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Partnership as an Independent Segment Participation Management Strategy in the National Health Insurance Program

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Abstract
Madiun is one of 6 regions in East Java that has reached UHC with the level of community participation in the JKN KIS program reaching more than 95%. Madiun City is included in the working area of the BPJS Kesehatan Madiun Branch Office which has the most work areas compared to other branch offices that have reached UHC. In the implementation of the JKN Cadre program there is an interesting thing there that the 15 Cadres who are still surviving in 2020 are known to have quite high loyalty and resilience, they have a minimum 3 year partnership period in the program, besides that there are two JKN Cadres from the Branch Madiun, who was ranked first and ranked third, achieved the highest contribution collectibility at the East Java regional office level. The National Health Insurance Program emerged in an effort to achieve Universal Health Coverage (UHC) in Indonesia by establishing BPJS Health as the implementer. In its financial management, BPJS Kesehatan always runs a deficit from 2014 to 2020. The biggest contributor to the deficit is the independent segment participants. The JKN-KIS Cadre partnership program which is expected to be able to increase the growth of the number of participants and increase the collectability of BPJS Health contributions for the independent participant segment has not been effective in its implementation. This study uses a qualitative descriptive paradigm with a case study method in researching and analyzing the partnership model in the JKN-KIS BPJS Kesehatan Cadre program in the Madiun branch office area. Informants were determined purposively based on certain considerations. Primary data was obtained directly from informants from the JKN Cadre and BPJS Health, while secondary data was taken from supporting documents and media reports. The validity of the data in this study was tested using observation and triangulation of data sources. The results of this study indicate that the partnership model used includes the subordinate union of partnership. With a level 3 partnership level, namely partnership (formal contracts through work agreements, new resources, risk sharing and rewards through the applied service reward system). Great support from the government for the JKN program is one of the main strengths in the success of the program. The work system used is considered quite appropriate by conducting direct house-to-house visits and involving the local community as partners directly because they have social and cultural closeness in conducting socialization and approaches to the community, especially the fostered families.

Keywords: BPJS Health, JKN Cadre, Partnership, UHC

I. INTRODUCTION

According to 2020 data in the East Java region, there are 6 regions that have reached UHC with the level of community participation in the JKN KIS program reaching more than 95%, namely Bojonegoro Regency reaching 98.76 percent, Mojokerto City reaching 100 percent, Probolinggo City reaching 97 .76 percent, Pasuruan City which reached 97.64 percent, Malang City which reached 95.57 percent, and Madiun City which reached 95.34 percent. The six regions come from 5 areas of the BPJS Health Branch Office. The BPJS Kesehatan Madiun branch office is the branch office that has the most area coverage, consisting of Madiun City, Ngawi Regency, Madiun Regency, Magetan Regency, Ponorogo Regency.

BPJS Kesehatan Branch Office	Work Area
Pasuruan Branch Office	Pasuruan City, Pasuruan Regency, Probolinggo City, Probolinggo Regency
Mojokerto Branch Office	Mojokerto Regency, Mojokerto City, Jombang Regency
Madiun Branch Office	Madiun City, Ngawi Regency, Madiun Regency, Magetan Regency, Ponorogo Regency
Bojonegoro Branch Office	Bojonegoro Regency, Tuban Regency.
Branch Office Malang	Malang City, Malang Regency, Batu City.

Table 1. BPJS Health Branch Office Work Areas. Source: Obtained from primary data.

There is an interesting fact that 15 JKN Cadres in the BPJS Kesehatan Madiun Branch who are still surviving in 2020 have a fairly high loyalty and are resilient, they have a minimum of 3 years of partnership in the JKN-KIS Cadre program, namely cadres who come from recruitment. In 2018, in addition there were 2 JKN cadres from the Madiun Branch who had good performance achievements where they ranked first and ranked third in achieving the highest contribution collectibility at the East Java regional office level. (BPJS Health, 2020).

BPJS Health data states that as of September 31, 2019, as many as 221,203,615 Indonesian citizens were registered as JKN-KIS participants or reached 84.1 percent. BPJS Kesehatan East Java data, as of June 26, 2019, the number of BPJS Health participants in East Java was 29.4 million out of a total of 40.9 million inhabitants of East Java. Only 72 percent of the population in East Java have become BPJS Health participants.

In 2012 the United Nations General Assembly reaffirmed the global goal of ensuring access to health care and financial risk protection by issuing a resolution advocating the implementation of Universal Health Coverage (UHC) including social protection and sustainable financing. Indonesia adopted UHC through social security which was manifested by the enactment of Law Number 40 of 2004 concerning the National Social Security System (SJSN) which mandated the implementation of social security and the first thing that must be implemented was health insurance which began on January 1st, 2014. A year before the implementation of JKN , through Presidential Decree No. 12 of 2013 concerning Health Insurance as amended by

Presidential Decree no. 111 of 2013 concerning Amendments to Presidential Regulation No. 12 of 2013 concerning Health Insurance article 6 paragraph (1) that Health Insurance participation is mandatory and covers the entire population of Indonesia with a target of all residents no later than January 1, 2019.

In terms of management, at the end of 2011 Law no. 24 of 2011 concerning the Social Security Administering Body (UU BPJS) to carry out the constitutional mandate of Law No. 40 of 2004 concerning the National Social Security System (SJSN).

Annual financial report data shows BPJS Kesehatan experienced a financial deficit of IDR 3.8 trillion in 2014, IDR 5.9 trillion in 2015, and IDR 9.7 trillion in 2016. This financial deficit continued to increase to IDR 9.75 trillion in 2017 In 2018, BPJS Kesehatan's financial deficit reached Rp. 16.5 trillion. Until the end of December 2019, BPJS Kesehatan had a deficit of IDR 13 trillion. This even after being injected back Rp 15 trillion. For 2020, where BPJS Kesehatan was reported to have had a surplus, it turned out that BPJS Kesehatan was still in a deficit of IDR 6.36 trillion (Source: BPJS Health in 2020). Based on BPJS Health's financial performance report, PBI (poor and underprivileged) still has a surplus of Rp. 11.1 trillion, ASN/TNI/Police have a surplus of Rp. 1.3 trillion, and private formal workers have a surplus of Rp. 12.1 trillion. Meanwhile, for informal workers, BPJS Kesehatan still recorded a deficit of Rp. 20.9 trillion, and from non-employee participants it was still a deficit of Rp. 6.5 trillion. The biggest contributor to the deficit is PBPU/BP participants, which are around 35 million people, with the largest segmentation in Class III as many as 21.6 million. Their total contribution is IDR 12.4 trillion, claims IDR 39.8 trillion, meaning a deficit of IDR 27.4 trillion. (Source: BPJS Health 2020).

One of the biggest challenges faced by BPJS Kesehatan is the recruitment and collection of contributions to the informal worker group. For this reason, since October 2016, BPJS Kesehatan has opened the JKN-KIS Cadre partnership program which is expected to increase the growth of the number of participants and increase the collectability of BPJS Health contributions for the informal participant segment or Non-Wage Recipient Workers (PBPU).

The use of the partnership model in the program is one form of application of the New Public Management concept in the field of health insurance in Indonesia. The public policy in the health sector, if viewed theoretically, cannot be separated from the paradigm shift in public administration. Public administration is a dynamic science and has undergone changes and updates from time to time in accordance with the challenges it faces. In some literature on Public Administration from home and abroad, in general, there are four paradigms that have developed in public administration, namely: Old Public Administration (OPA), New Public Administration (NPA), New Public Management (NPM), New Public Services (NPS). In 1992, David Osborne and Ted Gaeblet published the book Reinventing Government which was followed by the book Banishing Bureaucracy in 1997. Reinventing Government is one application of NPM which is essentially an effort to transform the spirit and performance of entrepreneurs (entrepreneurship) into the government bureaucracy. The spirit of entrepreneurship emphasizes efforts to increase the resources both economic, social,

cultural, and political owned by the government to become more productive and produce high yields. Janet and Robert (2007) explain that New Public Management refers to a group of contemporary ideas and practices that essentially use a private sector approach and business in the public sector. When viewed from the form of institutional organization, the Legal Entity of the Social Security Administering Body (BPJS) is a Hybrid Legal Entity, because the institution carries out two functions at once. Aside from being a public legal entity, BPJS Kesehatan can also be seen as a government institution that carries out a government function (governing function) in the field of public services, as well as functions as a self-regulation organ and acts as an organ operator. BPJS acts as a public body, which carries out the function of public services, and also carries out the function of a Private Legal Entity, namely the development of funds from the public – through membership fees. With the use of the partnership model in the JKN Cadre Program where Partnership is one of the business strategies used in the private sector and then in the program applied to the public sector, it is deemed appropriate if the author sees this using the New Public Management paradigm. Regarding the use of the partnership model in the public policy sector, Bournemouth (2006) argues that partnerships are the right solution to solve implementation problems in policies that are considered difficult for the government to do alone.

From the partnership program launched by BPJS Kesehatan, a number of questions emerged. The basic question revolves around in detail how the partnership model built between BPJS Health and the community in the JKN Cadre Program in the Madiun branch office is carried out, then what factors are the obstacles and supporters of the JKN Cadre program.

II. METHODOLOGY

This study uses a qualitative descriptive paradigm with a case study method in examining the partnership model of the JKN-KIS Cadre program in the BPJS Kesehatan Madiun Branch of Work area. Informants were determined purposively based on certain considerations. Primary data was obtained directly from informants from BPJS Health and the JKN-KIS Cadre, while secondary data was taken from supporting documents and media reports. The triangulation informants were selected by five informants who represented the community as JKN-KIS Cadres.

III. RESEARCH RESULT

A. Partnerships and Partnership Patterns in Public Policy Implementation

Partnership seen from an etymological perspective is adapted from the word partnership, and comes from the root word partner. Partner can be translated "partner, soul mate, ally, or campaigner". The meaning of partnership is translated into partnership or partnership (Ambar, 2017). Starting from this, partnership can be interpreted as a form of partnership between two or more parties that form a cooperative bond on the basis of an agreement and mutual need in order to increase

capacity and capability in a particular business field, or a specific goal, so as to obtain good results. Bournemouth (2006) argues that partnerships are the right solution to solve implementation problems for policies that are considered difficult for the government to do alone.

The emergence of considerations of the need to strengthen public-private cooperation can be seen from the following 3 (three) dimensions::

1. Political reasons: creating a democratic government and encouraging the realization of good governance and good society.
2. Administrative reasons: limited budget resources, human resources, assets, and management capabilities.
3. Economic reasons: reducing inequality or inequality, referring to growth and productivity, increasing quality and quantity, and reducing risk (Tri Widodo, 2004).

Meanwhile, other partnerships developed based on the principles of organizational life in general are as follows. (Sulistiyani, 2017).

1. Subordinate Union of Partnership
   Namely a partnership on the basis of the merger of two or more parties who are related in a subordinating manner. This kind of partnership occurs between two or more parties who have unequal status, ability or power. Thus the relationship created is not in a straight line that is balanced with one another, but is in a top-down, strong-weak relationship. Because of this condition, there is no sharing and a balanced role or function.
2. Linear union of partnership
   Partnership by merging the parties in a linear or straight line. Thus the parties who join to cooperate are organizations or parties that have relative similarities. The similarity can be in the form of goals, or missions, size/volume of business or organization, status or legality.
3. Linear collaborative of partnership
   In the context of this partnership, it does not distinguish the size or volume, status/legality, or strength of the partnering parties. The main emphasis is the vision and mission that complement each other. In this partnership relationship is established linearly, which is in a straight line, not subordinated to each other.

   In a partnership there is also a level of partnership. According to Heideneim (2002) in Ambar Teguh Sulistyani, there are five levels or levels in a partnership, namely: full collaboration, coalition, partnership, alliance, and network. Each stage is characterized by the following characteristics:

   a. Full collaboration: Written aggreement, Shared vision, Consesnsus decision, Formal work assignment
   b. Coalition : formal aggreement, All member involved in, New resources, Joint budget
   c. Partnership : Formal contract, New resources, Shared risk and reward
   d. Alliance : semi formal, Some new resources, Coordination of task

e. Network : Loose association, No significant demands

B. Universal Health Coverage di Indonesia

In the implementation of public policies in the health sector, Indonesia has a 1945 Constitution which is abbreviated as UUD 45. In the 45th paragraph of the 1945 Constitution, there are five precepts of the Pancasila Basic State of the Republic of Indonesia, namely 1. Belief in One God, 2. Humanity fair and civilized, 3. Indonesian unity, 4. Democracy led by wisdom in deliberation and representation, 5. Social justice for all Indonesian people. Article 28H of the 1945 Constitution states that everyone has the right to obtain health services. Furthermore, Article 34 states that the State develops a Social Security System for all people and the state is responsible for providing health service facilities. For the poor and neglected children, the state takes care of them. In the 1948 United Nations (UN) Declaration on Human Rights. Article 25 Paragraph (1) of the Declaration states that everyone has the right to health and well-being for himself and his family, including the right to health care and necessary social services.

Various efforts to implement the 1945 Constitution and the 1948 UN Declaration, starting from the implementation of the health insurance program for Civil Servants and Armed Forces of the Republic of Indonesia (ABRI) and the Indonesian National Armed Forces (TNI) and retirees and veterans using health insurance (Askes) organized by PT Askes, for private employees, uses social security insurance for workers (Jomsostek) with PT Jamsostek as the organizer. The government provides guarantees for the poor and underprivileged, through the Public Health Insurance (Jamkesmas) and Regional Health Insurance (Jamkesda) schemes. These various health insurances run independently so that health costs and service quality are difficult to control.

Finally, in 2004 Law No. 40 of 2004 concerning the National Social Security System (SJSN) was enacted, which applies to all Indonesians. The following year, the World Health Assembly (WHA) in its 58th session in 2005 in Geneva, agreed on the need to develop a health financing system that ensures public access to sustainable health financing through UHC. The trick is through the mechanism of social health insurance. In addition, WHA also recommends to WHO that in achieving UHC, WHO member countries evaluate the impact of changes in the health financing system on health services.

In Law 40/2004 it is stated that social security is mandatory for all Indonesians. Everyone has the same right to have access to safe, quality and affordable health care and health services. On the other hand, everyone also has an obligation to participate in the health insurance program. This is stated in Law 36 of 2009 concerning Health. Law No. 24 of 2011 stipulates that the National Social Security is administered by BPJS, which consists of BPJS Health and BPJS Employment. Furthermore, specifically for the poor or people who are unable to pay contributions, the Government issued Government Regulation No. 101 of 2012 concerning Contribution Assistance Recipients (PBI); To implement JKN the President issued Presidential Regulation No. 12 of 2013

concerning Health Insurance which has been amended three times, with PP No. 19 of 2016, and finally with PP No. 28 of 2016, especially regulates the rights and obligations of participants and the Government as the provider of contribution assistance for the poor (PBI).

The fulfillment of the right to health services and social justice began to be realized on January 1, 2014, namely the implementation of the National Social Security System (SJSN) in the health sector or the National Health Insurance (JKN) system. It is hoped that in 2019 all Indonesian people will become JKN (Universal Health Coverage) participants, but in reality this has not materialized until now. UHC is a complex process, fraught with challenges, many possible paths, and various pitfalls, but it is also feasible and achievable. (Reich et al., 2016).

C. JKN-KIS cadres in the Madiun Branch Office

JKN-KIS cadres are people who have the capacity according to certain criteria and are recruited by BPJS Health as a partner, to perform certain functions in a certain area based on BPJS Health Board of Directors Regulation Number 04 of 2017 namely: Contribution reminder function, Contribution collection function, Marketing function social function, membership function and function of providing information and complaints. The implementation of the JKN-KIS Cadre is carried out by all BPJS Health Regional Divisions. The payment system used is a fee system determined by BPJS Health based on the number of outstanding contributions that have been collected within one month. The percentage of tiered service fees is between 7% to 15% depending on the age of arrears in contributions with an age range of 2 months to 24 months. In its implementation, the JKN-KIS cadre program in the BPJS Kesehatan Madiun Branch Office is under the coordination of the Billing and Finance Sector, because related to the management of contributions, the related field is the Billing and Finance Sector. However, in the field implementation, JKN cadres can also coordinate with other fields such as the Participation sector and also the Participant Complaints field and also the District Office in the area of each JKN Cadre. Each JKN cadre oversees as many as 500 families who are fostered families who must be visited every month. The work agreement agreement between JKN Cadres and BPJS Health is valid for one year.

JKN-KIS cadres are not included in the organizational structure of BPJS Kesehatan Madiun Branch. Because this Cadre program is a partnership program built by BPJS Health with the community in the context of an efficient and effective contribution collection strategy considering the limited number of existing personnel, and this JKN-KIS Cadre program must be implemented by BPJS Health Branch Offices throughout Indonesia.

BPJS Kesehatan Madiun Branch has 5 personnel in the Billing and Finance Sector consisting of 1 Head of Division, 1 Cashier, 1 bookkeeping staff and 2 billing staff. This amount is certainly not proportional to the number of bills that must be managed.

The implementation of the JKN Cadre program in the Madiun branch office area began in April 2017. Recruitment of JKN-KIS Cadres is carried out through the installation of announcements in the form of banners and billboards at BPJS Kesehatan

branch offices, Regency offices, and also Kelurahan offices. Communities who will partner will go through several stages of selection. The first stage that must be passed is the selection of administrative completeness requirements, then the written test stage, the next stage is the interview and the last stage is the signing of the work agreement and debriefing related to information and services for the National Health Insurance program. For the BPJS Kesehatan office area, the Madiun Branch Office lastly recruited JKN-KIS cadres in 2018. Recruitment and determination of the number of quotas for JKN-KIS Cadres was determined by the Head Office, however in the implementation of the selection of JKN-KIS Cadre candidates and evaluation was carried out by the branch offices themselves.

No.	Area	Number of JKN Cadre
1	Madiun City	3
2	Madiun Regency	4
3	Magetan Regency	2
4	Ponorogo Regency	4
5	Ngawi Regency	2
	Total	15

Table 2. Number of JKN Cadres in Madiun Branch Office Work Areas in 2020. Source: Obtained from primary data.

Year	Number of JKN-KIS Cadre	Information
2017	12	Beginning of recruitment April 2017
2018	52	There is additional recruitment
2019	34	Extension of work agreement from previous years's cadre
2020	15	Extension of work agreement of previous years's cadre

Table 3. Number of JKN-KIS Cadres of BPJS Kesehatan Madiun Branch in 2017 – 2020. Source: Obtained from primary data.

The reduction in the number of JKN-KIS Cadres annually is carried out based on their performance. Evaluation and assessment of performance in the JKN-KIS Cadre Program is seen from several things, namely the level of attendance at the time of the evaluation, timely delivery of reports, the number of visits by the assisted families, and the last result of the visit is the number of arrears that have been successfully collected, and there are several cadres who resigned. self. Finally carried out the recruitment of JKN-KIS Cadres at the Madiun branch of BPJS Kesehatan in 2018. For the following year there was only a reduction based on their performance and for JKN-KIS cadres who felt their performance was good were called back to become partners as JKN Cadres for the following year.

D. Target and Realization of the JKN-KIS Cadre Program BPJS Kesehatan Madiun Branch

The implementation of the JKN Cadre program in the Madiun branch office area began in April 2017.

	Target Achievement (%)	
Year	Number of Visit	Amount of Due Collected
2017	9.7%	0
2018	12.7%	70.9%
2019	14%	67.9%
2020	46.9%	153%

Table 4. Targets and Realization of the JKN BPJS Health Cadre Program Madiun Branch. Source: Obtained from primary data

Based on the table above, it can be seen that from the initial year the program was not able to achieve the set targets. However, in the process of its journey from year to year, progress has been made in achieving the target. Based on this analysis, it can be concluded that there is a positive movement in the implementation of the program.

E. JKN-KIS Cadre Program Partnership Levels

The fulfillment of the right to health services and social justice began to be realized on January 1, 2014, namely the implementation of the National Social Security System (SJSN) in the health sector or the National Health Insurance (JKN) system. It is hoped that in 2019 all Indonesian people will have the partnership relationship established in the JKN-KIS Cadre Program if analyzed on the Partnership Level/Level According to Heideneim (2002), according to several characteristics encountered, it can be categorized in the partnership partnership level. In the partnership relationship carried out between the BPJS Health and the individual community as JKN-KIS Cadres in which there is a formal and written work agreement, individual community members who become JKN-KIS Cadres are also new resources outside the health sector, as well as risk sharing and rewards. through the applied performance-based remuneration system. JKN cadres who are new resources from the community are considered easier to accept and understand by participants because they have cultural closeness and also emotional closeness in encouraging the community to actively work together in the JKN-KIS program. The community becomes JKN Cadre voluntarily, with their background being active in community activities in their environment as JKN (Universal Health Coverage) participants, but in reality this has not materialized until now. UHC is a complex process, full of challenges, many possible paths, and various pitfalls, but it is also feasible and achievable. (Reich et al., 2016).

F. Partnership Model for the JKN-KIS BPJS Health Cadre Program Madiun Branch

From the results of research studies related to the flow of the partnership process in the JKN Cadre program, it can be seen that the BPJS Health is the most dominant party in determining the course of the partnership process in the JKN-KIS Cadre program. The

partnership that occurs between the two parties has a status, ability or power that is not balanced with each other. Thus the relationship created is not in a straight line that is balanced with one another, but is in a top-down, strong-weak relationship. Because of this condition, there is no sharing and balanced roles or functions. The JKN-KIS Cadres carry out more of what the BPJS Health decides to do, so the partnership is more of a subordinate relationship. Sharing and communication that occurs only in the technical area of carrying out tasks in the field and has not touched the agreements in the partnership process itself, giving rise to the impression that Cadres are only carrying out what is ordered by the BPJS Kesehatan which has delegated some of its duties and authorities to them. . For example, in determining the percentage of service fees or the fee system used and the contract period of the work agreement made by the BPJS Kesehatan which is only valid for one year. Based on the analysis above, it can be concluded that the partnership model in the JKN-KIS BPJS Health Cadre program can be categorized as a Subordinate Union Of Partnership model. The JKN-KIS Cadre Program has been efficient in supporting the success of the National Health Insurance program, especially in managing the membership of the independent segment. This can be seen from the application of the percentage of fee system that it uses, but if it is seen in terms of its effectiveness, it can be said that it is still lacking to see the existing data that as long as this program runs from 2017 to 2020 in the work area of the BPJS Kesehatan Madiun Branch, there is still no able to achieve the targets that have been set, especially related to the target number of visits to the assisted families.

G. Inhibiting and Supporting Factors for the JKN-KIS Cadre Program BPJS Kesehatan Madiun Branch Office

The JKN-KIS Cadre Program has the opportunity to be maximized by looking at some of the existing potentials. The existence of great support from the government for the National Health Insurance program is certainly one of the major strengths in the success of the program. Followed by the availability of support in the form of funds that can be optimized in its management. The work system used is considered quite appropriate by making direct visits from house to house. The involvement of the local community as a direct partner is deemed appropriate because they have social and cultural closeness in conducting socialization and approaches to the community, especially the fostered families.

The inhibiting factor in the JKN-KIS Cadre partnership program, among others, is the lack of socialization related to the National Health Insurance program, especially in remote rural areas that have not been touched by BPJS Health. Public awareness is still low on the importance of participating in the National Health Insurance program and the benefits obtained. There is public dissatisfaction with health facility services when using BPJS Health. The gap in service quality between using the JKN-KIS card and using the independent or public fee line is quite visible. In addition, the impact of the COVID-19 pandemic and the increase in membership fees add to the heavy burden of the community's economic condition which has an impact on the ability of the community to pay contributions. The loose part-time work system used so that the

profession of a JKN cadre is just a side job, which results in a less than optimal target achievement. The existence of a remuneration system that is applied only based on the percentage of contributions collected causes no guarantee of income certainty that a JKN cadre gets every month.

IV. CONCLUSION

This article tries to explain how the partnership model in the JKN Cadre program is implemented. The results of the study show that the partnership formed in the JKN-KIS Cadre Program is included in the Subordinate union of partnership partnership pattern. The partnership that occurs between the two parties has a status, ability or power that is not balanced with each other. Because of this condition, there is no sharing and balanced roles or functions.

The partnership level between BPJS Health and community individuals in the JKN-KIS Cadre program is included in the partnership partnership level because it has fulfilled 3 main factors, namely a formal contract through a work agreement, the existence of new resources, namely community individuals outside the health sector, as well as the sharing of risks and benefits. rewards through the applied remuneration system.

The JKN-KIS Cadre Program has the opportunity to be maximized by looking at some of the potential that exists even though there are several inhibiting factors in the program. The suggestion from the author is that there is an increase in two-way communication that is more intensive, not only related to technical work but can enter the area of the partnership relationship that exists between the two parties, for example related to the fee system used which is calculated only based on the amount of outstanding contributions collected, so it is hoped that other functions possessed by a JKN-KIS Cadre can run more optimally.

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