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The Policy Implementation of National Health Insurance in Bantul Regency – Yogyakarta Province, Indonesia (A Case Study of Premium Payment Assistance and Non Premium Payment Assistance)

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Abstract

Health insurance is one of the basic needs for people. Therefore, the State is required to develop a social security system that is based on justice. In order that the right of everyone to social security can be realized, the Act No. 40 of 2004 on National Social Security System (SJSN) states that the mandatory social security program covering the entire people (universal coverage) is achieved gradually through the Agency for Public Legal namely BPJS for Health (Social Security Organizing Agency for Health Insurance). The objective of this study was to describe the differences on the BPJS for Health policy implementation toward Premium Payment Assistance (PBI /Peserta Berbayar Iuran) and Non Premium Payment Assistance (Non-PBI /Peserta Berbayar Iuran). The research found that the policy of BPJS for Health in Bantul is implemented very well. It is based on the results of index value; the communication dimension index is 4.44 (very good), the dimension of the resource is 4.59 (very good), the dimension of the disposition is 4.44 (very good) and the dimension of bureaucratic structures is 4.57 (very good). The differences on effect of the BPJS for Health policy implementation toward Premium Payment Assistance (PBI /Peserta Berbayar Iuran) and Non Premium Payment Assistance (Non-PBI /Peserta Berbayar Iuran) in all dimensions; those are the dimension of participation with the value Fh=100, the dimension of service with the value Fh = 100 and a financial dimension with the value Fh= 100.

Keyword: Policy Implementation, BPJS for Health, Premium Payment Assistance and Non Premium Payment Assistance

Introduction

The social security system in Indonesia is known as the National Social Security System (SJSN) as described and regulated in chapters 2 and 3 of the Act No. 40 of 2004 on SJSN that the "National Social Security System is organized based on the principle of humanity, the principle of benefit and the principle of social justice for all Indonesian people. National Social Security System aims to provide a guarantee on the fulfillment of the basic needs of a decent life for each participant and/or their family members".

The scheme on the implementation of the national social security is further stated in the legislation that is the Act No. 24 of 2011 on the Social Security Organizing Agency (BPJS) as a body that organizes the social security. Social Security Organizing Agency (BPJS) is an institution or a legal entity established to administer social security programs in Indonesia. There are two forms of BPJS as described in Article 5, paragraph (2) that "BPJS as referred to paragraph (1) is: a) BPJS for Health; and b) BPJS for Employment.

In Yogyakarta, the problem is related to participants with poor category. People with disabilities who have physical limitations question the poor categories defined by BPJS for Health. In Kedaulatan Rakyat newspaper, the Head of Ombudsman as the Representation in Yogyakarta received complaints from people with disabilities who questioned how the poor category is defined (KR, February 15, 2014). In addition, BPJS implementation in Wonosari District was also criticized that the implementation of BPJS from 1 January or effectively starting on Thursday (2 January 2015) was still confusing the public as the rules and their implementation are not synchronized." (Keadulatan Rakyat, January 3, 2014).

Regarding the phenomenon related to the implementation of BPJS For Health in several regions including in Yogyakarta, it is necessary to conduct research specifically and more comprehensively. Furthermore, it can be seen in detail the problems that exist so the solution can also be found. For those reasons, this research aims to find out how the implementation of the policies of BPJS For Health in Bantul Yogyakarta as well as the differences on the influence of the policies of BPJS For Health towards Premium Payment Assistance (PBI /Peserta Berbayar Iuran) and Non Premium Payment Assistance (Non-PBI /Peserta Berbayar Iuran) in Bantul District of Special Region of Yogyakarta?

Theoretical Framework

1. Policy Implementation in the Health Sector

In line with the decentralization in the health sector, the role of the state has shifted from the previous as implementing health care becomes a regulator that makes a health policy. According to Susilawaty (2007), the purpose of health policy is to achieve national development in the health sector which is based on the initiative and aspirations by empowering, collecting, and optimizing potential areas for the benefit of local and national priorities.

Health policy in practice is not confined to the interests of individuals as the scope is very broad covering the public interest, general purpose and citizens in general. Thus, a health policy should be able to empower and improve community participation in health development. Thus, the health policy must seek the availability of health services which are equitable and evenly without differentiating between segments of society with each other including in ensuring the availability of health services for the poor and the nearly poor.

In general, policy implementation is a dynamic process, where the implementers perform an activity or activities that are likely to get a result that is consistent with the objectives or goals of the policy itself (Agustino, 2012, p. 139). While Nugroho (2012, p. 674) explains that the implementation of the policy in principle is a way for a policy to be able to achieve its objectives. Basically the policy implementation is an action/real program implemented based on the formulation of policies that have been developed previously to achieve specific goals. Nugroho (2012, p. 675) adds that the series of policy implementation include the start of the program, the project, and all activities.

Different from Nugroho, Suharno (2013, p. 169) argues that the implementation of policies that have gone through the stage of recommendation is a relatively complex procedure, so that there is not always a guarantee that the policy will work in practice. Meanwhile Agustino (2012, p. 140) argues that policy implementation is a very important stage in the overall structure of a policy, because through this procedure the overall policy process can be influenced by the level of success or failure in achieving goals.

According to Daniel Mazmanian and Paul Sabatier (1983, p. 61) as cited in Agustino (2012, p. 139), "policy implementation is the implementation of the basic wisdom decision which is usually in the form of legislation as well as commands or important executive decision or a decision of judicial body. The decision identifies the problem to be addressed, mentions the goals or objectives to be achieved and various ways to structure or organize the implementation process".

Meanwhile, Van Meter and Van Horn (1975) in Agustino (2012, p. 139) define the policy implementation as "actions done by either individuals or officials, or groups of governments or the private sector aimed at achieving objectives that have been outlined in the wisdom decision".

Merilee S. Grindle (1980) cited by Wibawa (1994, p. 22) in Nugroho (2012, p. 690) states that Grindle model is determined by the content and the context of policy implementation. Then it added again that "The basic idea is that once the policy is transformed, then the policy implementation is done". The contents of the policy include the following:

1. The interests affected by the policy

2. Type of benefits that will be generated

3. The intended degree of changes

4. Position of policymakers

5. (Who) program implementers

6. Deployed resources.

Meanwhile, the contexts of the implementation are:

1. Power, interests, and strategies of the involved actors

2. Characteristics of the institutions and authorities

3. Compliance and responsiveness (Nugroho, 2012, pp. 690 - 691).

Based on several theories reviewed earlier, the researcher used the theory of George C. Edward III (1980) as an implementation variable with the consideration that the policy implementation of BPJS for Health in its implementation process has several interrelated elements and there are levels of interrelated policy hierarchy. Besides, BPJS for Health has facilities including 1) first-level health facilities; 2) advanced level health facilities; and 3) supporting health facilities. Thus, by using the theory of Edward III, communication and bureaucratic structures needed to implement a policy will be described in detail and systematically.

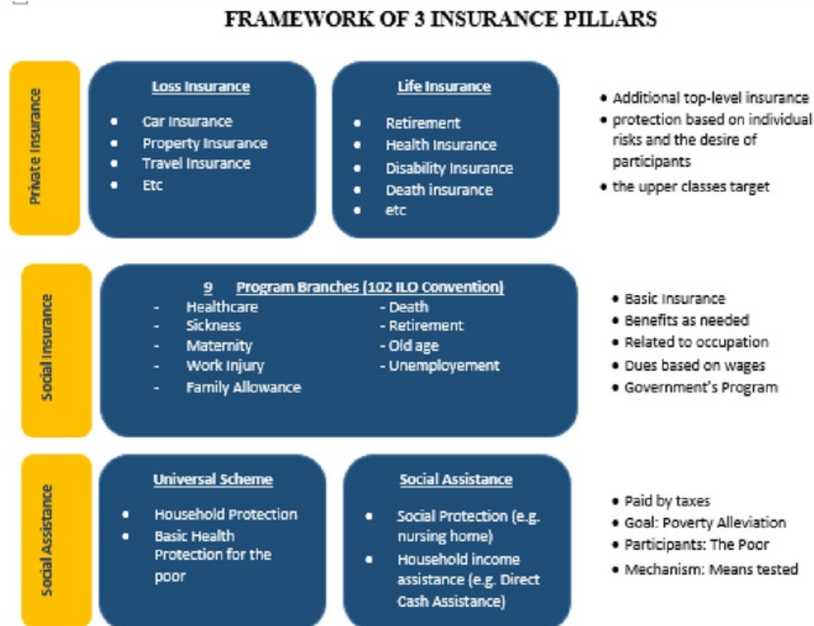
Meanwhile, the theory proposed by Merilee S. Grindle (1980) is used as a factor affecting the policy implementation as BPJS For Health has been implemented; therefore, it is necessary to know whether the policy is in accordance with what is expected by the implementers as well as whether it reaches appropriate targets. Therefore, the theory proposed by Merilee S. Grindle (1980) on Policy and Implementation Context is appropriate to analyze it.

2. Social Security Insurance

The definition of social security can be divided into two major groups, namely: social insurance and social assistance (Yohandarwati, 2003, p. 19). Viewed from a social insurance approach, social security means the technique or method of handling the risks associated with working relationship based on the law of large numbers. Meanwhile, when seen from the viewpoint of the social assistance, social security means income support for a disadvantaged community for consumption purposes (Situmorang, 2013, p. 4).

Based on 2012 - 2019 Health Roadmap, there are three pillars of insurance/guarantee as follows:

Figure of Insurance Pillars



Source: Jamsostek (2012)

Systematically, the social security system in Indonesia has built up a social protection program at each stage of the program's objectives of social protection. For the promotion stage, the government as the regulator has made the legislation relating to labor law, regulations regarding the regional minimum wage and regulations on health and other related regulations. Furthermore, on the prevention stage, the mechanisms have been set up in social insurance with social security programs, health insurance, pension insurance and savings and insurance for Indonesian National Army. The mechanism for the latter stage, Protection stage, is done through cash transfer social assistance programs, social safety nets, jamkesmas (society health insurance), and natural disaster assistance.

Social security within the framework of social protection which includes a formal sector and premium program eventually becomes a part of a broader poverty alleviation strategy. A guideline is needed to guide the implementation of the development of health insurance as mandated by the Social Security Act and the Act No. 24 of 2011 on the Social Security Agency (BPJS). According to the provisions mentioned in the legislation mentioned above, it can be explained that the social security program funding's consequence is not little because it provides protection which includes the participation aged 0-14 years old (pre-employment coverage), participation aged 15 - 64 years old (active contributor) and the participation of old age over 65 years old (post-employment coverage) (Situmorang, 2013, p. 27). Social security benefits include cash benefit for the income support of the breadwinner, financial

compensation for occupational accidents cases and accidental death as well as health services benefits (Situmorang, 2013, p. 24).

Explained again by Situmorang (2013, p. 27), there are five (5) connectivities in the administration of a comprehensive social security system which includes: 1) a program associated with the provision of financial compensation; 2) programs related to rehabilitation and provision of aids; 3) programs associated with the suspension of consumption or income; 4) programs related to health care and 5) medical care and immunizations.

3. Universal Health Coverage (UHC)

Universal coverage can be interpreted as a thorough coverage. The term universal coverage), more specifically universal health coverage, comes from WHO (World Health Organisation (Mundiharno, 2012, p. 209).

Universal health coverage aims to ensure that all people get needed health services without difficulty to figure out how to pay for it. Universal health coverage is constructed by three dimensions, namely population coverage, service coverage, and financial coverage dimensions. This is consistent with the conceptual framework described by the World Health Organization (WHO) that “The WHO's conceptual framework suggests three broad dimensions of UHC: population coverage, service coverage, and financial coverage”.

Mundiharno (2012, p. 209) explains further about the three dimensions of the universal health coverage. The first is the population coverage. From this dimension of universal coverage, it can be interpreted as “thorough participation”, in that all residents are covered as health insurance participants. By becoming participants of health insurance, it is expected they have access to health services. However, not all people who have participated in health insurance can immediately have access to health services. If the population lives in areas where there are no health facilities, the population will still lack access to health services.

Therefore, the second dimension of universal health coverage is the equitable access for all residents to obtain health services. It implies that the availability of facilities and health workers is necessary so that residents who participate in health insurance can really obtain health services. Third, universal coverage also means that the out-of-pocket payment becomes smaller so it does not lead to financial catastrophic which causes the participants to be poor.

The character of social security programs in Indonesia is still fragmented based on specific population groups. The characteristics of each population group are a social context that cannot be ignored.

Indonesia can attempt to achieve universal health coverage in three dimensions of UHC according to the World Health Organization (WHO) gradually. The key is that the first priority in achieving

universal health coverage is a guaranteed population expansion which aims all citizens are assured so every resident who is sick does not become poor because of high treatment costs. The next step is to expand guaranteed health services so that everyone can meet medical needs. The last is the guaranteed increase in medical costs so that the smaller the amount of direct costs is borne by residents.

Quick achievement of universal health coverage through a social security is influenced by several factors. Carrin and James in Mundiharno (2012, p. 211) states that "There are five factors that affect how quickly a country achieves universal health coverage. First, the income level of the population. Second, the economic structure of the country mainly related to the large proportion of the formal and informal sectors. Third, the distribution of the country's population. Fourth, the ability of countries to manage the social health insurance. Fifth, the level of social solidarity in society.

The low social security coverage which generally consists of the Health Insurance, Occupational Accident Insurance, Death Insurance, Old Age Insurance and Pension Insurance is inseparable from the development of a country's economic growth, unemployment, poverty, education included in the Human Development Index (Situmorang, 2013, p. 30). However, now universal health coverage in Indonesia as a whole has been regulated in the Act Number 40 of 2004 on National Social Security System. Similarly, the social health insurance is known as the National Health Insurance (JKN).

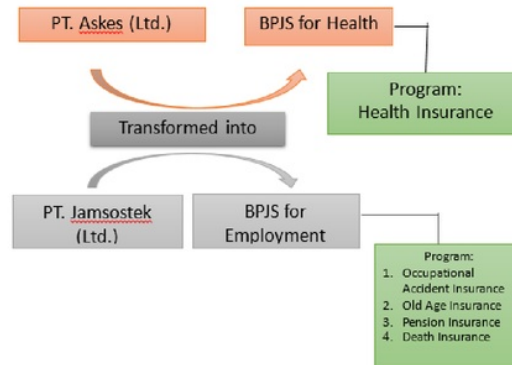
Therefore, the implementation of the national social security system is mandated to the Social Security Organizing Agency (BPJS) to provide social security in Indonesia. According to the Act number 24 of 2011 that the Social Security Organizing Agency (BPJS) is a statutory body set up to administer the social security program. The legal entity is a public legal entity. Furthermore, the Act in Article 5, paragraph (2) also clarifies that "BPJS referred to paragraph (1) is: a) BPJS For Health; and b) BPJS for Employment. Both of them organize programs of social security.

BPJS For Health is the transformation of PT Askes (Ltd.). BPJS For Health began organizing health insurance starting from January 2014.

Since the operation of BPJS For Health, Community Health Insurance program (Jamkesmas) organized by the Ministry of Health, Health Insurance Program organized by PT. Jamsostek (Ltd.), as well as health care program for Indonesia National Army and the Indonesian National Police were transferred to BPJS For Health (Eka Putri and Mahendra, 2013, p. 103).

Meanwhile, BPJS for Employment which is the transformation of PT Jamsostek (Social Security for Manpower) organizes social security and labor starting from July 2015. The program includes four insurance programs, namely (a) occupational accident insurance, (b) old-age insurance, (c) pension insurance, and (d) death insurance, further described in the following picture:

Figure on the Transformation of BPJS For Health



Source: Adapted from BPJS Regulation No. 1 of 2014

In addition, according to the Act number 24 of 2011 on BPJS, BPJS is in charge of the following:

conduct and/or receive participant registration;

collect the dues from participants and employers;

receive dues assistance from the Government;

manage the Social Security Fund for participants' interest;

collect and manage data of Social Security program participants;

pay the benefits and/or health care in accordance with the provisions of the Social Security program; and

provide information regarding the conduct of the Social Security program to the participants and the public.

BPJS For Health as stated in BPJS Rule No. 1 of 2014 states that this program carries out health insurance which covers: a) the membership; b) membership premium; c) health care providers; d) quality control and cost control; and e) reporting and utilization review. Meanwhile, according to Eka Putri and Mahendra (2013, p. 103) BPJS For Health is a public legal entity that is responsible to the President and to organize the health insurance program.

For its membership, BPJS For Health has membership categories; those are Premium Payment Assistance (PBI /Peserta Berbayar Iuran) and Non Premium Payment Assistance (Non-PBI /Peserta Berbayar Iuran). As described in BPJS Rule No. 1 of 2014 on health insurance, "The participants of Premium Payment Assistance (PBI /Peserta Berbayar Iuran). (PBI-JK) were classified as the poor and the disadvantaged".

Meanwhile, the participants of Non Premium Payment Assistance (Non-PBI /Peserta Berbayar Iuran) consist of:

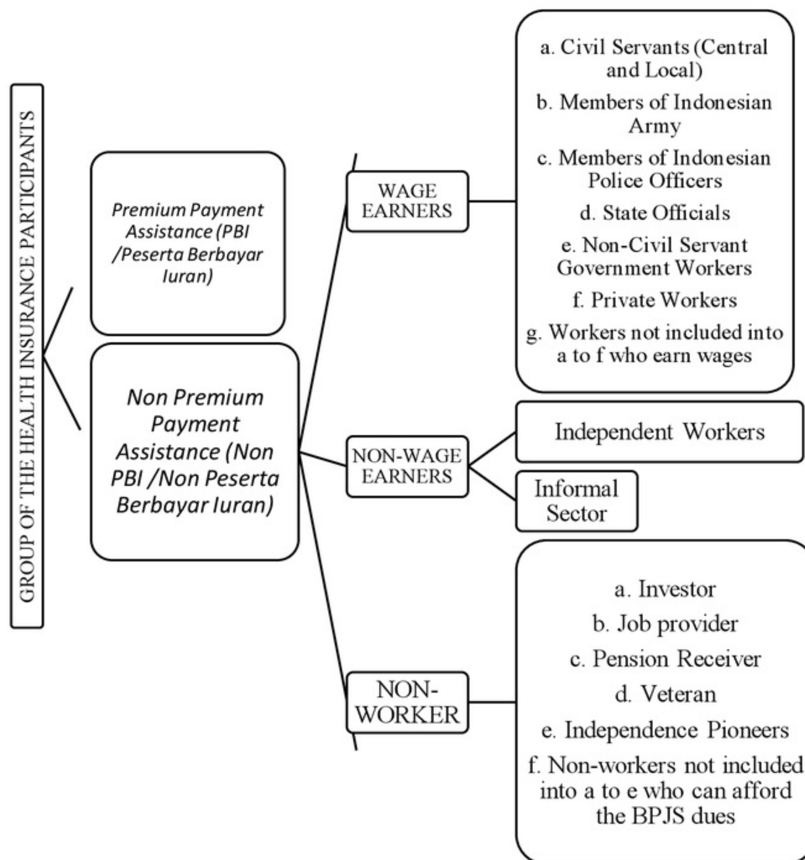
Wage earners and their family members including foreign citizens working in Indonesia for a minimum of 6 (six) months and members of their family;

Non-wage earners and their family members including foreign citizens working in Indonesia for a minimum of 6 (six) months and members of their family;

Non-workers and their family members.

The BPJS for Health membership can be shown in the following figure:

Figure on Participants Group of BPJS For Health



Source: Adapted from BPJS Regulation No. 1 of 2014

Research Method

This study is a research that combined qualitative and quantitative research paradigms. Hence, the method used is mixed methods. Mixed method is a research method which combines quantitative and qualitative methods (Sugiyono, 2012, p. 397). In mixed methods research, the quantitative and qualitative researches are not conducted together but their usage is intended to complete each other. It is in line with Sugiyono's opinion (2012, p. 400) that both methods can be combined but their usages are interchangeably.

The first step in this research was using descriptive qualitative method. After collecting qualitative data, then a research was conducted using quantitative method with survey approach. Therefore, this research refers to mixed method research using Sequential Exploratory Design. The first phase used qualitative method and the next phase used quantitative (Sugiyono, 2012, p. 409).

Research location was in Special Region of Yogyakarta, in the office of BPJS for Health branch of Yogyakarta and Regional Hospital (RSUD) in Yogyakarta by considering that BPJS for Health is the caretaker for the policy of BPJS for Health. Meanwhile, regional hospital is the advanced level of health facility that cooperates with BPJS for Health to implement the policy of BPJS for Health.

The data used in this research was primary and secondary data. Data gathering technique consists of: 1) Observation technique, 2) Interview technique, 3) documentation technique and 4) questioner technique. Next, in order to determine patients' sample in RSUD Panembahan Senopati Bantul, purposive sampling method was used. The populations of Askes in RSUD Panembahan Senopati Bantul in 2013 and from January to March 2014 were 79.197 people. Meanwhile, the patients' sample in RSUD Panembahan Senopati Kabupaten Bantul was counted using Slovin formula with margin of error is 10%.

Research Results and Discussion

In Yogyakarta the number of societies who are included in poor and disadvantaged or social welfare issues (PMKS) which is called Premium Payment Assistance (PBI) are high. From the number of population in Yogyakarta are 1.572.154 people in 2012 or 44.73% are registered as Premium Payment Assistance (PBI-JK)

Table 1: The Number of Premium Payment Assistance of Health Insurance in Yogyakarta

No	Regency/City	Registered Premium Payment Assistance of Health Insurance (People)	Percentage (%)	Note
1	Bantul Regency	472.442	30,05	
2	Gunung Kidul Regency	444.382	28,27	
3	The City of Yogyakarta	105.632	6,72	
4	Kulon Progo Regency	232.517	14,79	
5	Sleman Regency	317.181	20,17	
Total		1.572.154	100	

Source: Data taken from www.sosial.bantulkab.go.id

From the above data it can be concluded that Bantul is the regency with the population that has social welfare issues (PMKS)/ PBI-JK which is the highest in Yogyakarta as many as 30.5%. Followed by Gunung Kidul and Sleman Regencies respectively. Meanwhile, the city of Yogyakarta has low social welfare issues (PMKS)/ PBI-JK in Yogyakarta. Hence, the presence of BPJS for Health will bear the cost of the participants' social welfare issues (PMKS)/ PBI-JK in Bantul. On the other hand, there are a number of Premium Payment Assistance (PBI) who are not registered. It means that besides the Premium Payment Assistance (PBI) who are not registered as described in the following table:

Table 2: The Number of Non-registered Recipients of Premium Payment Assistance in Yogyakarta

No	Criteria	Number (people)	Percentage (%)
1	Disability displaced	1.436.896	79,85
2	Members of Social Health Insurance (Askesos)	225.000	12,50
3	Social Assistance of Elderly Displaced Recipients	26.500	1,47
4	Social Assistance of Severe Disabilities Recipients	22.000	1,22

No	Criteria	Number (people)	Percentage (%)
5	Resicende of Institution Receiving Subsidy Assistance (displaced children, the victims of drug, elderly, five-social disabilities)	89.031	4,95
Total		1.799.427	100

Source: www.sosial.bantulkab.go.id

From the table it is shown that disability displaced is the highest registerred PBI-JK as many as 79.85%. Meanwhile, the social assistance of severe disabilities recipients are the lowest non-registered participants that are as many as 1.22%.

In order to analyze the difference of BPJS for health policy implementation's influence to Premium Payment Assistance (PBI-JK) and Non-PBI participants, Analysis of Variants (ANOVA) using one way ANOVA was conducted. If it is seen from the dimensions that shape the influence difference, then there are three dimensions: membership, services and finance dimensions. In order to discover whether there were influence differences then those dimensions were tested one by one.

After that, reliability test was conducted for the overall question items on the same variable, that is implementation variable. This test was conducted using Statistical Product and Service Solution (SPSS) software by choosing statistical test Alfa-Cronbach' (α). An instrument is stated as reliable if minimal reliability coefficient is 0.6 (Sugiyono, 2012, p. 184). Based on the reliability test, it showed that coefficient value Alfa-Cronbach was higher than 0.6 that is 0.905. Therefore, this research instrument was reliable.

The respondents for this study were officials of BPJS for Health in Yogyakarta branch, the officials of RSUD Panembahan Senopati Bantul and the patients of RSUD Panembahan Senopati Bantul who are categorised as the (PBI-JK) and non-PBI participants. The total numbers of all respondents were 108 people; 42 males and 66 female respondents. The respondents' ages range from 21 - 30 year-old. Meanwhile, the education backgrounds of most respondents were Senior High School.

Respondents' Responses on The Variables of The Implementation of Badan Penyelenggara Jaminan Sosial (BPJS) for Health Policy

In order to analyze respondents' responses on variables of the implementation BPJS for Health policies then score index was determined firstly based on each dimension; those are communication dimension (Y1), resource dimension (Y2), disposition dimension (Y3) and bureaucracy structure (Y4).

The score index for each dimension is as follows:

Table 3: Summary of index Score Implementation Variables

Respondents' Score Answers							
Variable	Strongly Disagree	Disagree	Hesitate	Agree	Strongly Agree	Numb er	Index
	1	2	3	4	5		
Communication	0	0	2	4	2	8	4.00
Resource	0	0	0	10	14	8	4.59
Disposition	0	0	0	9	7	8	4.44
Buerecracy Structure	0	0	0	7	9	8	4.59
TOTAL	0	0	2	30	32	-	4.41
Implementation index (Y)						Very good	

The policy of BPJS for Health in Bantul is implemented very well. It is based on the results of index value; the communication dimension index is 4.44 (very good), the dimension of the resource is 4.59 (very good), the dimension of the disposition is 4.44 (very good) and the dimension of bureaucratic structures is 4.57 (very good).

The Difference of Policy Influence Badan Penyelenggara Jaminan Sosial (BPJS) for Health on Premium Payment Assistance (PBI /Peserta Berbayar Iuran) and Non Premium Payment Assistance (Non-PBI /Peserta Berbayar Iuran)

The influence difference which is explained previously can be summarized in the following table:

Table 4: The Difference of BPJS Policy Implementation's Influence on Premium Payment Assistance (PBI /Peserta Berbayar Iuran) and Non Premium Payment Assistance (Non-PBI /Peserta Berbayar Iuran)

Indicators	Premium Payment Assistance (PBI /Peserta Berbayar Iuran)	Non Premium Payment Assistance (Non-PBI /Peserta Berbayar Iuran)	ANOVA
The fulfilment of membership	The participants were not helped by the National Health Security program and had not fulfilled natural right of health because the registration process was too complicated and too many requirements to fulfil. They tended to agree with the scheme of Regional Health insurance (Jamkesda) and Community Health Insurance (Jamkesmas).	The participants felt being helped and that National Health Security operated by BPJS for Health had fulfilled their basic rights of health.	Fh=100 Ft 5%=3,94 So, Fh>Ft (100>3,94) Then, hypothesis is accepted It means that there is difference influence
Service guaranteed	When the participants were sick they felt secure and satisfied. They also felt that health services provided by National Health Security were good enough. It was supported by medicine provision that already used Case Based Groups (INA CBGs) system.	When the participants were sick they felt insecure and dissatisfied with health services provided by National Health Security organized by BPJS for Health. It was because they do not agree with health services for medicine provision used Case Based Groups (INA CBGs) system. The basic reason was that when they were sick and the medicine needed was not in INA CBGs' lists, then they had to find the medicine in other drug stores which means that they had to spend some more money.	Fh=100 Ft 5%=3,94 So, Fh>Ft (100>3,94) Then, hypothesis is accepted It means that there is influence difference

Indicators	Premium Payment Assistance (PBI /Peserta Berbayar Iuran)	Non Premium Payment Assistance (Non-PBI /Peserta Berbayar Iuran)	ANOVA
Finance availability	The participants felt that when they were sick they did not need to think about their health expense since it had been guaranteed by government and the expense was sufficient.	The participants felt that when they were sick they needed to think about their health expense since they still have to pay the premium every month in which the premium are varied depend on the service class they have chosen. However, the finance from the National Health Security provided by BPJS was sufficient. There were also some of the Non-PBI participants who were not problematized the premium since they were taken from their own salary or wages. The term used in National Health Security is Non-PBI participants which are categorized as wage-earners.	Fh=100 Ft 5%=3,94 So, Fh>Ft (100>3,94) Then, hypothesis is accepted. It means that there is influence difference

Source: Primary processed data, 2014

After Analysis of Variants (ANOVA) was tested using one way ANOVA for the Premium Payment Assistance (PBI) and Non-PBI participants, either using one by one test based on the dimension or overall dimensions, it can be concluded as following:

There is significant influence difference on Premium Payment Assistance (PBI) and Non-PBI participants related to the membership, services and finance dimensions.

There is significant influence difference on Premium Payment Assistance (PBI) and Non-PBI participants when it is measured overall.

Conclusion

The policy of BPJS for Health in Bantul is implemented very well. It is based on the results of index value; the communication dimension index is 4.44 (very good), the dimension of the resource is 4.59 (very good), the dimension of the disposition is 4.44 (very good) and the dimension of bureaucratic structures is 4.57 (very good).

The differences on effect of the BPJS for Health policy implementation toward Premium Payment Assistance (PBI /Peserta Berbayar Iuran) and Non Premium Payment Assistance (Non-PBI /Peserta Berbayar Iuran) in all dimensions; those are the dimension of participation with the value Fh=100, the dimension of service with the value Fh = 100 and a financial dimension with the value Fh= 100.

The suggestions for RSUD Panembahan Senopati Bantul are to maintain the implementation process of National Health Security program currently. However, if it is possible it is better to improve the health service especially in resources department. Another suggestion is intended to BPJS for Health of Yogyakarta branch for intensively conduct socialization for National Health Security programs which aims to enrich information related to its implementation. Therefore, Health Facilities (Faskes) understand their obligations and rights in implementing National Health Security programs.

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