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Strategy to Optimize Access to Health Service Financing for the Poor through the UHC Program in Bondowoso Regency

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ABSTRACT

This study aims to determine the Bondowoso district government's strategy for optimizing health service financing for low-income people in the Bondowoso district.

The method used in compiling this paper is a qualitative descriptive approach using direct field observations, interviews with related parties, and supporting documents, focusing on strategic efforts to achieve Universal Health Coverage (UHC) in Bondowoso Regency as part of accelerating the achievement of the Sustainable Development Goals. or the Sustainable Development Goals (SDGs), as well as an effort to ensure the fulfillment of citizens' rights to health, especially people with low incomes.

The sustainable synergy of implementing the UHC program in Bondowoso district is inseparable from the close ties of communication and collaboration across related sectors, namely, among others, the Bondowoso District Health Office as executor in administration and also as supervisor, Bondowoso Regency Government through the Regional Development Planning Agency as well as the Regional Finance and Asset Management Agency in terms of budget, BPJS Health in terms of management of claims and premium contributions and cooperation with First Level Health Facilities and Referral/Advanced Level Facilities as a provider of public health services, the Social Service and the Tape Manis Post as parties that recommend targets who can receive the Health insurance program and the Population and Civil Registration Office in terms of synchronizing population data.

In the implementation of the UHC Program in Bondowoso district, there are still several obstacles in terms of technical performance related to updating and synchronizing population data, human resources, technical financing, and supporting infrastructure so that the Government of Bondowoso Regency continues to evaluate and make improvements in terms of technical implementation and policies related to the performance of the UHC program, to optimize the achievement of UHC.

Keywords: optimization strategy, health service financing strategy, people with low incomes, UHC

1. INTRODUCTION

Since the early 2000s, universal health coverage (UHC) has gained wider attention and become an ideological reference for health systems worldwide. UHC means ensuring that health services, which society needs, are of adequate quality and that people can access them easily without financial hardship (Isabel Tavares &; Lopes Ferreira, 2019).

Universal health coverage (UHC) is defined as the desired outcome of health system performance whereby everyone gets the needed health services without financial hardship (Chalkidou et al., 2016). However, the scarcity of resources in most countries cannot guarantee that everyone obtains every helpful healthcare service at an affordable price. Therefore, priorities must be set to provide a comprehensive set of key services aligned with other social goals, which should be accessible to everyone. Several efficiency indicators of essential health services and financial protection have been suggested to guide countries in implementing UHC. Policymakers need to decide what health services will be provided, for whom, at what price, and how the quality of health services (Chalkidou et al., 2016).

The historical background of UHC begins in the period immediately after World War II. In 1948, the WHO constitution considered health a human right; in 1978, the Alma Ata declaration defended the importance of primary health care to provide "Health for All"; in 2005, WHO members signed a resolution aimed at the implementation of universal coverage (Isabel Tavares &; Lopes Ferreira, 2019). As of September 25, 2015, more than 150 world leaders adopted 17 Sustainable Development Goals (SDGs). SDG Goal 3 focuses on ensuring healthy lives and promoting well-being for all communities at all ages. According to Agyepong, the core of the goal is the achievement of

universal health coverage (UHC), including financial risk protection, access to quality essential healthcare services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all (Agyepong, 2018). Tavares and Ferreira write that in 2018, the government recommitted to the importance of primary health care as a key pillar of UHC in the Astana Declaration. In addition, the UN has set UHC as a target for achieving the Sustainable Development Goals by 2030 (Isabel Tavares &; Lopes Ferreira, 2019).

In 2005, the UHC concept was once again recognized, and for the first time, the World Health Assembly (WHA) explicitly endorsed UHC as a sustainable healthcare financing goal (Abiiro &; De Allegri, 2015). The World Health Assembly resolution explicitly calls for implementing a healthcare financing system centered on prepayment and payment mechanisms to achieve UHC. Based on this Resolution, WHO defines UHC as access to the primary promotive, preventive, curative, and rehabilitative health interventions for all at an affordable cost to achieve equity in access (Abiiro &; De Allegri, 2015). The 2008 World Health Report reiterated the prepaid and unification system as essential instruments for UHC by expressly stating that UHC requires the collection of prepaid contributions collected based on the ability to pay and use these funds to ensure that services are available, accessible, and produce quality care to those who need it, without exposing them to the risk of catastrophic spending (Abiiro &; De Allegri, 2015). In 2010, the World Health Report further emphasized the role of health system financing for UHC by stating that countries should raise sufficient funds, reduce dependence on direct payments to finance services, and improve efficiency and equity (Abiiro &; De Allegri, 2015). The UHC concept reflected in these WHO reports seems to be more focused on improving a health system's health service financing function (Abiiro &; De Allegri, 2015).

According to Abiiro and DeAllegri, citing the explanation of the Director General of WHO, UHC is the single strongest concept that offers public health (Abiiro &; De Allegri, 2015). UHC has proven its importance in improving population health, especially for the poor (Abiiro &; De Allegri, 2015). This phenomenon results in a third global transition and dramatically affects the reorganization and financing of global health systems (Abiiro &; De Allegri, 2015). As an important catalyst for poverty alleviation and economic growth, UHC is considered a prerequisite for sustainable development and has been advocated as an essential health goal in the post-2015 global development agenda (Abiiro &; De Allegri, 2015).

In their writing, Tavares and Ferreira (2019) stated that the government faces one of the main challenges, namely UHC funding. Funding must be efficient to ensure people's access to health services when needed and equality across society (Isabel Tavares &; Lopes Ferreira, 2019). As a legal concept, UHC implies the existence of a legal framework that mandates national governments to provide health services to all populations while forcing the international community to support poor countries in implementing this right (Isabel Tavares &; Lopes Ferreira, 2019). As a humanitarian, social concept, UHC aims to achieve universal population coverage by enrolling all residents into health-related social security systems and guaranteeing fair rights to the benefits of a health system for all (Isabel Tavares &; Lopes Ferreira, 2019). As a health economics concept, UHC guarantees financial protection by protecting against disaster consequences and reducing out-of-capacity expenditures by implementing a combined prepaid financing system (Isabel Tavares & Lopes Ferreira, 2019).

Chalkidou et al. (2016) mentioned that the government in low- and middle-income countries legitimizes the implementation of universal health coverage (UHC) following the UN resolution on UHC in 2012 and its strengthening in the sustainable development goals set in 2015 (Chalkidou et al., 2016). According to Chalkidou, UHC will differ in each country depending on the country's context and needs, as well as the demand and supply of healthcare. Therefore, policymakers and stakeholders have raised fundamental issues such as UHC's purpose, users, and cost-effectiveness (Chalkidou et al., 2016).

We might learn how UHC is implemented in Sub-Saharan African countries based on research conducted by Lisa-Marie Ouedraogo and Steffen Flessa. The study, which aimed to review various models of integrative Social Health Insurance (SHI) systems from low-income countries in sub-Saharan Africa regarding their contribution to Universal Health Coverage (UHC), focused on four example countries where community-based approaches play an important role in the implementation of national SHI systems namely Ghana, Burkina Faso, Tanzania and Rwanda (-Marie Ouedraogo &; Flessa, 2016). Marie Ouedraogo and Flessa note that public measures in the field of social health protection in Sub-Saharan African countries are regularly designed only for civil servants and formal employees. In contrast, private health insurance products are untailored and unaffordable for low-income people, p This leads to a devastating situation where the most vulnerable population groups i.e. informal sector workers and low-income farmers, are excluded from any kind of social health financing. At the same time, their exposure is high, decreasing household resilience levels and increasing the risk of falling deeper into poverty (-Marie Ouedraogo & Flessa, 2016).

It is against this backdrop, according to Marie Ouedraogo and Flessa, that innovative approaches are developing in most low-income countries in sub-Saharan Africa, aiming to serve the informal sector and provide a minimal level of social protection in health for low-income people. The most prominent example in this context is the Community-Based Health Financing (CBHF) scheme, which is based on a cooperative approach (-Marie Ouedraogo &; Flessa, 2016). In the theoretical background of micro health insurance, the CBHF scheme is classified as a shared model, in addition to three other types of micro health insurance (-Marie Ouedraogo &; Flessa, 2016). Because the community owns and manages it, CBHF can develop products and processes tailored to their target low-income groups (Marie Ouedraogo & Flessa, 2016). Furthermore, CBHF schemes operate on the trust of each community they serve, allowing them to gain support through local leaders and in partnership with local health facilities (Marie Ouedraogo & Flessa, 2016). CBHF schemes typically cover only a tiny percentage of the population (1-2%), leading

to perceiving CBHF schemes as low-impact institutions with weak technical and institutional capacities (-Marie Ouedraogo &; Flessa, 2016). The advantages and disadvantages of the CBHF scheme are widely discussed topics among international development actors (Marie Ouedraogo &; Flessa, 2016). Recent evidence suggests that innovative approaches to CBHF schemes can contribute significantly to UHC attainment in low-income countries (Marie Ouedraogo & Flessa, 2016).

In their research, Marie Ouedrago and Flessa (2016) mentioned that many governments of low-income countries in sub-Saharan Africa recognize the potential of CBHF schemes to cover the informal sector with innovative and tailored health financing measures. Hence, innovative integrative national Social Health Insurance (SHI) systems are developing. While recent evidence proves the promising potential of these integrative approaches, countries are implementing various integrated approaches that combine public and private efforts toward social health protection and UHC (Marie Ouedraogo &; Flessa, 2016).

In their research, Gera et al (2018) wrote that India has started taking steps to achieve the targets set in the SDG framework and achieve UHC. With the enactment of India's National Health Policy (NHP) – in 2017, the policy environment to transform the country's health landscape coincided with the global approach towards strengthening health systems and achieving UHC (Gera et al., 2018). To achieve the desired outcomes set out in the SDGs and NHP2017, decisive coordinated action is needed, including political action to make health an individual right; effective stewardship of the Ministry of Health and National Family Welfare; reorganization of health care delivery implementing a "systems approach"; ensuring financial protection of health care costs; and increasing participation and community accountability (Gera et al., 2018).

In Indonesia, Universal Health Coverage (UHC) is defined as a health system that ensures every citizen in the population has fair access to quality health services such as the National Social Security System (SJSN) legal guarantee and implemented by the Social Security Organizing Agency (BPJS) (Budiarsih, 2020). According to (Budiarsih, 2020), the local government had already implemented a health insurance system for regional communities known as regional health insurance (Jamkesda) before the national social security system was completed. The government has developed a strategy to integrate JAMKESDA into the National Health Insurance (JKN) which will be managed centrally by BPJS to face the challenges towards UHC. Still, the existing conditions in the regions do not support the policy, so there are various variations of the JAMKESDA system faced by the government center, including the management system, benefits packages received by JAMKESDA participants, and target recipients of contribution assistance (PBI) (Budiarsih, 2020). Things that affect the system are factors such as regional fiscal capacity, the commitment of regional leaders, and regulatory adjustments between regions and the center (Budiarsih, 2020). Prevention of problems arising from the integration system policy launched by the central government can be done by managing a good and targeted system, namely a dynamic centralized system, where the central government continues to provide space for regions to determine their policy directions according to the conditions of each region (Budiarsih, 2020).

In Indonesia, the basic principle of UHC has been answered by Law No.40 of 2004 concerning the National Social Security System (SJSN Law), that every resident must have access to comprehensive health services (Budiarsih, 2020). The development of the direction of the health financing system, as stated in the SJSN Law, requires the role of local governments, both provincial and district/city, not just the role of the central government (Budiarsih, 2020). By quoting Aulia's statement (2014), Budiarsih wrote that this is stated in article 22 of Law No. 32 of 2004 concerning Regional Government which states that local governments are obliged to develop a social security system that includes a health insurance system (Budiarsih, 2020).

The role of local governments in implementing the social security system is further strengthened by granting a judicial review of Law No. 24 of 2004 concerning the National Social Security System (SJSN) by the Constitutional Court of the Republic of Indonesia (Budiarsih, 2020). The obligations and priorities of regional spending are determined based on the decision of the Constitutional Court of the Republic of Indonesia to develop a social security system based on Article 22 letter h and Article 167 of Law Number 32 of 2004 concerning Regional Government (Budiarsih, 2020). All Constitutions should be aware of their obligations in implementing the development of the social security system in the regions to realize UHC coverage so that all residents are protected (Budiarsih, 2020). Based on this law, until 2010, many local governments have taken action to develop health financing systems in the regions in the form of Regional Health Insurance (Jamkesda) (Budiarsih, 2020).

According to (Budiarsih, 2020), achieving UHC is still challenging for Indonesia. Based on the results of an analysis conducted by Budiarsih (2020), five findings must be addressed. First, the lack of public awareness of health facilities provided by the government. This can be seen from the national index for cervical cancer screening indicators, which is only indexed nine. Second, the high prevalence of smoking and unhealthy lifestyles contribute significantly to the low index for non-communicable diseases. Third, high Out-of-Pocket spending on health care in Indonesia is hampering efforts to provide financial protection, with nearly 13 million people spending more than 10% of their total consumption on health services. Fourth, there is a gap between Java and western Indonesia provinces and other regions. This disparity occurs due to uneven distribution of health and inadequate workers and infrastructure in poor areas. Fifth, provinces with low service coverage indexes tend to have low disaster spending on health and vice versa. (Budiarsih, 2020)

For example, Papua and East Nusa Tenggara provinces have high poverty rates, low service coverage index, and low catastrophic expenditure. According to Achievements in (Budiarsih, 2020), a low incidence of disasters can

indicate inadequate access to health services due to geographical conditions, poor health infrastructure, and health inequality in their ability to seek health care which is limited due to low financial situation (Budiarsih, 2020).

Article 28 H of the 1945 Constitution and Law Number 36 of 2009 concerning Health stipulate that everyone has the right to get health services (East Java Provincial Health Office, 2022). Since 2017, the East Java Provincial Government has implemented a health service financing program for poor people in East Java Province without health insurance (East Java Provincial Health Office, 2022). The implementation of health service financing programs for the poor is one form of effort from the East Java Provincial Government to fulfill health welfare implemented for poor people in East Java who have not yet become participants in the National Health Insurance both PBI-N and PBI-D (East Java Provincial Health Office, 2022). This program aimed to improve health services for poor people in East Java Province who do not yet have any health insurance (East Java Provincial Health Office, 2022). The implementation of this program is the third net of health services for the poor in East Java Province, where the first net is the National Health Insurance Program (JKN). The second net is health service financing by the District/City Government (PBI D or SKTM/SPM) with the District/City APBD budget (East Java Provincial Health Office, 2022).

Several districts/cities in Indonesia have implemented various health service financing programs and policies, especially for low-income people, to make it easier for them to access health services to achieve Universal Health Coverage. An example is research conducted by Eko Bayu Nugroho in the city of Bandung. According to Nugroho et al. (2021), the Bandung Regency Health Insurance Financing Policy is based on the Presidential Regulation on Health Insurance Number 82 of 2018. This program ensures that underprivileged people have access to health insurance, in addition to providing direction and authority to local governments to be able to also register their communities outside the criteria for recipients of contribution assistance sourced from central funds (Nugroho et al., 2021). However, in the study, it was written that to take care of its health insurance, the Bandung Regency Government does not yet have a legal umbrella for the implementation of health insurance for the poor outside the quota of Contribution Assistance Recipients (PBI) and Maternity Insurance (Jampersal) (Nugroho et al., 2021). Guidelines for the implementation of Maternity Insurance in Bandung Regency are regulated in Regent Regulation Number 28 of 2018 (Nugroho et al., 2021). Financing for the Health Insurance program managed directly by the Regional Government is still experiencing many problems (Nugroho et al., 2021). The Bandung Regency Government has implemented a health insurance policy based on UHC achievement of 78.75% (Nugroho et al., 2021). The participation of the poor who have been determined through the Bandung Regent Decree is as many as 116,092 people. As of July 31, 2019, only 106,422 people were registered 2019 (Nugroho et al., 2021). Quoting the opinion of Dwicaksono et al. (2012), Nugroho et al. mentioned that this problem is exacerbated by how poor people do not have JKN security, but health insurance has exceeded the poverty threshold (Nugroho et al., 2021). This can be seen from the increase in SKTM users by 4,440 cases and do not have access to the Health insurance program (Nugroho et al., 2021). This community cannot be directly included in the JKN program because the criteria are not listed in existing regulations, even though this JKN program is mandatory and is the right of every Indonesian citizen (Nugroho et al., 2021). To support the achievement of Universal Health Coverage, this program was implemented in an integrated and coordinated manner by the Health Insurance Implementation Unit in Bandung Regency in 2015 through the Bandung Regent Decree Number 441 / Kep.25-Dinkes / 2015 with the main task of formulating and determining policy formulation, coordination and assessment and verification of poor families, government employees, and regional private employees in the context of implementing the program Bandung Regency regional health insurance (Nugroho et al., 2021).

Another research conducted by Delila Nisnoni (2020) also illustrates how the implementation of the UHC program in the city of Semarang. This study aims to evaluate how the implementation process of the UHC (Universal Health Coverage) program in Semarang City, as well as what are the driving and inhibiting factors for the implementation of the UHC (Universal Health Coverage) program in Semarang City (Nisnoni, 2020). In this study, it was stated that the Semarang City Government initiated a program providing health insurance for its citizens, aiming that residents, especially in Semarang City, could get free medical services (Nisnoni, 2020). Then, with the signing of Mayor Regulation Number 43 of 2017 concerning the Implementation of Health Insurance, UHC (Universal Health Coverage) or health insurance for residents is a program of the Government of Kota Semarang in collaboration with BPJS (Social Security Organizing Agency) Health which is health insurance service system for Semarang City residents as a whole where the costs are entirely borne by the Semarang City Government (Nisnoni, 2020).

On March 12, 2023, Bondowoso district received the UHC award from the Social Security Organizing Agency (BPJS) Health, together with 333 Regencies / Municipalities and 22 Provinces (Saphan, 2023). Bondowoso received the award for the coverage of the National Health Insurance (JKN) program of 95.54 percent until March 1, 2023 (Saphan, 2023). The national level award indicates that 766,718 residents of Bondowoso Regency have been registered in the National Health Insurance (JKN) program out of a total population of 802,535 people. This means that almost everyone in Bondowoso already has a protective umbrella to access services at health facilities (Saphan, 2023).

This study aims to determine how the Bondowoso district government's strategy in optimizing health service financing for the poor in the Bondowoso district through the UHC Program. The next chapter will discuss the methodology used in this study and describe the results and discussion of the research.

2. Research Methodology

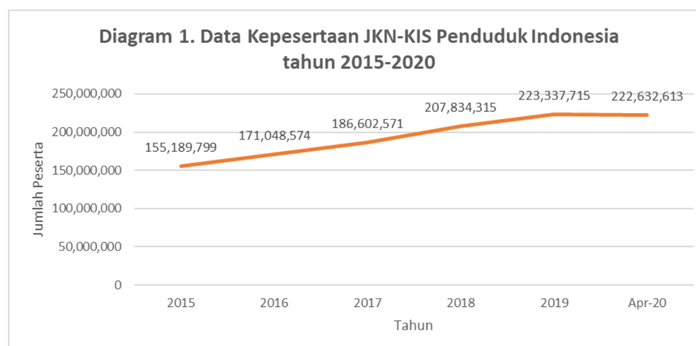
The method used in compiling this paper is a qualitative descriptive approach using direct observations in the field, interviews with related parties, and supporting documents, focusing on strategic efforts in achieving Universal Health Coverage (UHC) in Bondowoso Regency as part of accelerating the achievement of the Sustainable Development Goals (SDGs), as well as an effort to ensure the fulfillment of citizens' rights to health, especially the poor.

3. Results and Discussion

September 25, 2015, is one of the events that marked the adoption of Sustainable Development Goals (SDGs) by all 193 member states of the United Nations (UN) (Gera et al., 2018). The SDGs consist of 17 comprehensive and ambitious goals and 169 universally applicable targets relevant to developing and developed countries (Gera et al., 2018). Despite their inclusive nature, the SDGs emphasize a focus on individual thematic areas, including Health (Gera et al., 2018). Gera et al. (2018) in the study wrote that SDG3 aims to ensure a healthy life and promote well-being for all people of all ages (Gera et al., 2018). At the core of SDG3 is Universal Health Coverage (UHC), which signifies that all people should have access to quality healthcare in their time of need without facing financial hardship (Gera et al., 2018). UHC encompasses various preventive, promotive, curative, rehabilitative, and palliative services across primary, secondary, and tertiary care levels throughout the life journey and for all citizens (Gera et al., 2018). In addition, UHC also emphasizes the need for investment in the research and development of vaccines and drugs and increased allocation of finance and human resources (Gera et al., 2018). Law No.40 of 2004 concerning the National Social Security System (SJSN Law) in Indonesia has answered the basic principles of UHC by requiring every resident to have access to comprehensive health services (Budiarsih, 2020).

To realize the right to social security mandated in the 1945 Constitution, the Indonesian government passed Law No. 40 of 2004 concerning the National Social Security System consisting of five social security programs, one of which is the national health insurance (JKN) (BPJS Kesehatan, DJSN, 2020). Furthermore, in Law No. 24 of 2011, it is stated that social security is organized by the National Social Security Agency (BPJS) to realize the implementation of social protection to ensure that all people can meet the needs of a decent life (BPJS Health, DJSN, 2020). Health insurance is organized based on the principles of social insurance and equity with program benefits in the form of individual services consisting of promotive, preventive, curative, and rehabilitative (BPJS Kesehatan, DJSN, 2020).

From 2014 to February 2020, more than 220 million Indonesians registered as JKN program participants and increased the utilization rate of health services in Indonesia (BPJS Kesehatan, DJSN, 2020). However, there are several challenges, especially related to the sustainability of this program (BPJS kesehatan, DJSN, 2020). JKN program participation continues to increase yearly, with 222,632,613 participants registered with BPJS Kesehatan in April 2020, spread throughout Indonesia (BPJS Health, DJSN, 2020).



Source: based on BPJS Kesehatan data reprocessed (BPJS kesehatan, DJSN, 2020)

In addition to the participation aspect, the benefits of health services guaranteed by BPJS Kesehatan are also increasingly standardized. Before 2014 there were variations between Askes participants, JPK Jamsostek participants, and JAMKESMAS, which means the principle of social justice, which is one of the principles in the JKN program, can increasingly be realized (BPJS kesehatan, DJSN, 2020). To get the benefits of services, participants must access health facilities in stages ranging from primary health facilities (FKTP) consisting of puskesmas, individual practice doctors, clinics, and primary type D hospitals to type A hospitals (BPJS kesehatan, DJSN, 2020). In 2014, there were 18,437 FKTPs and 1,481 advanced health facilities (FKRTL) with referral hospitals and main clinics (BPJS kesehatan, DJSN, 2020).

The SJSN Law mandates that all residents must be participants in health insurance, including foreigners who have lived in Indonesia for more than six months (BPJS kesehatan, DJSN, 2020). Participants are everyone, including foreigners who have worked for at least 6 months in Indonesia and who have paid contributions or whose contributions are paid by the government (BPJS kesehatan, DJSN, 2020). JKN Program participants consist of 2 groups, namely: Participants of Contribution Assistance (PBI) of health insurance and participants who are not recipients of contribution assistance (PBI) of Health Insurance (BPJS Health, DJSN, 2020). PBI Health Insurance participants are indigent people. At the same time, Non-PBI Participants are Wage Receiving Workers (PPU) and

their family members, Non-Wage Receiving Workers (PBPU) and their family members, and non-workers and their family members (East Java Provincial Health Office, 2022).

Bondowoso Regency is a district that does not have a coastline, with the area of Bondowoso Regency reaching 1,560.10 Km² or about 3.26% of the total area of East Java Province, which is divided into 23 districts, ten kelurahan, 209 villages and 1,412 hamlets (Bondowoso Regency Government, 2019b). The population of Bondowoso Regency in 2018 was 772,297 people consisting of 376,074 men and 396,223 women (Bondowoso Regency Government, 2019b). Meanwhile, the population of Bondowoso Regency in September 2020, according to the results of the Population Census 2020, was 776,151 people, with a female population of 393,925 people and a male population of 382,226 people (Central Bureau of Statistics Bondowoso Regency, 2021).

The Strategic Plan of the Bondowoso Regency Health Office for 2018-2023 states that population development and population density have increased in the last five years (2018-2023) (Bondowoso Regency Government, 2019b). This is due to the high birth rate compared to the death rate and the many residents from outside who enter the Bondowoso Regency (Bondowoso Regency Government, 2019b). The development of population according to sex can be seen from the development of the sex ratio, namely the ratio of male residents to female residents (Bondowoso Regency Government, 2019b).

In the Health Profile of the Bondowoso Regency Health Office, it is stated that Bondowoso Regency is one of the districts in East Java Province which is categorized as a disadvantaged area. The problem of underdevelopment in Bondowoso Regency is the problem of Human Resources (HR) development, poverty, and the problem of meeting basic infrastructure needs, namely social infrastructure, such as health and education facilities, and infrastructure, such as inadequate road infrastructure (Bondowoso Regency Health Office, 2020). Most of the population of Bondowoso Regency are farmers Bondowoso's economic structure is dominated by 5 (five) categories of business fields, including Agriculture, Forestry, and Fisheries; Processing Industry; Wholesale and Retail Trade, Car and Motorcycle Repair; Construction; and Information and Communication (Bondowoso District Health Office, 2020). In the 2020 Health Profile, quoting the Official Statistical Gazette of BPS Bondowoso regency in 2021, it was stated that economic growth was recorded at 4.97 percent (2016); 5.03 percent (2017); 5.10 percent (2018); 5.30 percent (2019) (Bondowoso District Health Office, 2020). However, during 2020 there was economic growth of -1.36 percent, or contracted when compared to the previous year's economic growth, which reached 5.30 percent due to a decrease in production due to the Covid-19 pandemic, based on BPS Bondowoso sources in the Official Statistical Gazette No.05/04/3511/Th II/April 26, 2021 (Bondowoso Regency Health Office, 2020).

Based on data from BPS Bondowoso Regency in the Bondowoso Regency Health Profile in 2021, overall economic growth according to business fields in 2021 decreased due to the Covid-19 pandemic. Still, not all categories decreased (Bondowoso Regency Health Office, 2021). The transportation and warehousing category business field achieved the highest economic growth of 12.37 percent based on BPS sources of Bondowoso Regency in Bondowoso Regency in 2021 Figures (Bondowoso Regency Health Office, 2021). In the LKPJ Bupati, it was stated that in 2021 BPS recorded that during the Covid-19 pandemic, there were 20,835 unemployed people in Bondowoso Regency. This number increased by 1,362 people from 2020, or an increase of 6.99 percent. The open unemployment rate has also increased with the increase in the number of unemployed (Bondowoso Regency Health Office, 2021).

In the 2019 Bondowoso District Health Office Renstra, it is stated that Life Expectancy (AHH) is an indicator of the goal of improving the degree of public health (Bondowoso Regency Government, 2019b). AHH is one of the constituent indicators of the Human Development Index (HDI) of a region and is a complex indicator because it is influenced by various factors, such as environmental quality, quality of health services, lifestyle, and individual lifestyle (Bondowoso Regency Government, 2019b). Therefore, the increase in AHH needs to be followed by health development programs and other social programs, including environmental health, nutritional adequacy, and calories, including poverty eradication programs (Bondowoso Regency Government, 2019b).

Based on data in the Bondowoso Regency Health Office Renstra, the AHH of Bondowoso Regency always increases from year to year, which shows that every year the life expectancy of newborns in the relevant year is longer than newborns in the previous year (Bondowoso Regency Government, 2019b). The Health Office cannot calculate AHH, because the basic data involves data outside the authority of the Health Office and requires a special application to calculate it, namely Mortpak Lite (Bondowoso Regency Government, 2019b). Therefore, AHH 2017 data is official data released by the Central Statistics Agency (BPS) as below:

Table 1. Life Expectancy Data of Bondowoso Regency based on data in the Bondowoso District Health Office Strategic Plan 2018-2023

Indicator	Achievements Every Year					Performance Conditions at the End of the 2019 RPJMD Period
	The year 2014	The year 2015	The year 2016	The year 2017	The year 2018	
Life Expectancy (AHH)	65,43/th	65,73/th	65,89/th	66,04/th	66,77/th	66,77/th

Source: Bondowoso District Health Office Strategic Plan 2018-2023

Table 1 data shows that the AHH of Bondowoso Regency has still not reached the set target (Bondowoso Regency Government, 2019b). Achievement goal performance is still at 66.77 percent, still very low compared to East Java AHH (70.80), ranked lowest just below Probolinggo district with AHH 66.47 (Bondowoso Regency Government, 2019b). The end of AHH Bondowoso Regency can be caused by factors that involve various stakeholder roles outside health affairs or across sectors, such as the provision of infrastructure to support community access to health services, the economic level of the community, the community's living environment, limited road access, namely m There are areas in Bondowoso that do not have paved road access. Finding public transportation is difficult (Bondowoso Regency Government, 2019b). This condition represents the residential factors of people scattered in various corners of the Bondowoso area (Bondowoso Regency Government, 2019b). The percentage of poor people in Bondowoso is 14.54 percent, which is above the average percentage of poor people in East Java, which is 11.77 percent (Bondowoso Regency Government, 2019b). This causes them to have limitations in accessing health services, not only on service financing but on the psychological condition of the community, which causes them to decide not to seek health services (Bondowoso Regency Government, 2019b).

Efforts to improve the achievements of AHH Bondowoso Regency include increasing the achievement of health program targets by continuing existing innovation activities, carrying out various activities that focus on improving networks between stakeholders, and efforts to obtain various sources of funds for optimizing activities to reach remote areas of Bondowoso so that It is expected to encourage improvements in the basic factors of AHH (Bondowoso Regency Government, 2019b).

In the Strategic Plan of the Bondowoso District Health Office, based on the development of improving public health in Bondowoso Regency for the 2014-2018 period, several important challenges that will be faced are identified, namely:

1. Low life expectancy;
2. High maternal mortality rate;
3. High infant mortality rate;
4. High rate of stunting;
5. Implementation of SJSN (National Social Security System);
6. Community behavior that does not support a Clean and Healthy Lifestyle (PHBS);
7. Low infrastructure of puskesmas and its network;
8. Low environmental and residential health conditions;
9. Low public health status (Nutrition); and
10. Prevalence of Infectious and Non-communicable Diseases.

(Bondowoso Regency Government, 2019b)

Meanwhile, some of the opportunities found in the implementation of efforts to improve Bondowoso public health through programs and activities include:

1. The existence of minimum health service standards and operational standards for medical and non-medical actions;
2. The existence of BOK, Jampersal, and JAMKESDA funds;
3. The existence of posyandu and alert villages that are active in all villages;
4. Funding from the center is available for several health issues, such as maternal mortality and community nutritional status.
5. Local governments pay more attention to regulations related to health issues.
6. The existence of Toga, Toma, and cross-sector cooperation; and
7. The implementation of JKN (National Health Insurance) began in 2014 so that there is a source of funding for poor people's health services

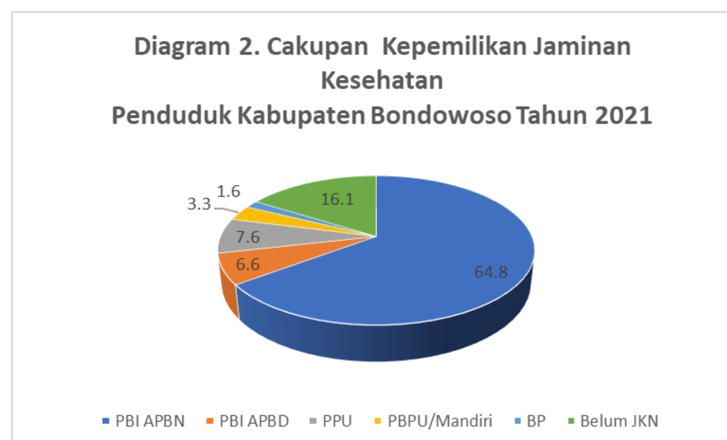
There are several strategic issues faced at this time, consisting of:

1. High incidence of tuberculosis
2. Global problems related to stunting
3. Low latrine access
4. High infant mortality rate
5. High maternal mortality rate
6. Infectious diseases
7. Non-communicable diseases
8. Poor healthcare infrastructure
9. Distribution of Health workers
10. Universal Health Coverage

(Bondowoso Regency Government, 2019b)

From the list of strategic issues, the issue of Universal Health Coverage is one of the priorities of attention of the Bondowoso Regency Government. Namely, several poor people are still not registered in the JKN insurance scheme.

Data in the Bondowoso Regency Health Profile in 2021 states that in 2020, the number of poor people who entered the National Health Insurance was 667,919 people, Contribution Assistance Recipients (PBI) APBN: 518,827 people, PBI APBD: 51,625 people, Wage receiving workers (PPU): 58,848 people, Non-wage earners (PBPU) / independent workers: 26,090 people and Non-Workers (BP): 12,529 people (Bondowoso District Health Office, 2021). In 2021, the number of poor people who entered the National Health Insurance was 661,392 (84.5%) people (Contribution Assistance Recipients (PBI) APBN: 507,047 people, PBI APBD: 59,654 people, Wage receiving workers (PPU): 55,998 people, Non-wage earners (PBPU) / independent: 25,970 people and Non-Workers (BP): 12,723 (Bondowoso Regency Health Office, 2021).



Graph-Based on Data in the Health Profile of Bondowoso District Health Office in 2021

As a manifestation of the vision and mission of the Bondowoso Regency Government as stated in the Regional Medium-Term Development Plan (RPJMD) of Bondowoso Regency, namely the vision of Realizing Bondowoso Regency as an advanced, religious, just, and prosperous agribusiness area, with one of the missions "Realizing the Meeting of Basic Community Needs to Improve the Quality of Life" (Bondowoso Regency Government, 2019a), and guided by:

1. Law Number 40 of 2004 concerning the National Social Security System;
2. Law Number 24 of 2011 concerning the Social Security Organizing Agency;
3. Minister of Home Affairs Regulation Number 22 of 2020 concerning Procedures for Regional Cooperation with Other Regions and Regional Cooperation with Third Parties;
4. Decree of the Board of Directors of the Health Social Security Organizing Agency Number 494 of 2022 concerning the Placement of Work Areas and Classification of Work Units of the Health Social Security Organizing Agency;
5. Bondowoso Regent Regulation Number 62 of 2020 concerning the Implementation of the National Health Insurance Program and Health Services Guaranteed by the Regional Government of Bondowoso Regency;
6. Presidential Instruction of the Republic of Indonesia Number 1 of 2022 concerning Optimization of the Implementation of the National Health Insurance Program;

so in order to ensure the health of the people of Bondowoso Regency, the Bondowoso Regency Government launched Universal Health Coverage (UHC) on October 11, 2022 (Kominfo@Bondowoso, n.d.). UHC is a health insurance system that ensures that all residents of at least 95 percent of the population have been registered as JKN

program participants and have fair access to health services. Hence, the Bondowoso Regency Government strives to organize UHC and, when launching the achievement of JKN Bondowoso Regency membership, has reached 95.18 percent (Kominfo@Bondowoso, n.d.). The target of this UHC program is intended for prospective participants/residents with the following conditions:

1. Prioritized those who are in need of health services at the Hospital / Puskesmas
2. Bondowoso residents, proven by KK/KTP
3. Willing to obtain Class III Nursing Rights and unable to Upgrade to Treatment Class
4. Residents are included in the Integrated Social Welfare Data (DTKS) or TAPE MANIS recommendation

(Bondowoso District Health Office, 2023)

Additional family members registered:

1. Spouse of a legal marriage due to the death of the previous spouse
2. Newborns of parents who have previously been registered as Non-Wage Earner Participants (PBPU) and Non-Workers (BP)
3. Legal adoption/stepchild

(Bondowoso District Health Office, 2023)

Provisions regarding Newborns:

1. Newborns who do not have a NIK when registered do not have a NIK, are registered using a family card number, and can use identity in the form of a Temporary Card valid for 3 (three) months.
2. Update the NIK data of newborns from biological mothers who have been registered as Wage Recipient Participants (PBU) and Non-Workers (BP) registered by the Regional Government of Bondowoso Regency no later than 3 (three) months from the time the baby is born.
3. Newborns who have not updated their NIK data for up to 3 (three) months from birth will be temporarily deactivated until they update their NIK data.

(Bondowoso District Health Office, 2023)

Administrative requirements that must be met:

1. FC KK and KTP
2. Recommendation of the Social Office of Women's Empowerment, Child Protection and Family Planning (DSP3AKB)
3. Certificate of illness / requires health services from Puskesmas / Hospital
4. MCH book (if pregnant)
5. Additional requirements for participants (Wage-Receiving Workers) PPU inactive: Letter of Termination of employment from the company

(Bondowoso District Health Office, 2023)

UHC participant registration is not approved if:

1. NIK is inactive
2. Not a resident of Bondowoso
3. Non-Wage Earner (PBPU) and Non-Worker (BP) Mandiri participants who are delinquent for less than three months
4. Still registered as Non-Wage Earner (PBPU) and Non-Worker (BP) Independent / Wage Receiving Worker (PPU) / Contribution Assistance Recipient (PBI)

(Bondowoso District Health Office, 2023)

The provisions mentioned above are as stated in Bondowoso Regent Regulation Number 62 of 2020 concerning the Implementation of the National Health Insurance Program and Health Services Guaranteed by the Regional Government of Bondowoso Regency. Article 3 states that the change of status to JKN-KIS participant registered by the Regional Government is intended for residents who have registered as non-PBI Health Insurance participants and are unable to pay contributions. The change in membership status does not remove the obligation of the participant or employer to pay off the arrears of contributions. The change in membership status applies to participants and their family members and is carried out in accordance with laws and regulations (Bondowoso Regency Government, n.d.).

This UHC program is implemented as one of the efforts to expand the scope of JKN Program participation, realize the right to social security mandated in the 1945 Constitution and Law No. 40 of 2004 concerning the National Social Security System, as a form of implementation of Presidential Instruction of the Republic of Indonesia Number 1 of 2022 concerning Optimization of the Implementation of the National Health Insurance Program and to expedite the implementation of the National Health Insurance Program and Health Services guaranteed by The

Dearah Government of Bondowoso Regency, especially for the poor and people who have not been registered as active participants in the JKN Program before. This policy is implemented to make it easier for the people of Bondowoso district to access health services without having to be burdened with various administrative requirements as before, especially for people who have not been registered in the JKN-KIS Program membership, as well as facilitate access for the people of Bondowoso district to register to become active JKN Program participants. Another effort of the Bondowoso Regency Government in expanding UHC coverage is by integrating JAMKESDA into the JKN Program.

Currently, to facilitate access to health service financing for prospective UHC participants, prospective UHC participants who are being treated, both at First Level Health Facilities (FKTP) / Puskesmas and at Advanced Health Facilities (FKTL) simply use an identity card in the form of an ID card, by activating the NIK number through the registration section at each of these health facilities, while still paying attention to the provisions mentioned above. If these conditions are met, then automatically, the BPJS membership of the population is active, and all health service financing at the health facility is fully borne by BPJS and the Regional Government with APBD funding sources. Health services for recipients of health insurance by the Regional Government, as mentioned in Bondowoso Regent Regulation number 62 of 2020, include health services in:

1. Puskesmas within the Bondowoso Regency Health Office
2. Regional General Hospital dr. H. Koesnadi Bondowoso
3. Regional General Hospital dr. Abdoer Rahem Situbondo
4. Dr. Soebandi Jember Regional Hospital
5. Other hospitals, in collaboration with the Bondowoso District Health Office

(Bondowoso Regency Government, n.d.)

Verification and validation of population data that will be proposed to become JKN-KIS participants registered by the Regional Government are carried out by the Social Service. The Decree of the Regent (Bondowoso Regency Government, n.d.) determines population data that has been verified and validated.

Regarding population data, to optimize the implementation of the UHC program, until now, related parties, namely the Population and Civil Registration Office, continue to synchronize population data and update data related to population birth and death data by holding monthly reports of the latest data and reconciliation efforts with BPJS regarding population data updates. The Population and Civil Registration Office also collaborates with operators in each village office as well as village midwives throughout Bondowoso regency in terms of reporting and updating the latest data on population birth and death data.

The success of the UHC Program in Bondowoso district cannot be separated from the close communication and cooperation between related sectors, namely, among others, the Bondowoso District Health Office as an implementer in administration and also as a supervisor, the Bondowoso Regency Government through the Regional Development Planning Agency and the Regional Finance and Asset Management Agency in terms of budget, BPJS Kesehatan in terms of managing claims and premium contributions and collaborating with Facilities First Level Health and Referral/Advanced Level Facilities as public health service providers, Social Services and Sweet Tape Post as parties that recommend target targets who can receive Health insurance programs and the Population and Civil Registration Office in terms of population data synchronization.

The Bondowoso Regency Government and all levels within the Bondowoso Regency Government continue to socialize with the Bondowoso community as a form of delivering information from the Bondowoso Regency Government, in collaboration with the Bondowoso District Health Office, Bondowoso Regency Population and Civil Registration Office, and BPJS to the community through existing Health service facilities, both at the first level (FKTP) and at Health facilities at the level referral/continuation (FKTL), as well as efforts to empower the community and tools and officials at the village and sub-district levels, to expand the coverage of participation in the National Health Insurance Program (JKN) and support the optimization of Universal Health Coverage achievements. This is in line with research conducted by Delila Nisnoni, which states that by quoting the General Guidelines for JKN-KIS Health Insurance, namely PERMENKES No.28 of 2014, the socialization of the UHC (Universal Health Coverage) Program to all parties, both directly and indirectly, is the key to the success of the UHC (Universal Health Coverage) program (Nisnoni, 2020).

Research conducted by Maximillian Kolbe to Domapielle in Ghana concluded that UHC is not a one-size-fits-all process, but the success of important health policies depends on three factors: strong support and strong political commitment to UHC goals, favorable economic prospects, and strong capacity of health care systems to realize UHC equity goals. Maximillian, citing the opinion of Maeda et al. (2014), argues that perhaps most important is long-term political commitment, that adaptive and resilient leadership is needed to mobilize and maintain broad-based social support while managing a sustained process of political compromise among various interest groups without derailing UHC objectives (Domapielle, 2021). In the case example in Ghana, NHIS, as subluminal points out, is the product of the New Patriotic Party's manifesto promise in Ghana to replace the cost of healthcare users introduced in 1985 under the Structural Adjustment Program (SAP) with national health insurance as a fairer financing system (Domapielle, 2021). As a result, its implementation enjoys the political support needed in terms of mobilizing funds and gathering technical experts to design the program and start its implementation (Domapielle, 2021). However, citing the opinions of the ILO (2008), Schieber et al. (2010), and Maeda et al. (2014), Maximillian

writes that a strong economy must support political commitment to the UHC goals; broader tax base; strong capacity to adequately mobilize taxes; and functional health systems reflected by strong health infrastructure and coordinated approaches to scaling up the health workforce to meet the increasing demand for healthcare accompanied by expanded coverage (Domapielle, 2021). In Ghana, for example, citing data from the World Bank in 2020, GNI per capita with the atlas method is estimated at US$ 2,220, and fiscal performance for the first half of 2019 based on cash data shows an overall budget deficit of 3.3% of GDP higher than the target of 2.9% of GDP (Domapielle, 2021). Citing 2017 GHS data, Maximillian wrote that per capita health expenditure in Ghana was around US$ 66.74; and lack of infrastructure and human resources with one doctor to 8481 people (Domapielle, 2021). Increased utilization accompanied by increased health insurance coverage over the years without commensurate improvements in infrastructure, human resources, equipment, and supplies burdens limited infrastructure, people, and other resources in the Health sector (Domapielle, 2021). This makes the search for universal health coverage in Ghana and Low and Middle-Income Countries (LMICs) in general a difficult goal to achieve (Domapielle, 2021).

Maximillian, in the results of the study in Ghana, citing the opinion of the ILO in 2008, wrote that based on this lesson, Low and Middle-Income Countries (LMICs) that have implemented or have political will are encouraged to approach UHC implementation from a pragmatic perspective as follows: first, learn critically from the experience of UHC implementation in countries with similar economic and social conditions; second, learning from developed and developing countries that have successfully achieved UHC and adopted relevant best practices; third, by citing the opinion of Agyepong et al. (2011), develop and implement financing models that are appropriate to their country context; and finally, citing the opinions of Abiiro and Deallegri (2015), gradually build resilient and responsive health systems to facilitate the movement towards UHC (Domapielle, 2021). This approach, along with sustainable economic growth, has the potential to expand health insurance coverage to the population while increasing the service delivery capacity for UHC (Domapielle, 2021). Therefore, the journey to UHC should be seen as an evolving process to identify gaps in the three thematic dimensions and design practicable strategies following the WHO framework for implementing UHC and to achieve the sub-goals of SDG 3, namely: achieving universal health coverage, including financial risk protection, access to quality and safe essential health care services, effective, quality and essential medicines and vaccines that are affordable for all (Domapielle, 2021).

In another study conducted and authored by Sulakshana Nandi and Helen Schneider in the Indian state of Chhattisgarh, India has been championed as a prime example of advancing towards UHC through PFHI schemes. According to Nandi, the stated purpose of this PFHI scheme is to improve access to health services and provide financial protection to the vulnerable (Nandi &; Schneider, 2020). However, Nandi and Helen argue that, as shown in this study, the impact of RSBY/MSBY on equitable access and financial protection is still weak (Nandi & Schneider, 2020). Moreover, as far as has been studied, the implications for the public sector and the financing of PFHI schemes which are mostly channeled through the private sector, are significant (Nandi &; Schneider, 2020). In terms of service provision, the normative and culturally dominant orientation of healthcare as a commodity for sale rather than a right remains unchallenged (Nandi &; Schneider, 2020).

The findings of this study have direct relevance to the current policy context in India, which is currently integrating existing PFHI schemes into a massively expanded scheme, PMJAY, for the entire country (Nandi & Schneider, 2020). The analysis results have shown that over-dependence and rapid expansion of PFHI schemes in the Indian health system is unlikely to achieve UHC. Chhattisgarh is currently reviewing the pitfalls of private sector emphasis in its PFHI schemes and repositioning the public health system as the core of service delivery (Nandi &; Schneider, 2020). The principles of solidarity, equality, and rights are essential as the basis of health policy for universal health care. India still has some way to go to chart a path to universal healthcare (Nandi &; Schneider, 2020).

Chhabi Lal Ranabhat et al., in their research aimed at exploring challenges and opportunities towards UHC in Nepal, wrote that constitutional provisions, global support, the progress of health insurance measures, decentralization of health services to the grassroots level, positive trend of increasing service coverage in Nepal are seen as opportunities (Ranabhat et al., 2019). However, existing types of voluntary health insurance, misleading trade union roles, and a high proportion of the population abroad are major challenges (Ranabhat et al., 2019). Political commitment in a changing political context, a sense of national priority, and international support were identified as factors facilitating UHC (Ranabhat et al., 2019).

Ranabhat et al. wrote that the situation at the time the study was conducted was an important time to take UHC action in Nepal as the political system has shifted, and the UN SDGs are highly focused on UHC in Health-related goals (Ranabhat et al., 2019). Of course, there are some challenges to achieving UHC, but those challenges can be overcome with high-level political commitment and an accountable workforce such as business (Ranabhat et al., 2019). Population coverage for quality care and financial protection would be a breakthrough in achieving UHC (Ranabhat et al., 2019). Government stewardship, stakeholder support, and policy contributions of experts can only accelerate the path to UHC wards in Nepal (Ranabhat et al., 2019).

At the same moment, on March 14, 2023, as well as Bondowoso Regency, six regencies, and five cities in Central Java received UHC awards and appreciation awards in 2023 (Central Java Provincial Government, 2023). The city governments receiving the UHC Award 2023 are Magelang, Surakarta, Salatiga, Semarang, and Tegal. Meanwhile, the six districts receiving the 2023 UHC Award include Purbalingga, Banjarnegara, Klaten, Rembang, Kudus, and Brebes (Central Java Provincial Government, 2023). Delila Nisnoni, in her research, said that the UHC (Universal Health Coverage) Program policy in Semarang has provided good benefits for the community as a

solution to alleviating health problems in Semarang City in relation to health insurance participation for residents who have not and cannot afford to get health insurance called Contribution Assistance Recipients (PBI) participants (Nisnoni, 2020). In the results of his research, Nisnoni concluded that the UHC (Universal Health Coverage) program funded by the government is expected to be able to close the budget deficit in BPJS Kesehatan (Nisnoni, 2020). Although overall reviewed based on the implementation approach, four aspects that support the implementation of the program have run well. However, there are still shortcomings in the communication aspect because there is still a lack of public awareness to realize that this program is really targeted at people who are not able and have not received health insurance so as not to cause targets that are not on target, and will actually become a burden on the government with an increase in the budget (Nisnoni, 2020).

In one of the conclusions of his research, Nisnoni also wrote that the emergence of the phenomenon of residents who deliberately do not pay their independent BPJS contributions in order to be included in the requirements for program recipients, namely delinquent citizens, even though these residents are in the capable category, which burdens the government's responsibility in budget matters, becomes a shortfall in the implementation of UHC (Universal Health Coverage) program policies in Semarang, in addition to the increase in BPJS Health contribution rates which also affects the increase in the amount of the budget (Nisnoni, 2020).

Bandung Regency is one of the districts receiving the UHC Award and Appreciation 2023 in West Java (Bandung Regency Government, 2023). Eko Bayu Nugroho, in his research in Bandung Regency, wrote that although there are still certain obstacles to access to health services, the number of decision-makers, program implementation, cigarette tax utilization, and data updates, the substance of political implementation or the essence of JKN in Bandung Regency can run smoothly (Nugroho et al., 2021). On the other hand, according to Nugroho et al., the problem of achieving performance that is still not maximal in achieving UHC is the main obstacle in evaluating the JKN program, which is a special point in the preparation of plans to increase participation outside the poor, namely types of JKN PBPU and independent participants (Nugroho et al., 2021). In his research, Nugroho concluded that the context of JKN Policy implementation and environmental conditions in Bandung Regency was adequate because conflicts of interest between existing stakeholders did not affect them in such a way that the implementers who are currently implementing the Bandung Regency National Health Insurance Policy showed a fairly good response. However, the role of the Satlak Jamkes team coordinator is still lacking in coordinating JKN activities with related SKPD, and the response from the implementer to respond to community needs in FKTPL services is still considered lacking (Nugroho et al., 2021).

By studying some of the research results above, we can analyze and conclude that commitment, cooperation, and strong political support are needed to realize the success of the implementation of a program. In the process of implementing Bondowoso Regency government policies to realize the success of the UHC Program, the Bondowoso Regency Government continues to conduct periodic evaluations and improvements in the entire scope of Government, both in terms of regulations and policies, evaluation of the budget, improvement of human resources in each related sector, especially resources in the fields of health, planning, administration, technology information, community empowerment, as well as strengthening communication and information between related parties, strengthening cooperation and political support as well as socialization to the community about what the UHC Program really is and the importance of being a participant in the National Health Insurance to meet the needs for access to health services and the achievement of Universal Health Coverage, to achieve the Sustainable Development Goals.

4. Conclusion

The success of the UHC Program in the Bondowoso district is inseparable from the close ties of communication and collaboration across related sectors, namely, among others, the Bondowoso District Health Office as executor in administration and also as a supervisor, Bondowoso District Government through the Regional Development Planning Agency and the Regional Financial and Asset Management Agency in terms of budget, BPJS Kesehatan in terms of managing claims and premium contributions as well as working with First Level Health Facilities and Referral/Advanced Level Facilities as community health service providers, the Social Services and Tape Manis Post as parties that recommend targets that can receive the Health insurance program and Department of Population and Civil Registration in terms of synchronizing population data. The Bondowoso District Government and its staff continue socializing the UHC program to the community. They are also working to empower the community and officials at the village and sub-district levels to expand the National Health Insurance Program (JKN) coverage.

In the implementation of the UHC Program in Bondowoso district, there are still several obstacles in terms of technical implementation related to updating and synchronizing population data, human resources, technical financing, and supporting infrastructure so that the Bondowoso Regency Government continues to evaluate and make improvements and improvements in terms of technical implementation, regulations and policies related to the implementation of the UHC program, to optimize the achievement of UHC in Bondowoso district.

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