services at their own expense. The Health Insurance System (SJK), administered by the government and financed by the government, has only been launched since 1998, after the economic crisis. In 2008 the JKN program, better known as Jamkesmas, was established to make it easier for people with a lower-middle financial income to get health services. The Government's effort to be present in the primary health policy, in this case, is health insurance for its citizens, so there is a National Health Insurance (JKN) policy. In this JKN, there are two health insurance policies, namely the Health Social Security Administration (BPJS) and the Healthy Indonesia Card (KIS). The KIS program is a Jamkes service program intended for citizens of low-income countries, and this program is levied with a monthly fee. The program is expected to provide health services that the poor can access anytime and anywhere.

Structural factors are part of society that is relatively unchanged. This factor includes the political system, and the openness of the scheme aims to provide opportunities for citizens to participate, participate in discussions, and formulate a regulation; Structural factors include the type of economy and the basis for labour. Other structural factors that can influence policies in the health sector are geographical conditions, demographics and the acceleration of the technology sector. For example, a country with a high elderly population should have more hospitals and medicines for the elderly. Acceleration and rapid technological advances affect the number of women giving birth by cesarean in many countries. This is due to the increasing dependence of the profession on rapid technological advancements. Thus resulting in the reluctance of doctors and midwives to take risks and fear of prosecution. Borders as a geographical factor also play a critical role, where limited access to health infrastructure strongly influences ensuring public health in general.

Cultural factors can also influence policies in the health sector. In the artistic community, opposing officials or superiors is still challenging to do. Cultures that believe in the existence of "smart people", for example, or what we usually call shamans. We still find this in the research area where supernatural powers are believed by the community to cure all diseases.

Neighboring (international) or exogenous factors greatly influence basic health policy. This is possible in the research area, which borders with other countries, namely Malaysia, where Malaysia has qualified health services compared to Indonesia, in this case, the Puskesmas in Aruk, Sambas Regency. However, it is certainly not easy to refer people who will seek treatment to Malaysia because Malaysia applies a guarantee for the treatment they do unless the people genuinely want to seek treatment in Malaysia through hospital agents who promote treatment at certain hospitals in Malaysia.

4. Conclusion

The political decentralization that occurred was the choice of the Republic of Indonesia citizens, so returning to the previous era, namely the era of centralization, was a policy that might be difficult to implement again. Decentralization in the health sector needs to be revisited. This is because there are still many problems found. It is hoped that there will be efforts from the central government and regional governments in strengthening the implementation of the decentralized system in the health sector through the revision of Government Regulation No. 38 of 2007, which is more comprehensive and accommodating to regional interests, without having to sacrifice national interests.

In strengthening the implementation of decentralization in the health sector by reviewing programs from the central government that need to be maintained and prominent government programs that are considered not to support the law on decentralization, especially in the health sector. Decentralization in the government system related to the Health sector is centralized. The health sector in the Republic of Indonesia still uses a market-based system or in other languages to obtain quality health goods or services at their own expense. Placing borders as Gate Keepers has become the obligation of the state to be present in essential health policy services, which is the right of every Indonesian citizen regardless of where they live. Based on the conclusions that have been described, the researchers provide constructive suggestions, including it is necessary to review the division of central and regional affairs, the mechanism for the appointment of health workers at the border needs to be reviewed, it is required to simplify regulations in regulating the health sector.

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