

## ABSTRAK

Angka kemiskinan di Indonesia masih cukup tinggi. Sejak tahun 1998 sampai sekarang pemerintah menerapkan kebijakan subsidi jaminan kesehatan RT miskin yaitu JPSBK, PDPSE Bidkes, PKPS BBM Bidkes, Askeskin, Jamkesmas dan PBI didalam JKN. Data IFLS tahun 2000 menunjukkan hanya sekitar 26,3 % RT miskin yang memiliki subsidi jaminan kesehatan dan meningkat menjadi 33,1 % di tahun 2007. Rendahnya cakupan subsidi jaminan kesehatan di Indonesia menunjukkan masih tingginya beban biaya kesehatan sehingga akan menurunkan akses dan pemanfaatan tenaga/ fasilitas kesehatan.

Penelitian ini merupakan penelitian observasional dengan data panel IFLS di tigabelas propinsi tahun 1997, 2000 dan 2007. Analisis data secara deskriptif dan analitik dengan multiple linier regression data panel. Penelitian bertujuan untuk mengetahui deskripsi upaya pengobatan sendiri dan pemanfaatan rawat jalan, rawat inap, beban biaya kesehatan mereka dan faktor berpengaruh pada beban biaya kesehatan RT miskin.

Hasil penelitian menunjukkan upaya pengobatan RT miskin sebesar 22,82% (1997), 23,17% (2000) dan 25,43% (2007), pemanfaatan pelayanan rawat jalan sebesar 25,37%, 17,17% dan 18,9%, pemanfaatan rawat inap yaitu 0,57%, 0,62% dan 1,04%. Sebagian RT miskin masih menanggung beban biaya pengobatan sendiri, rawat jalan dan rawat inap yang rata-rata dan maksimal biayanya meningkat dan cukup besar. Mereka juga masih menanggung biaya transportasi, biaya *inkind* yang dibayarkan ke faskes rawat jalan, biaya periksa kehamilan dan biaya keluarga berencana. Sampai dengan tahun 2007 subsidi jaminan kesehatan tidak berpengaruh pada beban biaya kesehatan RT miskin baik pada upaya pengobatan sendiri, rawat jalan maupun rawat inap karena masih rendahnya cakupan subsidi, tingginya pemanfaatan faskes swasta dan fasilitas jaringan tidak berada didekat mereka serta bebera faktor lain.

Saran yang diajukan yaitu: 1). Meningkatkan cakupan dan ketepatan sasaran penerima subsidi jaminan kesehatan dan melakukan kajian evaluasi kebijakan yang komprehensif. 2). Mengembangkan kegiatan promosi dan prevensi kesehatan dan mendanainya di dalam JKN. 3). Mengatur dan meningkatkan *supply* tenaga / fasilitas kesehatan untuk pemerataan penyebarannya ke seluruh wilayah Indonesia. 4). Melanjutkan kebijakan subsidi jaminan kesehatan untuk RT miskin dan mewujudkan *universal coverage* di dalam JKN.

Kata kunci : beban biaya kesehatan, jaminan kesehatan, keluarga miskin.

## ABSTRACT

Poverty rate in Indonesia is still relatively high. Since 1998 therefore the government has implemented health insurance subsidy for poor households namely JPSBK, PDPSE Bidkes, PKPS BBM Bidkes, Askeskin, Jamkesmas and PBI within JKN scheme. IFLS data in 2000 showed there were only 26.3% and 33.1% in 2007 of poor households that had health insurance subsidy and it shows that financial burden of healthcare in Indonesia is still high therefore it lowers the access and utilization of health workers/ facilities.

This study was undertaken to the panel data of IFLS in thirteen provinces in the year of 1997, 2000, and 2007. Data analysis was analytically with multiple linier regressions of panel data. The purpose of the study was to identify utilization of self medication, out patient care and in patient care, their financial burden of healthcare and factors influenced the financial burden of healthcare of poor households.

The result of the study showed the self medication rate were as much as 22,82% (1997), 23,17% (2000) and 25,43% (2007). The utilization of out patient care were as much as 25,37%, 17,17% and 18,9%,. The utilization of in patient care were 0,57%, 0,62% and 1,04%. Some poor households still bore self medication cost, out patient cost and inpatient cost which the average and maximum cost rose and fairly big. They also still bore transportation cost, *in kind* cost of outpatient, antenatal care and contraception. Until 2007 the health insurance subsidy did not influence financial burden of self medication, out patient and in patient care since the coverage of the subsidy was still low, the utilization of private health facilities was still high, healthcare network facilities were out of range and another factors.

The study proposes some suggestions namely 1) increasing the coverage and targeting accuracy of health insurance subsidy beneficiaries and the need of assessment for comprehensive of policy evaluation 2) the development of health promotion and prevention activities and financed this program in JKN. 3) Controlling and increasing the supply of health workers and facilities to the entire of Indonesia. 4) Continuing the policy of health insurance subsidy for poor and obtaining universal coverage in JKN.

Keywords : health financial burden, health insurance, poor family.