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Guarantee, Promotion and Ideas of Omnibus Law on Health in Indonesia Compared to Singapore and Taiwan

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Abstract

This study aims to compare and analyze macro health policies in Indonesia with those in Taiwan and Singapore. The results of the comparison and analysis will be used as lessons learned and input for improving health policies in Indonesia in the future. Health policies in the form of the BPJS Kesehatan program have not optimally improved the health of the Indonesian people in terms of services, medicines, medical personnel, and health facilities. Taiwan is the country with the most superior health services in the world in 2024 and Singapore is the country with the best health system in the world in 2023. Through a normative legal research method with qualitative legal data analysis, it is known that the health policies implemented by the Taiwanese and Indonesian governments are almost the same, namely using an insurance mechanism with contributions from participants, the government and the private sector, but the differences in the reach and standardization of health services in Taiwan are wider in scope compared to Indonesia, while the Singaporean government in its health policy implements four programs, namely medisave, medishield, medifund, eldershield with control over increasing health financing from the government. Health policies in Taiwan are easier for the Indonesian government to apply in perfecting the BPJS Kesehatan program than those implemented by Singapore because both have implemented health policies through mandatory insurance programs. BPJS Kesehatan must improve its service management and the government needs to increase the number of health facilities and standardization of health facilities by adjusting its characteristics as an archipelagic country. Formulate fair premi for participants so that participants get optimal health services. Health promotion must be encouraged to increase public health awareness. The health omnibus law as a national legal strategy can be used as a trigger to harmonize overlapping health policies so that health programs can be implemented optimally which has an impact on improving the health of the Indonesian people.
Keywords: *Health Degree; Health Omnibus Law; Role of the State*

1. INTRODUCTION

The health condition of a country's population is a determining factor in increasing human resources and has a fairly central influence on the country's economic growth. A country will function efficiently if individuals have better health conditions. The right to health in every country includes various factors that are important for healthy living, including but not limited to, individual rights, access to nutritious food, clean drinking water, proper sanitation, healthy housing, safe working conditions, and a healthy environment.[1] Health is an important concern for all individuals because it has a direct impact on the development of personal integrity and competence. Indonesia, as a developing country, faces challenges in providing excellent and affordable health services. Meanwhile, the government bears great responsibility for the health status of its people.[2] Indonesia adheres to the concept of a welfare state that requires the presence of the state in

[1] Fheriyal Sri Isriawaty, "Tanggung Jawab Negara Dalam Pemenuhan Hak Atas Kesehatan Masyarakat Berdasarkan Undang-Undang Dasar Negara Republik Indonesia Tahun 1945," *Jurnal Kesehatan*, 2015.
[2] Esterlita Nova Yaser Rantung, Toar Neman Palilingan, and Theodorus H W Lumonon, "Tanggung-Jawab Negara Atas Pemenuhan Kesehatan Di Bidang Ekonomi, Sosial, Dan Budaya," *Jurnal Lex Privatum*, 2023.

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social security. The state, in this case, the government, must be present to provide solutions to the basic needs of the community, one of which is health. Therefore, Indonesia needs public policies in the health sector that can improve the status and degree of public health. Social security can be achieved by providing social assistance and organizing social insurance. Several health insurance programs apply the principle of mutual cooperation which is interpreted as "the healthy help the sick." This guarantee has been regulated in the health law and is also contained in the Constitution of the Republic of Indonesia[3] which regulates health services provided by the government, in this article, the government guarantees the implementation of health services, health workers, and health facilities.

According to the 2024 edition of *the Ceoworld Health Care Index*, Taiwan is considered the top country with the most superior healthcare system globally. Indonesia ranks 39th on the list with a score of 42.99. The Ceoworld Healthcare Index assessment is determined by various factors, including the quality of medical infrastructure and professional staff, accessibility and affordability of medicines, and the level of government preparedness. Taiwan scored 78.72 out of 100 for all three components.[4] Meanwhile, according to statistical analysis, Singapore achieved the top ranking for the world's best healthcare system in 2023, followed by Japan and South Korea in the next rank. The health index score is determined by socializing several measures of public health and the availability of essential healthcare services, including health conditions, health systems, diseases and risk factors, and mortality rates.[5]

How can health policies in Taiwan and Singapore provide lessons for health system reform in Indonesia? What is the role of health promotion and the urgency of the health omnibus law in Indonesia? This is an urgent need to improve health policy management through BPJS Health, which the public still complains about. There are still many people who do not know about the procedures and benefits of BPJS Health and there are still overlapping regulations which hinder the implementation of health policy programs in Indonesia.

Taiwan and Singapore can be a model for implementing health policies for Indonesia because both Taiwan and Singapore are the best countries in the world for implementing their health policies. The health policies set by Taiwan and Singapore are strongly supported by their communities and businesses. The people in both countries are very satisfied with the health policies made by their governments. *National Health Insurance* (NHI) in Taiwan is currently referred to as one of the best social protection policies in the

[3] Valen Nainggolan and Tundjung Herning Sitabuana, "Jaminan Kesehatan Bagi Rakyat Indonesia Menurut Hukum Kesehatan," *Sibatik Journal: Jurnal Ilmiah Bidang Sosial, Ekonomi, Budaya, Teknologi, Dan Pendidikan* 1, no. 6 (May 5, 2022): 907–16, https://doi.org/10.54443/sibatik.v1i6.109.

[4] Asri Novitasari, " Negara Dengan Kualitas Kesehatan Terbaik, Ada Indonesia?," https://www.rri.co.id/index.php/kesehatan/706966/, n.d.

[5] Ilmam Restu, "10 Negara Dengan Sistem Kesehatan Terbaik Dunia," https://www.cnbcindonesia.com/lifestyle/20230725181626-36-457271, 2023.

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world.[6] A policy will be considered successful if the community is satisfied with the policy made. Policies in the form of regulations must meet at least three requirements to be effective, namely philosophical, legal, and sociological requirements. Policies in the form of regulations that meet sociological requirements mean that the policy is needed by the community and this can be seen from the community's response to the policy. Health services provided by Singapore and Taiwan are attractive to citizens outside Taiwan and Singapore to utilize health services in the two countries. The conditions in Indonesia are different. Social health security is managed by BPJS Kesehatan with a social insurance mechanism. Many people are dissatisfied with the health services using the Social Security Administering Agency (BPJS) Health. This is confirmed by the increasing number of public complaints to the Ombudsman of the Republic of Indonesia. The number of complaints amounted to 400 complaints in 2022, an increase compared to the number of complaints the previous year, which was around 300 complaints.[7] The Ombudsman is an institution that has the authority to oversee the implementation of public services organized by state-owned enterprises, regional-owned enterprises, and state-owned legal entities as well as private entities or individuals who are tasked with organizing certain public services, some or all of which are funded from the State revenue and expenditure budget and/or regional revenue and expenditure budget (Article 1 of Law of the Republic of Indonesia Number 37 of 2008 concerning the Ombudsman of the Republic of Indonesia). BPJS has a bad image such as a complicated and long process, a limit on the number of patients who receive services per day, and sometimes the prescribed drugs are not available.

As a developing country, there are still many challenges that must be faced to catch up and improve the health profile of every citizen so that it can create an Advanced Indonesia. Some obstacles that need to be considered and planned for the health service system are JKN financing, equitable distribution of health workers, uneven health services between cities and villages, and the quality and satisfaction of patients with BPJS and health facilities.[8] Some factors inhibit the implementation of BPJS Health for the community, namely the problem of rates and medicines, membership problems, problems with the quality of health services, referral problems, the socialization of the BPJS Program is not optimal, the group of Jamkesmas cardholders is not included in BPJS participants, there are still many people who do not understand that the health insurance provider has changed to BPJS, the health service process is still categorized as complicated (gradual), there is no data on National Health Insurance (JKN) participants separately.[9] Inequality in health

[6] Ardila Putri et al., "Kebijakan Asuransi Kesehatan Taiwan (Taiwan National Health Insurance) Dan Pembelajaran Bagi Negara Berkembang," *Jurnal Kebijakan Kesehatan Indonesia* 9, no. 3 (2020).

[7] Bellinda W Dewanty, "Pembatasan Layanan Pasien BPJS Kesehatan Diskriminatif," https://ombudsman.go.id/, n.d.

[8] Jevon Agustinus Dwi Putra and Amal Chalik Sjaaf, "Comparison of the Health Service System and the Universal Health Insurance among Indonesia's Neighboring Countries," *Daengku: Journal of Humanities and Social Sciences Innovation* 2, no. 4 (August 17, 2022): 502–8, https://doi.org/10.35877/454RI.daengku1039.

[9] Endang Kusuma Astuti, "Peran BPJS Kesehatan Dalam Mewujudkan Hak Atas Pelayanan Kesehatan Bagi Warga Negara Indonesia," *Jurnal Penelitian Hukum Indonesia* 1, no. 1 (2020).

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services and facilities in various regions is not evenly distributed between urban and rural areas, in western Indonesia and eastern Indonesia, in Java and outside Java.

The increasing number of public complaints from the Indonesian Ombudsman is proof that there are still many public complaints about the implementation of BPJS Health as an implementation of the health policies being implemented. This is in direct contrast to what is implemented by the Taiwanese government through its NHI as well as the medisafe, medishield, medifund, and eldershield programs implemented by Singapore. Taiwan and Singapore have implemented the health policies that society needs. The implementation of Taiwan and Singapore's health policies needs to be analyzed in order to provide lessons learned for improving health policies in Indonesia through the BPJS Health program, the importance of health promotion, and the urgency of the health omnibus law as a solution to anticipate overlapping regulations which could become an obstacle to the lack of implementation of health policy programs.

2. METHOD

This study uses a normative legal method by examining secondary data sources that include primary legal materials, such as laws and regulations related to health policy. Secondary legal materials such as books and journal articles that discuss health policy and social security. Electronic documents in this study are considered tertiary legal materials. The normative legal research method is a method commonly used in legal research. According to Soekanto and Mamudji, normative legal is legal research that studies various sources of literature or secondary data, known as library legal research.[10]

In addition to reviewing the legal framework, this study also includes an evaluation of health policies implemented in Indonesia and how they compare to Taiwan and Singapore. The collected data were analyzed using qualitative legal methods. Qualitative legal is in the form of in-depth interpretation of legal materials. By conducting qualitative legal analysis, the aim is to identify potential improvements in the implementation of national health policies by considering the practices carried out in Taiwan and Singapore which are quite successful as *lessons learned*.

3. RESULTS AND DISCUSSION

3.1 National Health Policy in Singapore, Taiwan and Indonesia

Referring to world population review data, Singapore is ranked 6th globally, while Indonesia is ranked 92nd. Due to this situation, it is only natural that some Indonesian citizens are happy to seek health services outside Indonesia, such as Singapore as one of their preferred destinations. The influx of Indonesians seeking health services in Singapore has had a significant economic impact, generating annual revenues of up to 100 trillion.[11] The quality of Singapore's healthcare system is seen through two parameters namely life expectancy and infant mortality rate. Singaporean citizens have a life expectancy of 84 years, while Indonesian citizens have a life expectancy of 71.5 years. The infant mortality

[10] Soerjono Soekanto and Sri Mamudji, *Pengantar Penelitian Hukum Normatif* (Jakarta: Rajawali Pers, 2015).
[11] Sirus Teknologi Utama, "Ayo Tenggok Sistem Kesehatan Singapura," https://sirus.io/24, 2021.

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rate in Singapore is 2.59, but in Indonesia, the figure is 20. Singapore dedicates 4% of its Gross Domestic Product (GDP) to healthcare services. In Singapore, healthcare management is separated into two sectors: the government sector and the private sector. The government class is divided into five classes: class A, B1, B2+, B2, and C. The government bears 80% of maintenance costs only for class C.[12] Singapore's total GDP in 2022 is 367.42 billion US dollars with a total population of 5.64 million people. The Singapore government has provided a budget for health benefits of Rp. 5.5 million/month for the poor for daily medical expenses, but ironically as many as 72% of Singaporean citizens still admit that it is difficult to cover the costs and obtain optimal services in the health sector.[13] The most innovative factor in health services Financing in Singapore is a comprehensive health insurance structure and system.[14] Indonesia, with its archipelagic characteristics, large population, even number 4 in the world, low level of community income, means that funding for public health is still limited.

There are 4 programs to protect health in Singapore, namely Medisave, Medishield, Medifund, and Eldershield. In the Medisave program, the Singapore Government requires working Singaporeans to allocate 20% of their monthly salary for savings. In this specific percentage, 7-9.5% of an individual worker's monthly salary is allocated to a Medisave account. This account aims to cover costs related to health services. The funds will continue to be added every month until they reach a maximum of $43,500 or equivalent to IDR 500 million. After reaching the maximum limit, the savings allocation will be reallocated to another account. Then the Medishield program with additional low-cost coverage is available for dangerous diseases such as cancer, leukemia, and stroke. The annual cost consists of $33 for patients aged 29 to $372 for patients aged 69 years. The maximum coverage limit for this policy is $50,000 per year or $200,000 over a person's lifetime. Then the medifund program is an additional protection for Singapore citizens that is applied if the MediSave and MediSave accounts have run out. This Medifund is funded by the Singapore Government. Patients will be given the most basic level of care. Furthermore, the eldershield program is insurance protection available to individuals aged between 40 and 65 years. Patients will be given a monthly allowance of up to $ 400 for 72 months to cover home care costs.[15] Singapore's healthcare system is based on a funding model that combines MediSave, MediShield, and MediFund or known as "3M".[16] Singapore has a healthcare system that is renowned for its wide accessibility, has the same and high standards of healthcare services, has succeeded in creating a sustainable healthcare system including in

[12] Novy Diah Anggraini, "Sistem Asuransi Singapura, Perbandingan System Pelayanan Kesehatan Indonesia Dan Singapura," https.//osf.io, n.d.

[13] Sapto Praditnyo, "Susahnya Miskin Di Negeri Singa," *Majalah Detik*, 2014.

[14] Rosliza Manaf et al., "A Systematic Review on Healthcare Financing in Singapore," *International Journal of Public Health and Clinical Sciences* 3 (October 2016): 96–106.

[15] *Ibid.*

[16] Naili Shifa; Pujiyanto ,Studi Komparasi Sistem Pembiayaan Pelayanan Kesehatan Perorangan Singapura dan Indonesia = Comparative Study of Singapore and Indonesia's Individual Healthcare Financing Systems, Fakultas Kesehatan Masyarakat Universitas Indonesia, 2022

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its financing and management, well-integrated healthcare financing that helps reduce the burden of healthcare costs for its citizens.[17] The health system in Singapore is not easy to adapt, the obligation to save only in Indonesia is difficult to implement because income levels are low and it is used up for consumption, especially for people at lower economic levels. Standardization of health facilities in Singapore, which is the government's responsibility, can be followed even though the quality is difficult to compare. Another thing is that by bringing in contributions from the private sector, it can be optimized.

Another country for comparison is Taiwan. Taiwan, located in East Asia, has been recognized as the country with the highest health index globally. Taiwan, although not a member of WHO, has offered comprehensive health insurance to its 23 million citizens since 1995. Taiwan's National Health Insurance (NHI) is implemented through a combination of health programs derived from the insurance system for workers, farmers, and civil servants. However, its coverage is limited to half of the total population of Taiwan. The goal of Taiwan's national health insurance is to ensure equitable access to health services for every citizen, regardless of their age, financial situation, or job position. In addition, all non-native individuals with legal employment or residency status in Taiwan are entitled to equal services.[18] Providing justice for society in the health sector is one of the goals of health law.

National Health Insurance (NHI) is a government program run with a single-payer approach. National Health Insurance in Taiwan is run by the National Health Insurance Administration as regulated by the National Health Insurance Act of Taiwan in 1994. National Health Insurance participation is mandatory and is funded through participant contributions, investment returns, and government allocations.[19] Life expectancy in Taiwan has reached a level comparable to that of major countries in *the Organisation for Economic Co-operation and Development* (OECD). Specifically, the average life expectancy for women in Taiwan is 83.4 years, while for men it is 76.8 years. Healthcare costs in Taiwan are below those of other wealthy countries in Europe and North America. In 2016, Taiwan spent 6.3 percent of its GDP, equivalent to US$1,430 per capita per year, on health care. Administrative spending is less than 1% of total spending, while public satisfaction is high, at 85.8 % in 2017. These data show that the health policies implemented by the Taiwanese government meet sociological requirements, namely that they are needed by Taiwanese citizens. Lessons learned from Singapore include improving health services, including facilities and infrastructure, with international reputation standards. The policy is the same as Indonesia, namely providing assistance to the poor, while those who are not included in the poor are required to have health insurance.

[17] Karina Fachrun Nisa, Timbul Dompak, and Karoi Teovani Lodan, "Pembandingan Sistem Pelayanan Kesehatan Di Indonesia Dan Singapura," in *Proseding Seminar Nasional Ilmu Sosial Dan Teknologi (SNISTEK)*, 2024.

[18] Taiwan Today, "Asuransi Kesehatan Nasional Taiwan: Sebuah Percontohan Untuk Cakupan Kesehatan Universal," https://nspp.mofa.gov.tw, 2018.

[19] Zahrashafa Putri Mahardika, "Perbandingan Peraturan Perundangan Tentang Skema Program Jaminan Kesehatan Nasional Di Indonesia Dengan National Health Insurance Di Taiwan" (Universitas Indonesia, 2023).

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Taiwan's healthcare system has undergone several adjustments over the past two decades to maintain long-term viability in response to changes in socio-economic conditions. The cost-saving method has been replaced by the full-cost approach. Since 2003, this program has proven quite effective in limiting the annual increase in healthcare spending from 12% to 5%. The premium payment mechanism was changed from relying solely on income to an additional premium based on *capital gains*. This has resulted in a surplus for the fund. The main motto of the national health insurance in Taiwan is "*one for all, all for one.*" The main sources of funding for health insurance in Taiwan come from three entities: insured individuals, employers, and government subsidies. The Taiwanese government provides assistance to low-income or no-income citizens as a way to finance their health insurance. Policyholders pay a national health insurance premium every month, which is calculated based on their monthly income. As the employee's salary income increases, the monthly health insurance cost also increases. The salaries allocated to workers are categorized into 48 levels by the national health insurance. The minimum monthly compensation is NTD 23,800 (equivalent to 12 million rupiah), while the maximum monthly income at level 48 is NTD 182,000 (equivalent to 89 million rupiah).[20] The motto one for all, all for one is the same motto that is applied in Indonesia, namely by working together everyone will be helped.

Taiwanese citizens are responsible for 30% of the monthly health insurance premium, 60% is borne by themselves, and the remaining 10% is borne by the government. As an illustration, for a monthly wage of NTD 23,800, each individual is required to contribute NTD 335 (around 160,000 rupiah) per month, employers are required to contribute NTD 1058 (around 520,000 rupiah), and the Taiwanese government is responsible for the contribution of NTD. 176 (around 86,000 rupiah). Due to this, in Taiwan's national health insurance system, most working residents can get the best health services at relatively affordable prices.[21] Taiwan has several claim categories for reimbursement of its national health insurance. In most countries, health insurance offers limited coverage and often lacks coverage for medical and dental expenses. However, Taiwan's national health insurance provides comprehensive coverage for medical and dental expenses. Taiwan's national health insurance covers expenses related to general outpatient services, surgical procedures, hospital stays, and medications. Healthcare in Taiwan is satisfactory. Taiwan's national health insurance partners are 90% of major hospitals and clinics. Taiwanese residents have unlimited access to medical care at major hospitals and clinics throughout Taiwan, as long as they have a national health insurance card. Accessing medical care or undergoing surgical procedures can sometimes require a long waiting period, ranging from weeks to months, in many countries. This is not the case in Taiwan. One additional benefit of Taiwan's universal health insurance is the computerization and storage of patient medical

[20] Liputan 6, "Menengok BPJS Kesehatan Taiwan, Iuran Menyesuaikan Upah Bulanan," https://www.liputan6.com/11 Juli 2020, July 11, 2020.
[21] *Ibid*

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data in the cloud. Every time a patient receives therapy, the diagnosis results and the name of the prescription prescribed are sent to *the cloud* for data storage. This information can serve as a diagnostic reference for other doctors later. The goal is to prevent unnecessary use of medical resources and minimize the risk of drug rejection in patients.[22] Awareness of healthy living is still not widespread in Indonesia, including environmental health. Likewise with technology, there are still many people who are unfamiliar with technology and patient medical history data is still stored in hospitals so that when they change hospitals, the medical history data will be compiled again.

What is the health policy situation in Indonesia? Indonesia has established a social insurance system to organize a national health insurance program. The legal basis is stipulated in the Social Security System Law Number 40 of 2004 and the Social Security Administering Agency Law Number 24 of 2011. The National Social Security System Law has undergone several amendments, including the Job Creation Law Number 11 of 2020, the Job Creation Perppu Number 2 of 2022, and most recently through the Law on the Development and Strengthening of the Social Security System Number 4 of 2023, especially in the financial sector. The BPJS Law has been amended through two laws, namely the Job Creation Law No. 11 of 2020 and its replacement, namely the Job Creation Perppu No. 2 of 2022 which has now been enacted by Law No. 6 of 2023.

BPJS Kesehatan is mandatory, so individuals have no choice but to register for it. BPJS has a motto: through collaborative efforts, everyone gets help (with mutual cooperation everyone will be helped). This *tagline* aims to motivate Indonesian people to allocate part of their monthly income to save. The BPJS Kesehatan program reduces the burden of expensive medical expenses by distributing the costs to all Indonesian citizens. This collective effort makes things more manageable. The Indonesian government has implemented this program as an important step to ensure that individuals in need have easy access to high-quality and affordable health services throughout the country. BPJS participants are categorized into four different groups, namely a) PPU PN refers to individuals who are citizens of the Republic of Indonesia and have met certain criteria. They are selected by authorized officials to hold government positions or carry out other state responsibilities. Applicable laws and regulations determine the criteria and amount of wages; b) Residents registered by the Regional Government (PBPU Pemda) are individuals who have not been registered as participants in the Health Insurance Program. The individual is selected and registered by the provincial or district/city government to be included in the Health Insurance Program organized by BPJS Kesehatan. The Cooperation Agreement (PKS) between BPJS Kesehatan and the provincial and/or district/city governments is the reference for registration; c) Non-Wage Workers (PBPU) are those who work or try to run their own business without receiving a salary. PBPU participants are required to register themselves and their family members according to those listed on the Family Card, including spouses, children, and other relatives. Registration is carried out in

[22] *Ibid*

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the category of care that is equal to all family members listed on their Family Card. Participants who register for PBPU or participants who are not working can make the first contribution payment between 14 to 30 calendar days from the date of registration. This payment can only be made after the participant's eligibility has been verified through registration verification. Payment must be made using the auto debit mechanism; d) Health Insurance Contribution Assistance (PBI-JK) is a program that provides health insurance for the underprivileged and poor. The Central Government through the APBN and the Regional Government through the APBD cover the payment of the contributions.[23]

Financing for BPJS Health for Private Wage Recipients (PPU), BUMN, BUMD is 5% of the total salary received consisting of 1% paid by participants and 4% paid by employers. BPJS Health contributions for Contribution Assistance Recipients (PBI) are paid by the Government, PPU Civil Servants are 5% of PNS salaries consisting of 1% paid by participants and 4% paid by Employers, namely the Government. Contributions for additional participants are 1% of salary. Contributions from veterans, independence pioneers, widows, and orphans are 5% of 45% of the basic salary. For poor communities, all BUJS Health contributions are borne by the State.

Participants receive various benefits, including first-level basic health services, both outpatient and inpatient. They also have access to more specialized health services, including advanced referral services and follow-up care for outpatient and inpatient needs. However, what is unfortunate for participants is the mechanism and services in practice which are sometimes complicated, waiting for a longer time, and practical discrimination from health service personnel in their hospitals. Another issue is the transparency of money received from participants and the health services received. Disinformation often creates a negative public perception of BPJS Kesehatan.

According to BPJS Kesehatan, the projected expenditure of health insurance providers in 2023 is estimated at around IDR 158.85 trillion. As of December 31, 2023, the number of participants is estimated to reach 267.31 million people, or equivalent to 95.75% of the total participants. The total expenditure for health insurance is projected at IDR 176 trillion in 2024.[24] BPJS Kesehatan reported that as of June 1, 2024, there were 273 million participants in the National Health Insurance (JKN) program. This statistic represents 97% of the total population in Indonesia.[25] The health budget in 2024 is projected at IDR186.4 trillion or 5.6% of the APBN. This amount grew by 8.1% or IDR 13.9 trillion compared to the 2023 budget.[26] Indonesia's total GDP in 2022 is 1,390 billion US dollars. The state budget will continue to increase every year and it is part of the logical consequence of the goal of the Indonesian state to provide welfare for all its people. This has been stated in the

[23] BPJS Kesehatan, Peserta Jaminan Kesehatan," https://bpjs-kesehatan.go.id, n.d.

[24] National Kontan, "Biaya Jaminan Kesehatan Nasional Tahun 2024 Diprediksi Mencapai Rp 176 Triliun," https://nasional.kontan.co.id/1, 2024.

[25] Monavia Ayu Rizaty, "Data Jumlah Peserta BPJS Kesehatan Di Indonesia Hingga 1 Juni 2024," https://dataindonesia.id/kesehatan/detail/data-jumlah-peserta-bpjs-kesehatan-di-indonesia-hingga-1-juni-2024, 2024.

[26] Redaksi Sehat Negeriku, "Anggaran Kesehatan Indonesia Tahun 2024," https://sehatnegeriku.kemkes.go.id/16, 2024.

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state constitution as a reference for legal sources for laws and their implementing regulations.

Access to Health in Indonesia with its archipelago type is still a problem, especially in rural and remote areas, health facilities are not evenly distributed, and the sustainability of the health system in Indonesia is still a challenge, especially related to financing and resource management, health costs in Indonesia are a heavy burden for some people, especially those who are not covered by the JKN program or cannot afford additional costs.[27]

The health policy implemented by Taiwan has similarities with the health policy in Indonesia. Both use social insurance mechanisms and specifically for citizens who work/are unable to pay insurance premiums. However, what distinguishes them is the process of implementing the scope of health services in Taiwan is much wider and easier compared to Indonesia. Taiwan has optimally used technology and information technology in its health system, with land areas of course access constraints are not a problem in Taiwan, but unlike Indonesia, the island region is sometimes an obstacle to public access to BPJS Health, the uneven distribution of health facilities in the regions is certainly very difficult to reach. Health policies in Singapore are difficult to adopt because many of their programs have the same distribution of health facilities, coupled with its small area, land, and high income levels, making the programs implemented not encounter obstacles. This is different from what happens in Indonesia, the island region, the uneven distribution of health facilities and the average income of the community is still a problem, not to mention the problem of accountability for the management of BPJS Health funds which is still questioned by the community. As a country that adheres to the concept of a welfare state, Indonesia continues to improve in making health policies and is able to improve the health of its people. The development of standardization of health facilities in each region continues to be improved. The regulatory basis is sufficient but implementation in the field encounters many obstacles. Other factors that contribute are the low income of the community, the low public health budget from the government, and the number of middle class supporting public consumption is also still low. Adopting and adapting good things that are applied in Taiwan and Singapore to the conditions in Indonesia is certainly quite good and recommended. When the government budget is insufficient, this is where the collaborative role of the private sector is needed. The health policies implemented need support from all ministries, BPJS Kesehatan audits need to be carried out continuously to avoid misuse, and law enforcement officers must consistently assist in law enforcement. Health policies in Taiwan and Singapore cannot be separated from the health awareness of their communities and their law enforcement.

3.2 Health promotion as an effort to improve health status and level

Communication must be maximized between the government and its citizens. Socialization and communication are sometimes a challenge for Indonesia. Lack of

[27] Nisa, Dompak, and Lodan, "Pembandingan Sistem Pelayanan Kesehatan Di Indonesia Dan Singapura."

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socialization and communication often results in policies and programs that are made quite well but in their implementation are poorly responded to by the community. To improve the welfare of the Indonesian people, it is important for the government to play an important role by providing public services that meet the basic needs of its citizens, including health services, education, and other important needs. The state plays an important role in meeting the basic needs of its citizens, especially in the field of health services.[28] Health is a basic human need in order to achieve general welfare as stated in the Preamble to the 1945 Constitution. The 2023 Health Law, especially Law Number 17, defines health as the welfare of an individual as a whole which includes physical, mental, and social aspects, not just being free from disease. This definition aims to promote a more productive and satisfying existence for individuals .

According to a 2001 WHO study, Indonesia's public health is far behind other Asian countries, including Thailand, Malaysia, Brunei Darussalam, India, and China. The country is also behind poor countries such as Sri Lanka[29]. Indonesia's health status is ranked 103 out of 109 countries according to the "life expectancy" metric used by the World Health Organization (WHO). In 2001, a UNDP report related to health development classifies Indonesia's health status at 109 out of 174 countries. In 2005, Indonesia's ranking position remained unchanged and showed no improvement for five years.[30] For that, Indonesia needs serious and consistent development in the field of health services.

Health development is intended to improve the overall health level of the community. The Jakarta Declaration outlines the main priorities of the health sector in the 21st century, including enhancing social responsibility for health services, enhancing capital in health service development, encouraging collaboration to improve community capacity and individual empowerment, and ensuring the availability of health promotion facilities[31]. The Jakarta Declaration formulates it as follows: a) Health promotion is the main capital in influencing health determinants and providing the most significant health benefits for the community. b) Health promotion provides a very profitable output in improving health equity for the community, compared to other efforts. c) Increasing social accountability in the health industry, increasing financial resources for health progress, consolidating and expanding collaboration in the health sector, strengthening community capacity and improving individual capacity, and guaranteeing accessibility to health promotion facilities and infrastructure. The development of health education is a key element for better health development.[32]

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[28] Hubab Alif Khariza, "Program Jaminan Kesehatan Nasional: Studi Deskriptif Tentang Faktor-Faktor Yang Dapat Mempengaruhi Keberhasilan Implementasi Program Jaminan Kesehatan Nasional," *Kebijakan Dan Manajemen Publik* 3, no. 1 (2015).

[29] WHO, "World Health Report," 2001.

[30] UNDP, "Human Development Report," 2005.

[31] Ditha Prasanti, "The Communication Barriers in The Health Promotion of Familiy Planning Program IUP in Bandung," *Jurnal Penelitian Komunikasi dan Opini Publik* 22, no. 1 (July 25, 2018), https://doi.org/10.33299/jpkop.22.1.1146.

[32] Henni Febriawati, *Puskesmas Dan Jaminan Kesehatan Nasional* (Yogyakarta: Deepbublish, 2019).

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Another aspect related to improving health promotion in the community is the Ottawa Charter formulated at the first International Conference on Health Promotion in Ottawa, Canada, in 1986. The findings of this charter resulted in three basic tactics that must be applied in the health sector. Promotion is empowerment, environmental development, and advocacy.[33] Community empowerment in this context refers to a method of health promotion that involves utilizing and maximizing the potential that exists in a community by actively involving them in the development and implementation of program policies from the beginning. The target to be achieved is to recognize the capacity of individuals to uphold and improve their well-being. Atmosphere building is a deliberate step to provide a social environment that encourages community members personally to want to comply with socialized standards in regulating individual behavior patterns in the local community. The atmosphere-building process is divided into three categories: Individual atmosphere building: This category involves the implementation of initiatives or socialization by certain local community leaders, who serve as role models for desired behavior. Group atmosphere building: This category involves many community groups, including RT administrators, RW administrators, religious study groups, professional organizations, student organizations, and so on. Public atmosphere building: Implemented similarly to the initial criteria, by involving the community in general through collaboration and utilization of existing media platforms to shape public sentiment. The media in question includes various formats such as print media, electronic media, radio, periodical tabloids, internet sites, and other platforms that actively promote and shape communal behavior.

Advocacy is a deliberate and systematic approach used in obtaining commitment and support from stakeholders from related parties in the implementation of community initiatives. This strategy is carried out as an action to develop healthy public policies by prioritizing preventive measures without neglecting the treatment and rehabilitation aspects.[34]

According to WHO, health promotion is a systematic approach to improving the ability of individuals and communities to manage the determinants of their overall health. Health promotion is a reinvigoration of health education that goes beyond raising public awareness and increasing knowledge in the field of health. It also serves as a means to facilitate behavioral change, both at the community level, in organizations, and in the environment. The goal of health promotion is none other than to increase the capacity of individuals, families, groups, and communities to engage in healthy behaviors and to build community-based health initiatives that foster an environment conducive to the development of such capacity.[35]

[33] Makmur Makmur, Treesia Sujana, and Angkit Kinasih, "Strategi Program Kesehatan Puskesmas di Sekolah Dasar," *Jurnal Ilmu Keperawatan Dan Kebidanan* 8, no. 2 (July 15, 2017): 107, https://doi.org/10.26751/jikk.v8i2.301.

[34] Juwita Mandasari, Linda Ishariani, and Eko Arik Susmiatin, "Gambaran Pelaksanaan Promosi Kesehatan Tumbuh Kembang Balita Di Puskesmas Se-Kabupaten Kediri," in *Prosiding Seminar Penelitian Kesehatan*, 2019.

[35] Ira Nurmala et al., *Promosi Kesehatan*, Surabaya: Airlangga University Press, 2018.

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Health promotion initiatives are a collective obligation, which is not focused on the health industry alone but extends to other fields, society, and the economy. Health promotion requires the support of all stakeholders. Cohesive understanding, efficient performance, and collaboration between health officials at every level of government and other stakeholders from various sectors in the country are essential to achieving success in achieving these goals. vision, intent, and purpose of national health promotion. This is done to build the foundation of a prosperous Indonesia, characterized by a society that is aware of its health and has easy access to quality health services, to enable a productive and prosperous life in the future.[36]

Health promotion must be carried out at the lowest level, meaning it must touch directly on the community. One of the health services closest to the community in general is the Community Health Center (Puskesmas). The Minister of Health has issued Decree No. 585/Menkes/SK/V/2007 concerning Guidelines for Implementing Health Promotion in Community Health Centers, namely (1) empowerment, (2) building an atmosphere, (3) advocacy, and imbued with a spirit of (4) partnership. Implementation: Health promotion that has been carried out, for example at the Dinoyo Community Health Center, is through the following strategies: a. Community empowerment in the form of health cadres in each sub-district to assist the performance of the community health center b. Build an atmosphere in the form of creating a sense of comfort that can be felt by the community in providing counseling c. Advocacy in the form of collaboration with the community and the Health Service in providing information to the public about health. d. The supporting media for health promotion used by community health centers is the result of the creativity of special health promotion officers.[37] The results turned out to be still less than optimal in motivating people to behave in a clean and healthy lifestyle (PHBS) which can be seen in the following table1:

Table1: Dinoyo Health Center Clean and Healthy Living Behavior

Year	Sub District	Healthy Household	PHBS
2011	Merjosari	37,4%	69,2%
2012	Sumbersari	21,4%	76,7%
2012	Tlogowaru	30,0%	80,3%
2013	Tunggulwulung	26,7%	63,0%
2013	Ketawanggedhe	22,4%	54,9%

Source: Puskesmas Dinoyo

Health promotion and prevention initiatives play an important role in Indonesian society. According to the Ministry of Health of the Republic of Indonesia, community-based empowerment in the context of health promotion in areas with health problems refers

[36] Dwi Widiyaningsih and Dwi Suharyanta, *Promosi Dan Advokasi Kesehatan* (Yogyakarta: Deepublish, 2020).
[37] Indah Pratiwi Wibawati, Soesilo Zauhar, Riyanto, Implemntasi Kebijakan Promosi Kesehatan, *Jurnal Administrasi Publik (JAP)*, Vol .2 , No. 11.

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to the provision of continuous and ongoing information to individuals, families, or groups, as well as community assistance in health matters. become more knowledgeable. Individuals who have a strong understanding of a subject matter are more skilled in applying related skills in practical situations.[38] Health promotion and advocacy must be able to be a preventive measure to improve the health of the community. The performance and incentives for health human resources need to be measured by increasing public health awareness. Health promotion and advocacy must reach the lowest level in government so that the reach is wider with a shorter span of control.

3.3 Omnibus Law on Health to Improve the Status and Level of Health of the Indonesian People

Ideas must always be raised to get a better life in the future. Ideas can come from anywhere and from anyone. Ideas must be facilitated to develop. Ideas should not be hampered but their existence needs to be appreciated. Overlapping regulations in Indonesia are a problem that has not been resolved. Synchronization and harmonization are eagerly awaited by millions of people in Indonesia. Institutional and sectoral egos have made Indonesia's competitiveness with countries in Southeast Asia still inferior when compared to other countries in Asia and Europe. To do business in Indonesia alone, many investors complain about the long, complicated procedures and the high costs. Many investors leave Indonesia because conditions have not changed from year to year. Changing many regulations with one regulation has been practiced in other countries such as Canada, the Philippines, and Turkey. Canada uses the *Omnibus Law approach* to implement international trade agreements. Canada modified 23 old laws to be subject to WTO rules. The Philippines uses omnibus law in terms of investment. *The Omnibus Investment Code* is a series of regulations that provide comprehensive fiscal and non-fiscal incentives that are considered by the Philippine government in the context of national development. Turkey in January 2019 issued Omnibus Law No. to amend tax regulations. The model is called *Omnibus Law*.[39]

Omnibus law is a legislative step to comprehensively harmonize overlapping related legislation.[40] The nomenclature of "*omnibus law*" does not merely refer to a particular regulation, but is a regulation created with a particular approach called "*omnibus*". Omnibus law is a regulation with a scope of several provisions and themes[41]. Gunter explained that the name " *omnibus* " is a Latin name and means "for everything". In a legal context, it refers to a single document that comprehensively covers various points of debate based on

[38] I Nyoman Bagiastra, "Gagasan Omnibus Law Kesehatan Sebagai Kebijakan Hukum Nasional Dalam Upaya Meningkatkan Derajat Kesehatan Masyarakat Di Indonesia," *ICLEH*, 2020, 33–46.

[39] Tirta Citrandi, "Tak Cuma Di RI, Omnibus Law Banyak Dipakai Negara Lain," https://www.cnbcindonesia.com/news/20200121152155-4-131621/, 2020.

[40] Firman Freaddy Busroh, "Konseptualisasi Omnibus Law Dalam Menyelesaikan Permasalahan Regulasi Pertanahan,HAN," *Arena Hukum* 10, no. 2 (August 1, 2017): 227–50, https://doi.org/10.21776/ub.arenahukum.2017.01002.4.

[41] Rio Christiawan, *Omnibus Law: Teori Dan Penerapannya* (Jakarta: Bumi Aksara, 2021).

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various criteria.[42] Then, *Black's Law Dictionary* defines the term *omnibus* as "*relating to or dealing with numerous objects or items at once; including many things or having various purposes.*"[43] Adam M. Dodek stated that the omnibus law technique offers efficiency advantages, allowing the government to efficiently model changes to a large number of regulations in force through one comprehensive regulation. If the amended law remains relevant to its essence, then the law can cover all negotiations between the government and parliament simultaneously.[44] Some people call *the omnibus law* a universal law.

Several regulations made in one regulatory package are the health *omnibus law*. The health *omnibus law* designed by the government consists of several laws and regulations, such as the Nursing Law No. 38 of 2014, the Medical Practice Law No. 29 of 2004, the Health Workers Law No. 23 of 2013, the Hospital Law No. 44 of 2009, the Medical Education Law No. 20 of 2013, and the Health Law No. 17 of 2023. This health *omnibus law* theoretically aims to provide quality health services carried out by doctors, other health workers, and health service institutions to patients or the community as recipients of health services. Therefore, the health *omnibus law* that has been designed can accommodate the interests of the parties involved clearly, firmly, and fairly as a form of legal certainty and protection.

The proposal for *an omnibus law* on health has sparked a long debate among bureaucrats and health experts. Efforts to implement *an omnibus law* on health in Indonesia have been rejected by various health professions. Indonesia as a country that ratified the agreement on the establishment of *The World Trade Organization* (WTO) and *the General Agreement on Trade in Services* (GATS) must fully prepare themselves in terms of regulatory compliance and fair competition, especially in the health sector. This includes compliance with agreed commitments and ensuring readiness to compete with other member countries.

The importance of revising health regulations in Indonesia through the implementation of *the omnibus* health law. The many overlapping regulations in the health sector have triggered many health programs to be unable to be implemented in the field, resulting in a decline in health services to the community. The health sector is currently regulated by at least 13 laws, making it the sector with the most laws.[45] The health omnibus law aims to consolidate health policies and regulations. Investing in health in Indonesia is both a promising opportunity and a significant problem in the future.

Service obligations as regulated in GATS. Such as the discovery of gaps in regulations regarding the definition of doctors and dentists as stated in Article 1 paragraph (2) of the Law. No.29 of 2004 and Article 1 paragraph (9) and (10) Law No.20 of 2013.

[42] Muladi, "RKUHP Sebagai Omnibus Law," *Harian Kompas*, 2019.
[43] Bryan A Garner, *Black's Law Dictionary 9th Edition* (West, 2009).
[44] Adam M Dodek, *Omnibus Bills: Constitutional Constraints and Legislative Liberations*, vol. 48 (Ottawa L, 2016).
[45] Kementrian Kesehatan, "Urgensi RUU Kesehatan Untuk Perbaiki Layanan Ke Masyarakat," https://partisipasisehat.kemkes.go.id/topik/detail/4846c4f5-12d5-4266-a5ce-0fcc4e431526, n.d.

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According to Article 1 paragraph (2) of Law No. 29 of 2004, doctors and dentists are those who have completed medical or dental education, either domestically or abroad, which is recognized by the government. Including specialist doctors and specialist dentists. Article 1 paragraph (9) and paragraph (10) of the Law No. 20 of 2013 states that specialist doctors in primary care and subspecialist doctors who have completed their medical education are selected from graduates of accredited medical education programs, both domestically and internationally, as recognized by the government. Likewise, the dentists selected are specialist dentists who have completed dental education programs both domestically and internationally and have been accredited and officially recognized by the government. The inclusion of the name of the professional organization in Article 1 paragraph (12) of the Law No. 29 of 2004 has given rise to various interpretations in its application. This can be seen from the inconsistent use of the terms "medical professional organization" and "dental professional organization" in Article 14 paragraph (1) and 28 paragraph (2) of the Law. No. 29 of 2004. The definition of a professional organization as stated in Article 1 paragraph (12) of Law No. 29 of 2004 differs from the definition contained in Article 1 paragraph 20 of Law No. 20 of 2013. The first regulation states the name of the professional organization, while the second regulation does not mention it in the provisions of this article.

This problem causes the need for legal transparency and differences of opinion in the implementation of the organizer's duties. The lack of uniformity in the use of the terms "training" and "supervision" and the existence of different rules regarding the entities authorized to organize training and supervision is seen in the development of Article 7 paragraph (1) letter c. Article 54, especially paragraph (1) and paragraph (2) of Law No. 29 of 2004 (Medical Education and Training) and Professional Organizations. In contrast, Article 71 uses the term “training” together with “supervision” and involves the Central Government, Regional Government, Indonesian Medical Council, and Professional Organizations (Other Parties). As a result, there is a gap in understanding and inefficiency in the implementation of training and supervision in medical practice. Furthermore, Law No.29 of 2004 suggested that several tests be conducted by the general public, and the Constitutional Court (MK) approved three specific cases to be tested. The cases were identified as Decision Number 4/PUU-V/2007, Decision Number 40/PUU-X/2012, and Decision Number 10/PUUXV/2017. Law No.29 of 2004 has been amended based on three Constitutional Court Decisions. The provisions that were amended include Article 14 paragraph (1) letter Article 14 paragraph (2), Article 73 paragraph (2), Article 75 paragraph (1), Article 76, Article 78, and Article 79 letter c. The implications that arise from the task of the Constitutional Court's decisions are: a) Eliminating imprisonment. b) Eliminating imprisonment. c) Eliminate the obligation to increase knowledge and follow scientific developments, except for the dental profession. d) Prohibition of the management of the Indonesian Doctors Association from sitting on the membership of the Indonesian Medical Council.

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Currently, lawmakers have not reached a consensus to change the articles and verses of Law No. 29 of 2004 in response to the Constitutional Court's ruling. Therefore, to provide legal certainty in Indonesia and maintain the integrity of national judicial institutions, especially the Constitutional Court, lawmakers must immediately change the articles or verses that have been changed by the Constitutional Court's ruling.

The Covid-19 pandemic has brought about significant advances in technology, especially in the health sector. This has resulted in the introduction of new health services and technologies that were previously unavailable. *Virtual* and *augmented reality* is one of the medical technologies that is currently being developed. Another thing, medical practice is open to graduates from both within and outside the country. Article 30 paragraph (2) of Law No. 29 of 2004 formulates the assessment of doctors and dentists who have received training from abroad and wish to practice in Indonesia. Its implementation has been less successful considering the lack of effective cooperation between the interests of the organizers. Effective collaboration between stakeholders *in* accelerating the integration of doctors and dentists trained abroad, because this is directly related to the constitutional rights of these professionals to obtain employment and income.

The above matters show that many health regulations in Indonesia are not in harmony. Therefore, it is necessary to understand the concept of regulations and policies that guarantee diplomatic relations between countries by prioritizing national interests. As well as the urgency of policies, laws, and regulations that uphold Universal human rights, local wisdom, and fostering justice and civilized international relations. The omnibus law on health is a solution amidst overlapping health regulations in Indonesia and can answer the health needs of the Indonesian people so that the quality of health of the Indonesian people increases because policies and programs can be implemented effectively and efficiently.

4. CONCLUSION

Indonesia has implemented the concept of national social security with a cooperation model. This model is the same as that implemented in Taiwan through its insurance program. Although the same concept was implemented, the health index is very far from where Taiwan is in 2024. Singapore implements 4 programs, namely Medisave, Medishield, Medifund, and Eldershield. Health services involve 3 elements, namely the government, the business world, and the community. Indonesia's health service index is at a low level and the community is less satisfied with BPJS Kesehatan services. In contrast to the people of Taiwan and Singapore who are satisfied with the health policies implemented by their governments. The regulatory framework for health insurance in Indonesia is sufficient, but the implementation of regulations and governance still needs to be improved. Improving public health and welfare includes utilizing health development, optimizing social responsibility, increasing community capacity, empowering individuals and community workers, and ensuring the availability of quality health infrastructure. These efforts aim to improve and prevent health problems, thereby improving the overall level of public health. The implementation of the health omnibus law as a public policy in the realm of national

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legislation functions to improve the health standards of the Indonesian people. For this reason, it is urgent to review and align regulations at the national level as a whole, while still adhering to the basic principles of the State, to ensure the achievement of public welfare goals in the health sector.

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