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ANALYSIS OF THE ROLE OF DOMPET DHUAFA IN FILLING THE GAP IN ACCESS TO UNIVERSAL HEALTH COVERAGE FOR POOR PEOPLE IN INDONESIA

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Abstract

The Government of Indonesia through The Social Security Administrator for Health (BPJS Kesehatan) has tried to provide Universal health coverage (UHC) to health services for all Indonesian people. In 2022, there are 88 million poor people recorded in BPJS PBI (Contribution Assistance Recipients) data from a quota of 96.8 million allocated from the State Budget. In 2023, the BPJS PBI quota will be reduced to 60 million people and in 2024 to 40 million people. In an effort to realize its vision as a philanthropic organization and fulfill the basic health rights of the poor, Dompet Dhuafa has mapped the gap that occurs based on data on health services carried out through the Dompet Dhuafa Free Health Service (LKC) in 12 provinces in Indonesia. The gap is in the limited public knowledge of BPJS PBI participation rights, procedures for accessing health services, and efforts to fulfill complementary support in the health sector. To overcome this gap, Dompet Dhuafa has conducted a Health Emergency Response program and opened access to health insurance advocacy. This program aims to provide knowledge, protection, assistance, and strategic partnerships between various parties in an effort to fulfill UHC for the poor. The purpose of this research is to analyze the role of Dompet Dhuafa in bridging the gap in accesss to universal health coverage for the poor people in Indonesia trough advocacy activities and emergency Health Response (RDK). The research method used is a quantitative model with descriptive data sourced from service and beneficiary data, distribution, and expansion of networks, and achievements of advocacy for health services and insurance in 12 provinces in Indonesia. From the available data, the efforts made by Dompet Dhuafa have contributed to filling the gap in access to universal health coverage for poor people in Indonesia.

INTRODUCTION

Universal Health Coverage (UHC) is a health insurance system that assures that every citizen in the population has equitable access to high-quality preventative, curative, and rehabilitative health care at reasonable rates. The government hopes that by 2019, 95% of the population will be enrolled as JKN members and have access to basic health services, or that UHC will be achieved for up to 95% of Indonesia's whole population (World Health Organization, 2021).

The Indonesian government, through BPJS Kesehatan, has endeavoured to offer universal health coverage for all Indonesians. In 2022, BPJS Kesehatan participant coverage was expected to reach 91% of the population of 279,577,400, with a claim's ratio of 92.2%. Based on this coverage, 88 million impoverished persons were registered in the BPJS PBI (Contribution Assistance Recipients) statistics in 2022, out of a quota of 96.8 million given from the State Budget. The BPJS PBI limit will be decreased to 60 million individuals in 2023 and 40 million persons in 2024. BPJS PBI stands for BPJS Contribution Assistance Recipients. This is a type of BPJS Health membership intended for underprivileged people and meets the criteria of social services. BPJS PBI contributions are paid by the government, so participants do not need to pay money to get health services. The deterioration has the potential to contribute to the rise in extreme poverty and the denial of basic health care to an increasing number of poor people (BPJS 2022).

There are many challenges hindering the achievement of Universal Health Coverage (UHC) in Indonesia, one of which is the burden of three types of diseases, as mentioned by Moeleok in 2017: non-communicable diseases (NCDs), infectious diseases, and neglected tropical diseases. The results of the 2018 Basic Health Research (Riskesdas) show an increase in the prevalence of Non-Communicable Diseases compared to the 2013 Riskesdas, including cancers, strokes, chronic kidney disease, diabetes, and hypertension. These conditions have a significant impact on the lives of people across all socioeconomic classes, both young and old. Non-communicable diseases have long-term prognoses, and the treatment of these diseases can be costly, with healthcare expenses amounting to trillions of rupiah per year, whether funded through National Health Insurance or private financing. If the prevalence of NCDs cannot be controlled, they may pose a greater economic burden in the future. The rise in NCD prevalence is partly due to the consumption of unhealthy products such as cigarettes, alcoholic beverages, and high-calorie packaged or fast foods.

Infectious diseases are illnesses that are transmitted through various means. These diseases are a major health concern in nearly all developing countries due to their relatively high morbidity and mortality rates over a relatively short period. Unlike non-communicable diseases, which are often chronic and influenced by lifestyle, infectious diseases are generally acute and can affect people from all walks of life. They are given priority attention due to their infectious nature, which can lead to outbreaks and significant losses.

Tropical diseases are common in tropical and subtropical regions in 149 countries. Some organisms that cause tropical diseases are bacteria and viruses. Given Indonesia's geographical location near the equator, it experiences a tropical climate, leading to various types of tropical diseases caused by viruses, non-viral diseases, and specific microorganisms and bacteria that are contagious. Some of these tropical diseases include typhoid fever, dengue fever, chikungunya fever, malaria, chickenpox, tuberculosis (TB), diphtheria, pertussis, severe acute respiratory syndrome (SARS), lymphatic filariasis (elephantiasis), and many other tropical diseases. Therefore, tropical diseases remain a significant health issue in Indonesia, requiring special attention and potentially causing significant losses and financial burdens.

National Health Insurance (JKN) is a government attempt to ensure public health through insurance. Through a well-functioning referral system, the government wants social protection to assure comprehensive, low, affordable, and high-quality public health (Primasari, 2015). Various other barriers have been raised, beginning with the amount of contributions, the difficulty of BPJS Kesehatan in encouraging the participation of informal sector workers and young people, and the unequal distribution

of health facilities (so participants have difficulty accessing health services). As a result, some people opt not to participate in the JKN because health services fall short of expectations. The socio-historical circumstances of society can help explain why certain individuals are hesitant to become participants.

BPJS Kesehatan, as the Health Insurance administering organization, cannot operate alone to achieve UHC. In order to improve community awareness in rural regions, BPJS-Kesehatan must work with NGOs (Non-Governmental Organizations) and local governments, including village administrations, traditional, and religious organizations, and others. Aside from that, the socialization program's content must focus on rights, duties, benefits, and processes while conforming to local socio-cultural situations. It is no longer enough to just introduce BPJS Kesehatan.

In an effort to realize its vision as a philanthropic organization and fulfill the basic health rights of the poor, Dompet Dhuafa has mapped the gap that occurs based on data on health services carried out through the Dompet Dhuafa Free Health Service (LKC) in 12 provinces in Indonesia. The gap is in the limited public knowledge of BPJS PBI participation rights, procedures for accessing health services, and efforts to fulfill complementary support in the health sector. To overcome this gap, Dompet Dhuafa has conducted a Health Emergency Response program (RDK services) and opened access to health insurance advocacy. This program aims to provide knowledge, protection, assistance, and strategic partnerships between various parties in an effort to fulfill UHC for the poor.

Dompet Dhuafa's position in management promotes the notion of compassion or love as the basis of the philanthropic movement, which focuses on five program pillars, including health, education, economy, social, and da'wah and culture. Dompet Dhuafa aims to broaden the advantages (social impact) for society through prospective alliances between corporations and social organizations. We can lower the burden of health insurance for individuals who cannot afford it through advocacy campaigns like Health Emergency Responses (RDK) Services. Advocacy and membership is one component whose function is to verify prospective members' access to Health Insurance and the criteria for the poor by using specific techniques such as physical observations and interviews with sources to obtain good and correct data. Health Emergency Responses (RDK), is a great service to promote public health standards, particularly for the poor, LKC (Free Health Services) Dompet Dhuafa offers health support needed by people in Indonesia who have barriers to receiving health services. This study aims to review existing data regarding the contribution of Dompet Dhuafa in filling the gap in access to universal health insurance for poor people in Indonesia.

The purpose of this research is to analyze the role of Dompet Dhuafa in bridging the gap in access to universal health coverage for the poor people in Indonesia through advocacy activities and Health Emergency Response (RDK)

LITERATURE REVIEW

Universal health coverage Definition of the World Health Organization (WHO) defines Universal health coverage as a condition that ensures that all residents have access to promotive, preventive, curative, and rehabilitative healthcare services of adequate and effective quality while also ensuring that all residents do not face financial difficulties when paying for healthcare services

Efforts to Achieve UHC

WHO also recommends six foundations for achieving Universal Health Coverage in a country, including (Tulchinsky, 2018):

a. Sufficient healthcare financing supported by risk pooling.
b. Adequately remunerated and well-trained healthcare workforce.
c. Availability of information to support policy-making and decision-making.
d. Effective logistics management to obtain necessary medicines, vaccines, and technologies.

e. Well-maintained healthcare facilities, managed as part of service delivery, and in cooperation with networks.
f. Strong leadership in setting the rules, providing clear guidance and mobilizing the energy of stakeholders, including communities and cross-sector collaborations.

UHC itself is a part of the 17 goals in the Sustainable Development Goals (SDGs). Goal 3 of the SDGs focuses on ensuring a healthy life and promoting well-being for all. To achieve this, efforts to attain UHC are required, which include: Financial risk protection for the entire population, Access to quality healthcare services for all, and Access to safe, high-quality, and affordable treatment and immunization for the entire population (Agyepong, 2018).

WHO and the World Bank aim for 80% of the population to receive basic healthcare services and 100% of the population to have financial risk protection. To measure UHC, WHO has established a framework consisting of three indicators, namely (Han, et al., 2018): Coverage of basic healthcare services, Financial risk protection, and Equity in healthcare services for the entire population.

The Dimensions of UHC

There are four dimensions of Universal Health Coverage (UHC), which are:

1. The extent of the population covered.
2. The comprehensiveness of the services guaranteed.
3. The proportion of cost-sharing by the population.
4. The quality of healthcare services.

Measuring UHC

Achievement There is no specific formula for measuring the achievement of UHC in a country. In its latest report, WHO uses four indicators that essentially employ a proxy approach. These indicators are Life Expectancy, Healthcare Coverage, Financial Protection, and Equity in healthcare services. A study suggests a method for measuring UHC achievement using 16 indicators divided into four main groups. These indicators are (Hogan, Stevens, Hossienpoor, & Boerma, 2018):

1. Reproductive, Maternal, Infant, and Child Health
   a. Family Planning. This indicator is measured based on the demand for modern contraceptive methods among married women aged 15-49 or based on agreement.
   b. Maternal Care Services. This indicator is measured based on the number of women receiving Antenatal Care (ANC) services four times or more.
   c. Child Immunization. This indicator is measured based on the number of 1-year-old children receiving three doses of Diphtheria, Tetanus, and Pertussis vaccine.
   d. Child Health Services. This indicator is measured as the behavior of seeking healthcare for children at risk of pneumonia.
2. Infectious Diseases
   a. Pulmonary TB Treatment. This indicator is measured as effective coverage of pulmonary TB services.
   b. HIV Treatment. This indicator is measured as the number of people with HIV who receive Antiretroviral (ARV) treatment.
   c. Malaria Prevention. This indicator is measured as the number of people in malaria-endemic areas using insecticide-treated bed nets.
   d. Water and Sanitation. This indicator is measured as the number of households with basic sanitation facilities.
3. Non-communicable Diseases
   a. Cardiovascular Disease Prevention. This indicator is measured as the prevalence of the population without hypertension based on treatment status.

b. Diabetes Management. This indicator is measured based on the average fasting blood glucose level.
c. Cancer Detection and Treatment. This indicator is measured as the number of women aged 30-49 years who undergo cervical cancer early detection.
d. Tobacco Control. This indicator is measured as the number of adults aged 30 who have not smoked tobacco in the last 30 days.

4. Health Service Capacity and Access
   a. Hospital Access. This indicator is measured as the number of hospital beds per population.
   b. Health Workforce Level. This indicator is measured as the number of healthcare professionals per population, including doctors, psychiatrists, and surgeons.
   c. Access to Essential Medicines. This indicator is measured as the proportion of healthcare facilities capable of providing essential medicines as recommended by the WHO.
   d. Health Insurance. This indicator is measured as the ability to ratify the International Health Regulation (IHR) index.

Research Related to Universal Health Coverage (UHC)

Table 1: Research Related to Universal Health Coverage (UHC)

No	Researcher	Year	Tittle	Method	Finding
1	Melisa	2023	Implementation achievement of the Universal Health Coverage in Indonesia: Narrative Review	Literature review	Achieving UHC in Indonesia is still faced with the challenge of informal sector membership coverage and there are several strategies and policies issued by regional governments to achieve UHC in their regions, including the role and commitment of actors, cross-sector coordination, efforts to expand JKN membership coverage, providing sufficient budget , improving the quality of health services and capacity of health human resources, creating innovative programs to achieve UHC. indicators in measuring UHC achievements by calculating the essential health service coverage index and financial protection against health costs.
2	Cipto Rizqi Agung Saputro	2022	Universal Health Coverage: Internalization of Norms in Indonesia	Descriptive qualitative design	UHC is a new international standard that is attempting to spread around the world. Aside from that, it was discovered that the Indonesian government has internalized norms and has reached the third and final step of the internalization process with assigned local actors, especially BPJS Kesehatan.

3	Fani Dwi Yanti	2023	Analysis of community perspectives on the national health insurance program in the Teluk Mengkudu region	a phenomenological approach to descriptive qualitative research	This health is excellent, and this program can go out to all areas, making it easy for people to get treatment at the local health facility. 52% still do not believe the JKN program can ensure all health-care funding. They lack faith in the finance provided by JKN due to a lack of socialization. The JKN initiative in the Teluk Mengkudu region is doing well, but there is still a lack of public knowledge of JKN finance and use.

THEORETICAL FRAMEWORK

Universal Health Coverage Dimension

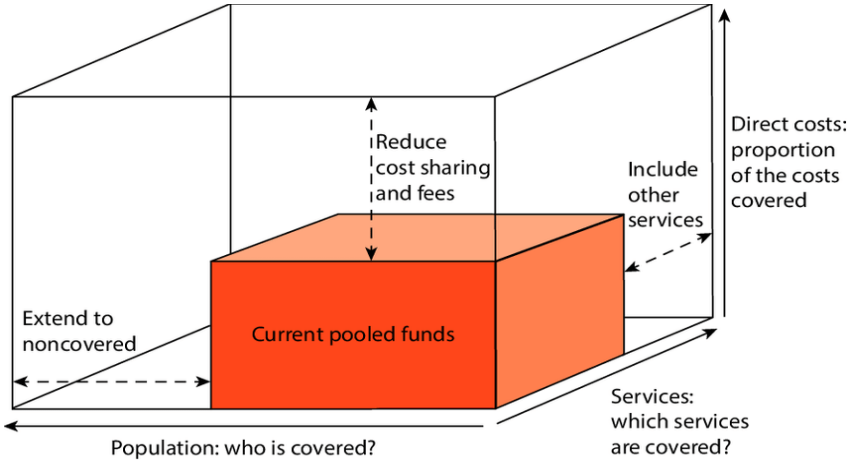

Figure 1. Universal Health Coverage Dimension
Source: WHO, The World Health Report (2010)

METHODS

A quantitative technique was applied in this study. The data collected was descriptive in nature, derived from service and beneficiary data, distribution, and network expansion, and advocacy accomplishments for health and insurance services in 12 Indonesian provinces, namely LKC Aceh, LKC South Sumatra, LKC Banten, LKC Jakarta, LKC West Java, LKC Java Tangeh, LKC East Java, LKC Jogyakarta, LKC NTB, LKC NTT, LKC South Sulawesi, and LKC Papua. According to the available statistics, Dompet Dhuafa's initiatives helped to close the gap in access to universal health coverage for poor people in Indonesia.

Advocacy, membership, and RDK services were among the activities carried out. Advocacy and membership were carried out in the form of verifying prospective members' access to Health Insurance and verifying the criteria for the poor using specific techniques such as physical observations and interviews with resource persons.

Individual services with Hotline Emergency of Dhuafa (HED), Disaster, Event, and Volunteer services were all available through RDK. Ambulance services, assistance, and health care were examples of HED activities. RDK for disasters implements ALS (Healthy Service Action) and COZI (Corner Nutrition) initiatives. Training, mass circumcision, blood donation, ALS (Healthy Service Action), and medical standby were all examples of RDK event.

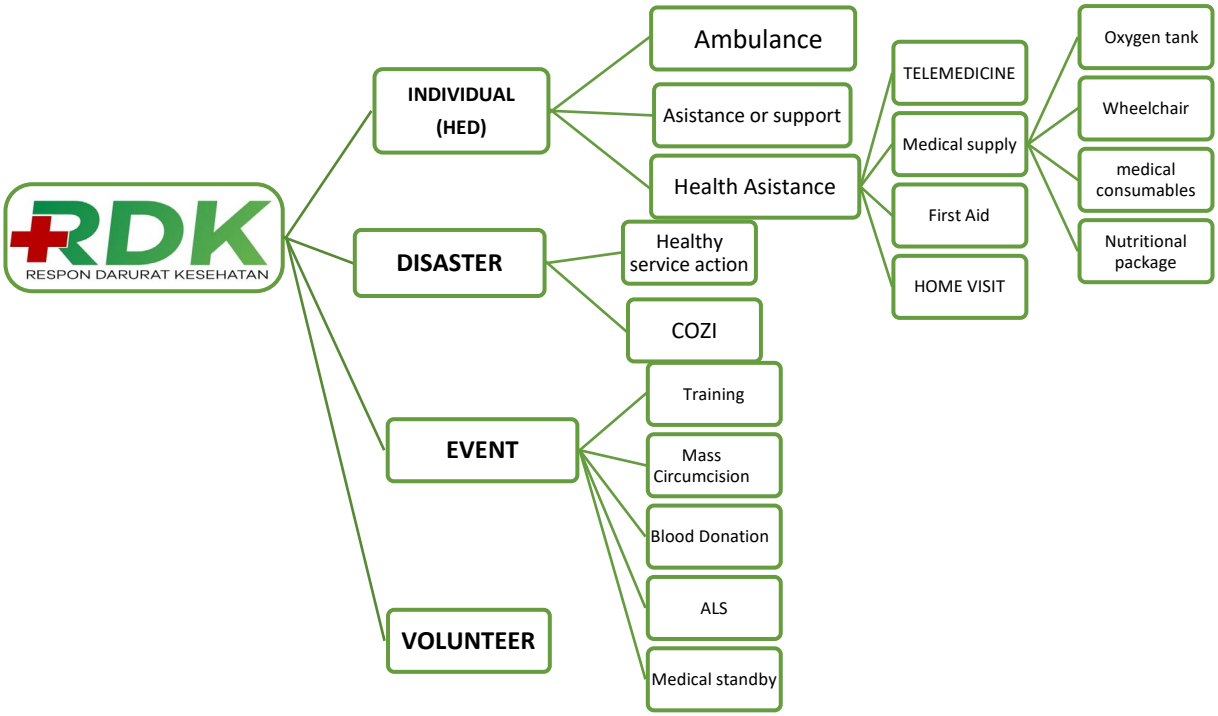

Figure 2. Health Emergency Response (RDK) Workflow

RESULTS

Univariate Analysis

Advocacy and Membership

Table 2: Dompet Dhuafa LKC membership for the period January-December 2022

No	Region	Total Participants	Total BPJS	APBD	APBN	Independent	Non-BPJS	DB	DU
1	ACEH	1116	703	344	318	41	266	1116	0
2	Jakarta	3048	3016	2129	672	215	32	3048	0
3	Banten	3266	2302	937	713	652	964	2853	413
4	West Java	4292	3830	1132	1260	1438	462	2255	2037
5	NTT	3224	2420	230	1660	530	790	3224	0
6	Papua	208	103	3	97	21	84	208	0
7	NTB	110	63	3	48	12	47	110	0
8	South Sumatra	392	179	0	79	100	213	392	0
9	Central Java	985	734	49	372	313	251	985	0

10	South Sulawesi	1731	0	0	0	0	0	1731	0
11	Yogyakarta	4478	4030	0	-	-	448	4478	0
12	East Java	394	236	39	112	85	158	396	0
	Total	23.244	17616	4866	5331	3407	3675	20796	2450
	Percentage		76%	21%	23%	15%	16%		

Based on **Table 2,** Dompet Dhuafa membership for the period of January-December 2022, out of 12 regions in Indonesia, there were a total of 23,244 participants. Among them, 17,616 (76%) had BPJS, 4,866 (21%) were covered by APBD, 5,331 (23.5%) by APBN, 3,407 (15%) by Mandiri, and 3,675 (16%) did not have BPJS

Table 3: Overall Funding for Advocacy Services

No	LKC Corner Funding	Total Beneficiaries	Cost (Rp)
1	BPJS premiums and penalties	2545	1,068,205,639
2	Inpatient and outpatient claims	6747	2,614,380,662
	Total	9292	3,382,256,301

Based on **Table 3.** the funding for advocacy services conducted by LKC Corner consists of premiums and BPJS fines totaling 2545 with a cost of Rp 1,068,205,639, and inpatient and outpatient care claims totaling 6747 beneficiaries with a cost of Rp 2,614,380,662

Table 4: Hospital Services

No	Hospital Name	Total Beneficiaries	Claim
1	RST Dompet Dhuafa	3282	643,538,295
2	AKA Medika Lampung	328	370,559,600
3	Lancang Kuning	343	945,965,928
4	Achmad Wardi	0	-
5	Sayyidah	0	-
6	Griya Medika	158	306,022,185
7	Annisa	6	14,823,000
8	RS Non DD Net	0	-
	Total	9292	2,280,909,008

According to **Table 4,** hospital services with a total number of beneficiaries of 9292 have claims amounting to Rp 2,280,909,008

Table 5: Clinics

No	DD Clinics Name	Total Beneficiaries	Claim
1	DD Ciputat Clinic	105	11,361,418
2	DD Tangerang Clinic	0	-
3	DD Makassar Clinic	0	-
4	DD Rorotan Clinic	0	-
5	DD Bandung Clinic	0	-
6	DD Kupang Clinic	1726	167,55,000
7	DD Aceh Clinic	414	107,800,000
8	DD Parung Clinic	0	46,470,236
9	DD Annisa Dua Clinic		-
	Total	2.720	333,471,654

Based on **Table 5,** the number of beneficiaries at the DD clinic is 2720 with claims amounting to Rp 333,471,654

Table 6: DD Net Hospital Claim Financing

Hospital Name	2020		2021		2022 (December)	
	Total Beneficiaries	Claim of Ina CBGS	Total PM	Claim of Ina CBGS	Total Beneficiaries	Claim of Ina CBGS
RST Dompet Dhuafa	3620	1,614,8222,443	2752	669,761,716	3270	597,031,695
AKA Medika Lampung	81	116,995,000	103	116,997,513	-	-
Lancang Kuning	657	1,350,151,054	401	1,089,227,001	0	
Achmad Wardi	45	28,000,000	0	-	0	-
Sayyidah	0	-	0	-		
Griya Medika Annisa	2961	567,255,000	2637 0	525,948,490	110	167,626,460
Total	7364	3,677,223,497	5893	2,401,934,720	3885	**1,872,605,056**

According to **Table 6**, the Claim Financing from 6 DD Net Hospitals in the year 2020 had a total of 7364 beneficiaries, with a total Ina CBGS Claim amount of Rp 3,677,223,497. In the year 2021, there were 5893 beneficiaries with a total Ina CBGS Claim amount of Rp 2,401,934,720. In December 2022, there were 3885 beneficiaries with a total Ina CBGS Claim amount of Rp 1,872,605,05.

Health Emergency Response (RDK)

Table 7: RDK Beneficiaries

No	Region	Number of Beneficiaries
1	RDK Pusat	814
2	Aceh	103
3	Banten	71
4	Jabar	108
5	DKI Jakarta	99
6	Central Java	1839
7	East Java	45
8	NTB	136
9	NTT	66
10	Central Kalimantan	1
11	South Sulawesi	23
12	Papua	16
13	DIY	139
14	South Sumatera	2
15	Jambi	1
	Total	3463

Based on **Table 7**, the number of beneficiaries of Health Emergency Response (RDK) in 15 regions, namely RDK Center, Aceh, Banten, West Java, DKI Jakarta, Central Java, East Java, West Nusa Tenggara (NTB), East Nusa Tenggara (NTT), Central Kalimantan, South Sulawesi, Papua, Yogyakarta, South Sumatra, and Jambi, amounts to 3463.

RDK Disasters

Table 8: RDK Disaster Beneficiaries

No	Region	Disaster Type	Total Beneficiaries
1	Aceh	Flood	1689
2	West Sumatera	West Pasaman Earthquake	2573
3	West Java	Floods and Earthquakes	10230
4	DKI Jakarta	Fire	440
5	Central Java	Flood	8423
6	East Java	Semeru landslides and eruptions	778
7	NTT	Sinking ship	1
8	Central Kalimantan	Flood	459
9	South Sulawesi	Flood	263
10	Papua	Flood	5279
		Total	30135

Based on **Table 8**, the number of beneficiaries of Disaster Health Emergency Response (RDK) from 10 regions in Indonesia, which include Aceh, West Sumatra, West Java, DKI Jakarta, Central Java, East Java, East Nusa Tenggara (NTT), Central Kalimantan, South Sulawesi, and Papua, amount to 30,135

Table 9: Beneficiaries of the RDK Events

No	**Region**	**Events**
1	Aceh	1185
2	Banten	1373
3	West Java	1779
4	DKI Jakarta	9594
5	Central Java	1320
6	East Java	1569
7	NTB	302
8	NTT	264
9	Central Kalimantan	570
10	South Sulawesi	481
11	Papua	524
	Total	**18961**

Based on **Table 9**, The number of beneficiaries of the Disaster Health Emergency Response (RDK) Event from 11 regions, including Aceh, Banten, West Java, DKI Jakarta, Central Java, East Java, West Nusa Tenggara (NTB), East Nusa Tenggara (NTT), Central Kalimantan, South Sulawesi, and Papua, amount to 18,961.

Table 10: Beneficiaries of Health Assistance

No	Region	Total Beneficiaries
1	RDK Pusat	547
2	Aceh	77
3	Banten	56
4	West Java	85
5	DKI Jakarta	68
6	Central Java	592
7	East Java	24
8	NTB	130
9	NTT	54
10	Central Kalimantan	1
11	South Sulawesi	18
12	Papua	16
13	DIY	138
14	South Sumatera	2
15	Jambi	1
	Total	1809

Based on **Table 10**, the number of beneficiaries of Health Aid in 15 regions, namely RDK Center, Aceh, Banten, West Java, DKI Jakarta, Central Java, East Java, West Nusa Tenggara (NTB), East Nusa Tenggara (NTT), Central Kalimantan, South Sulawesi, Papua, Yogyakarta, South Sumatra, and Jambi, amounts to 1809

DISCUSSION

Advocacy and Membership

According to Table 1. BPJS covered 76% of the total membership of 23,244 persons. Dompet Dhuafa is one of the free services offered in Indonesia's 12 provinces. Advocacy and membership are the kinds of actions carried out. According to Table 2, a total of 9,292 LKC Corner financing participants paid premium financing and BPJS fines. Apart from premiums and penalties, 2,545 BPJS premiums and fines paid amounted to 1,068,205,639. This effort aims to provide guarantees for poor people to be able to access health services by paying premia or BPJS arrears to be further advocated to social services to get rights as recipients of BPJS contribution assistance (BPJS PBI). LKC corner funding, namely making inpatient and outpatient claims from a total of 6,747 claims paid totaling 3,382,256.30. The total number of claims at hospitals, namely RST wallet Dhufa, AKA Medika Lampung, Lancang Kuning, and Griya Medika, with a total of 9,292 beneficiaries, was 2,280,909,008. Meanwhile, at DD Clinic, 2,720 claimants were found to have filed 333,471,654 claims at DD clinics in Ciputat, Kupang, and Aceh.

According to the findings in Table 5, there had been a drop in claims and beneficiaries from DD Clinic Net to Dompet Dhuafa. This decline was due to the poor maximizing their access to National Health Insurance / BPJS, as well as DD Klinik Net partnering with BPJS. There was a Net Clinic DD with no claims to Dompet Dhuafa since impoverished people in the area utilize their BPJS access to seek care at the clinic. According to Table 5, finance for poor patients who received treatments at 6 DD Net Hospitals and 1 Non-DD Net Hospital was near the poor patient's location and domicile. Because the impoverished individuals who previously sought care used the Dompet Dhuafa Guarantee, and because BPJS was operating, the DD Net Hospital got their claims from BPJS. Dhuafa beneficiaries who were DD Net facility patients continued to get treatment at that facility by simply transferring their insurance to BPJS, causing the value of DD Net Hospital claims to Dompet Dhuafa to decrease.

Advocacy and membership activities are one component whose function is to verify prospective members' access to Health Insurance and carry out verification regarding the criteria for the poor using specific techniques such as physical observations and interviews with sources to obtain good and correct data. Members are participants who have undergone data and eligibility verification in order to get services from Dompet Dhuafa. Members are based on a Family Card (KK) in the Membership System and verification, and verification is performed to confirm the existence of Health Insurance and its eligibility.

Poor people (Dhuafa) services at hospitals or clinics can use DD Net Hospital / Clinic services with DD guarantees. The finance assurance technique is that verified Dhuafa can receive services at any time by displaying a member card or Dhuafa ID at the DD Net Hospital/Clinic. If you have not registered as a member, the member verification procedure is carried out with a response time after visiting the DD Net Hospital/Clinic. The DD Net Hospital / Clinic will file a claim to DD via LKC 1x24 hours or 3x24 hours depending on the severity of the ailment. LKC will validate the data and send it to DD, who will subsequently pay the validated claim bill.

Advocacy and membership initiatives aim to achieve UHC (Universal Health Coverage) by guaranteeing that every citizen in the population has equitable access to high-quality promotive, preventative, curative, and rehabilitative health care at reasonable prices. With Dompet Dhuafa's presence, we can lessen the burden of health problems, particularly on the Dhuafa, by providing free health services. Collaboration across sectors is required to achieve the vision of a healthy Indonesia by 2025. Synergy with the community and the appropriate government is also required to support the development of solutions for people who are experiencing social challenges, particularly in relation to their health insurance.

Health Emergency Response (RDK)

Based on Table 6, the number of individual RDK beneficiaries was 3,463 spread across several provinces. In Table 7, the RDK disaster had a total of 3,0135 beneficiaries spread across several provinces, namely Aceh, West Sumatra, West Java, DKI, Central Java, East Java, NTT, Central Kalimantan, Central Sulawesi, and Papua. Apart from Individual RDK recipients, there are Event HER recipients. The number of RDK Event recipients was 18,961 spread across 11 provinces. In 2022, the RDK provided 1809 health assistance, with the most assistance provided in September, and the region that provided the most assistance was Central Java, followed by RDK Central. The central RDK itself, before the transformation of the regional RDK in August, had served beneficiaries in the Banten, DKI Jakarta, and West Java regions. Apart from the 12 LKC working areas, RDK health assistance has also reached other areas such as Jambi and Central Kalimantan.

Health Emergency Response activities include Individual, Disaster, Event, and Volunteer. Individual RDK is an excellent service to improve public health standards, especially for the poor. LKC Dompet Dhuafa is present through the RDK in providing health assistance needed by people who have limitations in accessing health services in Indonesia, through the Dhuafa Emergency Hotline 08111617101, a hotline number that is always active every day and can be contacted by people from all over Indonesia to access RDK services. This hotline makes it easier for poor people to apply for assistance and makes it easier for the team to quickly assess patient needs. HED activities include ambulance services, help, and health assistance. RDK for disasters carries out ALS (Healthy Services Action) and COZI (Corner Nutrition) activities. RDK Events include training, mass circumcisions, blood donations, ALS, and Medical Standby.

Health assistance, free ambulance services, and help are among the services offered by RDK. Telemedicine, a communication method used to facilitate online consultations with competent medical staff, is one type of health aid. This program is available to anybody who has questions or concerns about health issues, not only the poor. Another type of health help is emergency first aid, which is

medical support offered in an emergency situation based on the patient's needs. Patients are treated according to medical triage, and if required, they are referred to the nearest hospital by the team.

RDK also provides support in the form of a home visit, which includes inspecting the patient's health, monitoring vital signs (blood pressure, pulse, bodily condition, etc.), healing wounds, and offering basic treatment. The RDK service also includes assistance with Health Support Equipment. Providing equipment or supplies that are not covered by health insurance but are required to support the patient's health. Wheelchairs, colostomy bags, NGT tubes, wound care equipment, formula milk, and medications not covered by BPJS are examples of products that may be supplied. Oxygen support is another type of help. The RDK team is also continuing to provide oxygen cylinder loans, particularly in Jabodetabek and Central Java. Top-ups are also accessible at the central LKC DD office in Ciputat, in addition to loans.

The free ambulance service given during RDK activities takes the form of free transportation to and from the hospital. Services will always be provided free of charge to patients who are already LKC members and have had their needy status verified. RDK services take the form of accompaniment, in which the RDK team accompany patients during the first treatment process and offers education on the flow of health services so that patients may thereafter seek care on their own. Other RDK services will be provided to patients in the form of financing actions outside of BPJS coverage and payment of BPJS arrears by the LKC Dompet Dhuafa Advocacy and Membership team, which collaborates with the RDK team in conducting surveys to determine patient membership status before assistance can be provided. The Advocacy and Civil Affairs team will distribute applications for prostheses such as Hearing Aids and prosthetic limbs itself, rather than the RDK team.

Even though the majority of RDK Individual beneficiaries have government health insurance, namely BPJS, there are many other health-related needs and measures that are not covered by BPJS, such as wheelchairs, oxygen cylinders, wound care materials, colostomy bags, catheters, and various other medical procedures. These requirements necessitate a significant financial investment, particularly for underprivileged individuals; this is where the RDK can assist our patients. RDK also provides help in the form of Nutrition Packages, which include doctor-prescribed formula milk and essential dietary elements needed to maintain the beneficiaries' health. Aside from material aid, the RDK team also performs critical condition checks, rehabilitation, and direct care for recipients. The team will also educate beneficiaries on the course of treatment that must be followed, as well as advocate for the optimum use of government health insurance. Dompet Dhuafa is able to deliver significant advantages and impacts for Dhufa, both those who receive health care and those who do not, through Advocacy Service activities, membership, and RDK services. Advocacy and RDK services are creative approaches to reducing the burden of health issues that will have an influence on health insurance.

CONCLUSION

Dompet Dhuafa has provided access to health services and health insurance for the poor with access to services at Dompet Dhuafa service facilities both clinics and hospitals, also provided health insurance in the form of BPJS premium payments and BPJS arrears in emergency situations and advocated to the government for the right to access health, in an effort to overcome the gap in UHC implementation.

Health Emergency Response (RDK) services are a fast response program for disadvantaged people, both individuals and communities, who require health care and insurance. This program covers the Poor People's Emergency Hotline, health visits for health members, individual emergency response, disasters, and poor people's health insurance advocacy. For Health members who pass poor people eligibility verification, the RDK program offers a flow and structure of Health emergency response services. The Dompet Dhuafa Health Program focuses on providing inexpensive access and services, addressing gaps in the field, raising community awareness, actively involving the community, and finally forming collaborative relationships with diverse stakeholders.

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