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The Dilemma of Local Health Service Policy in the Era of National Health Insurance: A Political Perspective Analysis

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Abstract

The strengthening of political priorities in terms of developing health policies for various parties needs to be carried out both for the doctor and for the recipients of health services. Various health policies are influenced by various things based on certain contextual factors. In the Minister of Health Number 59 of 2014, it is stated that the amount of capitation funds is for first-level dental health services in independent practices, but it is not stated how much the capitation rate is for dental health services at community health centers. This research uses quantitative descriptive methods. The calculation method used is the Activity-Based Costing (ABC) method. The results of this study show that the average unit cost of dental health services at the Community Health Center is IDR. 104714. The largest unit cost is the GIC patching action. By using the activity-based cost calculation method, it can be seen that the largest costs for dental health services at the Community Health Center come from employee costs. And this shows that the situation is not fair for various parties. This raises a dilemma that is important to be discussed. The capitation rates set by the government are considered inappropriate for dentists in first-level health facilities. This can cause a decrease in the quality of health services provided by dentists at community health centers.

Keywords: Activity-based costing · Politics · Health services policy

BACKGROUND

Health insurance is the most important basic need for all Indonesians. The government in ensuring the health of its people has created a system called the National Health Insurance system (JKN) which has been implemented since 2014. The legal entity formed by the government to run this JKN program is Health Social Security Organizing Agency which is abbreviated with the term of BPJS (Ministry of Health, 2014).

Health management in the health insurance system needs to be structured and tiered services through a referral mechanism whose purpose is to order services and control the cost of health services (Dharmawan, 2017; Masic, 2024; Mosadeghrad, et al. 2022; Obermann et al., 2018) Tiered services mean that when participants need health services, participants are required to come to the First Level Health Facility (FKTP) first before getting advanced level services at Advanced Health Facilities (FKTL). One of the FKTP that plays a role in dental health services is the Puskesmas.

Dental treatment actions guaranteed by BPJS includes consultation, extraction of primary teeth, extraction of permanent teeth, composite resin (ray) fillings, glass ionomer cement fillings, pulp capping, orodental emergencies, scaling and

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premedication. BPJS will then make the tooth. The formula for calculating capitation is utilization rate multiplied by unit cost (Dewanto, 2014).

In addition to unit cost, the average utilization also affects the amount of capitation given to the Puskesmas. Utilization can be calculated from the number of patients and the number of participants in a health service (Yoseph et al., 2023). Ideal utilization for dental health services is 2% (Dewanto and Lestari, 2014; Malik et al., 2020). While the average utilization of dental clinics at Puskesmas in Padang City is calculated based on the data obtained from the health department which is still less than 1% to be precise, 0.55% (Public Health Services of Padang City, 2019). Therefore, it is necessary to calculate the unit cost to find out whether the utilization that is still less than 1% of the capitation given is appropriate.

The calculation of unit costs by the Puskesmas as a primary health facility or First Level Health Facility (FKTP) is needed. So that, it can determine the costs required to provide dental health services (Mulyadi, 2017). The calculation of unit costs is also needed to calculate capitation which can be used as reference material and input to the government to set the appropriate capitation rate so that neither the dental health service provider nor the BPJS Health is harmed.

There are also many dentists at FKTP who demand an increase in capitation to the government (detik.com., 2019) This shows that the amount of capitation set by the government is currently too low. This capitation rate is considered too low for dentists because based on the PB PDGI Working Group calculation, the capitation calculation obtained is Rp 3.206 (Dewanto, 2014).

In calculating and determining the unit cost of dental health services, the right method is needed so that the money paid to the Puskesmas is in accordance with the performance of health workers and also in accordance with the needs of patients (Hilfi at al., 2015; Mahomed & Mthethwa, 2022; Yanti et al., 2019). The Activity Based Costing (ABC) method is a unit cost calculation method that is considered effective and recommended to be applied to companies with many products, such as health services. This method produces more accurate and reliable cost information in calculating the product costs incurred compared to the pre-existing costing system (conventional costing system). This method uses more than one cost driver so that it can measure more precisely the resources consumed by the product/service based on the activities performed (Abdurraafi, 2022). The ativities carried out in dental health services are obtained from the clinical pathway, which is a clinical pathway that summarizes each step starting from the patient's arrival, getting action until the patient returns home.

Seeing the importance of Puskesmas as a gateway to access to dental health services in this JKN era, the authors are therefore interested in conducting further research on unit costs per-action on dental health services at one of the Padang City Puskesmas using the ABC method and analyze this condition in political perspective. This analysis is important because political policy about public health in the era of national health insurance promises to cover the people welfare both patients and doctors. However, this circumstances create ambiguity.

METHODS

There are several methods used in measuring the results of this study. And, generally, it will use a simple method. The simplest method is to distribute the costs incurred in the supporting cost centers directly to the various production cost centers. This method ignores the possibility of linkages between supporting units and only recognizes the linkages between supporting units and relevant production units, which are known to be functionally supported by the supporting units. The advantage of this method is that it is simple, so it is easy to do, but the disadvantage is the assumption that functional support only occurs between the support unit and the production unit, even though in practice it is known that between fellow support units there can also be a transfer of services; for example, the directors supervise the kitchen unit, the kitchen unit feeds the directors and administrative staff, and so on.

Step-down method

To overcome the weakness of the simple distribution, the step-down method was developed. In this method, the costs of other supporting units and production units are distributed. The method of cost distribution is carried out successively, starting with the supporting unit whose costs are the largest. The cost of the supporting unit is distributed to other units (supporting and relevant production). After completion, continue with the distribution of costs from other supporting units, which are usually the second largest. The process is carried out until all costs from the supporting unit have been distributed to the production unit. The advantage of this method is that the distribution from supporting units to other supports has already been done.

Double distribution method

Double distribution is one of the methods grouped into conventional methods in unit cost

analysis because the calculation is based on a lot of cost data at the institution (Agastya, 2009; Yoseph et al., 2023)) Broadly speaking, this method is the same as the step-down method; the difference lies only in the way the cost allocation is carried out, namely in two stages. The first stage is the distribution of costs incurred in the supporting unit to other supporting units and production units. The result is that some of the supporting units have been distributed to the production unit, but some are still in the supporting unit (costs received from other supporting units).

In the second stage, all costs (allocations) in the supporting unit are transferred to all related production units to obtain the final (total) costs in the production units. After obtaining the final total cost of a production unit, which is the sum of the original cost and the allocation cost obtained, the unit service cost can be known by dividing it by the number of services provided by the unit during the same year. This method is considered quite accurate compared to other methods and is the preferred method for the cost analysis of health centers in Indonesia.

Multiple distribution methods

In this method, the distribution of costs is done in full, namely between fellow support units and production units and between fellow production units. Of course, the distribution between these units is done if there is a functional relationship between them. So it can be said that multiple distribution is basically double distribution plus allocation between fellow production units.

RESULTS AND DISCUSSION

The descriptions on brief concepts

Activity-Based Costing

Activity-Based Costing (ABC) is a cost information system that is oriented towards providing complete information about activities to enable company personnel or employees to manage the activities performed . Activity-Based Costing System is basically a careful determination of the cost of products or services for management decisions by carefully measuring the consumption of resources in each activity used to produce products or services. Activity-Based Costing System is a costing method designed to provide managers with cost information for strategic decisions and other decisions that may affect capacity and fixed costs (Kim, 2017)). The basic concept of the ABC method lies in the sources of direct and indirect costs, facility activities owned by health services, service activities, and also trigger costs (Kuchta, 2011; Rizki & Hartanti, 2018).

ABC System Basis

According to Mulyadi (2009), the ABC system is based on two beliefs: Cost is caused, cost is the cause, and the cause of cost is activity. The cause of cost can be managed; the cause of cost is activity, and activity can be organized or managed. The terms in the ABC method in the activity-based costing method need to understand the meaning of the following terms: Activity is the work done in an organization; Collection of actions performed in the organization that are useful for the purpose of determining activity-based costs; An activity cost pool is a grouping of all cost elements related to an activity. The resource driver is the basis used to allocate the cost of a resource to the different activities that use the resource. Activity driver is a measure of the frequency and intensity of demand for an activity based on the cost object. This activity driver is used to charge costs from cost pools to cost objects (Islahuzzaman, 2011).

Levels of Activity in Activity-Based Costing

According to Supriyono (2002), there are 4 categories of activities in the ABC system, as follows: unit-level activity is an activity that is done every time a unit of a product is produced. The size of this activity is influenced by the number of units collected. For example, direct labor activity. Batch-level activity: batch-level activity is an activity whose size is influenced by the number of batches collected. Examples are setting activity costs and production scheduling costs. Product-level activities (product-sustaining activities) are activities that are carried out to support the various products supported by the company and are not related to the batch of products produced or each unit of product produced. Examples include product design and development activities.

Facility-level activities are activities that support the general manufacturing process and are necessary to provide the facilities or plant capacity to produce products, but the amount of these activities is not related to the volume or mix of products produced. Examples include factory lighting, property tax, factory depreciation, building maintenance, cleaning, security, and landscaping costs.

Cost Driver

The cost driver is a factor that causes activity costs. The selection of cost drivers, according to Supriyono (2002), requires the following considerations: Cost measurement. In the ABC System, there are cost drivers that can be selected for use. The selected cost driver should have available data or information to minimize indirect measurement costs and tolerance levels. The existence of a previous information structure can be

used in other ways to minimize the cost of obtaining the quantity of the cost driver.

ABC Stages

The stages in applying the activity-based costing system method are as follows (Supriyono, 2002). First-Stage Procedure The first stage to determine the cost of goods manufactured based on the activity-based costing system consists of five steps, namely the classification of various activities. The first step is to classify various activities into groups that have a physical interpretation that is easy, clear, and suitable for the production process being managed. Associating various costs with various activities. The second step is to link various costs with each activity group based on resource drivers, with the aim of determining the amount of cost for each activity performed.

Determining the right cost driver The third step is to determine the appropriate cost driver for each cost consumed by the product. Cost drivers are used to charge costs for activities or products. In the application of the activity-based costing system, several types of cost drivers are used. Determination of homogeneous cost groups (homogeneous cost pool). The fourth step is to determine homogeneous cost groups. A homogeneous cost pool is a group of factory overhead costs whose cost drivers are the same. Determination of the group rate (pool rate) The fifth step is to determine the group rate. Pool rate is the factory overhead rate per unit cost driver calculated for a group of activities.

In the second stage, the costs from each pool are traced back to the production output. This is done by using the pool rates calculated in the first stage and by measuring the amount of resources used by each production output. Benefits of Implementing an Activity-Based Costing System. The activity-based costing system also emphasizes that the products or services produced do not directly absorb resources but absorb activities.

Kim (2017) suggests the main benefits of ABC are as follows: ABC presents more accurate and informative product costs, which leads to more accurate measurements of the ability to earn profits on products and better informed strategic decisions regarding selling prices, product lines, customer markets, and capital expenditures. ABC provides a more accurate measurement of activity-driving costs, which helps managers improve product and process value by making better product design decisions, better controlling costs, and helping increase the value of various projects. ABC helps managers more easily access information about costs that are relevant in making decisions (Islahuzzaman, 2011).

National Health Insurance and its dilmma: A political perspective analysis

National Health Insurance is a guarantee in the form of health protection so that participants get health care benefits and protection in meeting basic health needs provided to everyone who has paid contributions/contributions paid by the Government. The National Health Insurance Program or JKN Program aims to provide certainty of comprehensive health insurance for every Indonesian people so that the Indonesian population can live healthy, prosperous and productive lives (Eko, 2016)

To organize JKN, the government formed a legal entity, namely BPJS health (Health Social Security Organizing Agency). BPJS is a transformation of PT ASKES (Persero). BPJS health is tasked with organizing health care insurance, especially for civil servants, civil servant pension recipients and TNI / Polri, Veterans, independence pioneers and their families and other business entities or ordinary people.

All Indonesian citizens are obliged to become JKN participants and are required to pay contributions to BPJS, except for those who cannot afford where the contribution will be paid by the government or commonly called PBI (Penerima Bantuan Iuran). Those included in PBI are poor and underprivileged people who have no source of livelihood at all and / or have a source of livelihood but do not have the ability to meet the basic needs that are appropriate for the life of themselves and / or their families. For PBI participants, BPJS obtains funds from the state budget, while for non-PBI participants funds are obtained from civil servant contributions, local government employee contributions, *TNI / Polri* contributions, *Jamkesda* contributions, independent participant contributions and reserve funds originating from the transition of PT Askes (Persero) to BPJS (Ministry of Health, 2014).

Puskesmas organize first-level community health efforts and first-level individual health efforts. Health efforts are carried out in an integrated and sustainable manner. First-level public health efforts as intended include public health efforts and community health development efforts (Permenkes RI No. 75 of 2014). Mandatory health efforts of Puskesmas are efforts that are determined based on national, regional, and global commitments, and have a high level of power to improve public health status. Mandatory health efforts that must be organized by each PHC center are health promotion efforts, environmental health efforts, maternal and child health and family

planning efforts, nutrition improvement efforts, prevention and eradication of infectious diseases, treatment efforts.

These efforts are useful for obtaining a diagnosis as early as possible by carrying out treatment actions and referral and rehabilitation efforts if needed. The treatment programs are general outpatient clinic, dental outpatient clinic, inpatient unit, nursing, emergency unit (ER), mobile health center (Efendi, 2009; Isnaini, 2023). Puskesmas health efforts are efforts that are determined based on health problems found in the community and adapted to the capabilities of the health center. The development of health efforts are: School health efforts, sports health efforts, community health care efforts, occupational health efforts, dental and oral health efforts, mental health efforts, eye health efforts, elderly health efforts (Hartono, 2010; Isnaini, 2023).

Primary Clinic is a health care facility that organizes individual health care efforts that provide basic medical services, organized by more than one type of health worker and led by a medical staff (Kemenkes RI, 2014). A primary clinic is a clinic that organizes basic medical services. Based on its license, a private clinic can be owned by a business entity or individual.

The medical staff of a primary health care clinic consists of at least 2 (two) doctors and/or dentists. The types, qualifications, and numbers of other health and non-health professionals are determined by the needs and types of services provided by the clinic. Service components include: consultation services; action services; medical support services; pharmacy service fees; treatment rooms (for inpatient care); administration; or other components that support services (Ministry of Health, 2014).

Unit costs are calculated using the Activity-Based Costing (ABC) method. Based on the results of the study, the unit cost value per action was obtained, namely consultation Rp.50,735, permanent tooth extraction Rp.136,571, primary tooth extraction Rp.84,433, filling with glass ionomer cement Rp.167,179, pulp capping Rp. Rp.114,652, and premedication Rp.62,735.

Table 1. The comparison of the unit cost values between two sample research, Regional Public Hospital of Pasar Rebo and Puskesmas Alai

No.	Activities	Cost Unit (in Rupiah)	
		Puskesmas Alai	Regional Public Hospital of Pasar Rebo
1	Dental consultation	75.219	35.000
2	Permanent Tooth Extraction	129.659	125.000
3	Extraction of primary teeth	81.737	75.000
4	Fillings with glass ionomer cement	149.580	130.000
5	Pulp capping	123.257	126.000
6	Premedication	68.833	35.000

Based on table 1. above, it can be seen that the unit cost obtained at this time for consultation, permanent tooth extraction, primary tooth extraction, filling with glass ionomer cement, and premedication is higher compared to the unit cost obtained in the previous study conducted by Iwan Dewanto in Pasar Rebo Hospital in 2014. The difference that occurs between the unit cost of dental health services at puskesmas and RSUD makes it interesting to discuss why the unit cost value of puskesmas is higher than that of RSUD. This could be due to the differences in the number of employees and also the amount of salary received by the employees in each place, because when looking at the costs that affect all actions at the puskesmas, the cost of employee salaries is the largest and most influences the amount of unit cost generated compared to other costs. This is due to the large number of employees and the amount of incentives provided to motivate employees at Puskesmas to perform their duties to serve the community (Gabriela, 2012).

The number of employees working at the Puskesmas greatly affects the amount of cost requirements for employee salaries for both non-medical and medical employees. The higher the number of employees, the higher the cost requirements for employee salaries. This is supported by a study conducted by Bunga in 2017, which states that the greater the number of employees and the more intensive for employees, the greater the costs incurred for employee salary costs and vice versa. Employee costs are the operational costs that contribute the most to determining the value of service unit costs.

The number of patients visiting the Puskesmas Dental Clinic also affects the amount of costs required and incurred in providing dental health services. The more patients, the higher the costs required and incurred. The increasing number of

patients will result in more activities being carried out, so the costs required will be even higher. The number of patients is one of the cost drivers used in calculating the unit cost of health services. (Wahyuni, 2017).

The prices of dental medical equipment and materials, which increase every year, also affect the amount of unit cost generated. Price increases occur due to shifts in the level of supply and demand for dental devices and materials and also due to an increase in the amount of money in circulation.

The average unit cost of dental health services of Rp 104,714 obtained in this study is higher compared to the average unit cost of Rp 90,840 obtained in a previous study conducted by Febrian (2019) on health centers in the city center and suburbs of Padang. This is due to the difference in the number of human resources and the amount of salary cost given to employees, both at the unit level and at the batch and facility level. When compared with the unit cost at the health center. The unit cost value is not much different because the ratio between the number of patients and the number of employees between the two health centers is not too different.

In the Health Workers Act, health workers are divided into two categories, namely health workers and assistant health workers. Health workers must have a minimum qualification of diploma three, except for medical personnel; while assistant health workers must have a secondary education, diploma one or diploma two in the health sector. Health workers are classified into 13 types, namely medical personnel, clinical psychology personnel, nursing personnel, midwifery personnel, pharmaceutical personnel, public health personnel, environmental health personnel, nutrition personnel, physiotherapists, medical technicians, biomedical engineers, traditional health personnel, and other health personnel as determined by the minister of health.

WHO uses the ISCO-08 guidelines as the basis for categorizing health professionals used in WHO international reports. In ISCO-08, health professionals are categorized as physicians, consisting of general practitioners and specialists; nurses and midwives, consisting of professional nurses and professional midwives; practitioners of traditional and complementary medicine; paramedical practitioners; veterinarians; and other types of health professionals such as dentists, pharmacists, occupational health and safety professionals, environmental health professionals, physiotherapists, dieticians and nutritionists, audiologists and speech therapists, optometrists and refractive opticians, and other health professionals not categorized above. In addition to medical staffs, supporting health professionals such as medical and pharmacy technicians, nursing and midwifery support professionals, traditional and complementary medicine practitioners, veterinary technicians and assistants, and other types of support professionals are grouped together (ILO, 2012; Park, 2024).

In David Easton's theory of political systems, policy formation cannot be adequately considered in isolation from its environment. Demands for policy action arise from the environment and are transmitted to the political system. Public policy is seen as the response of a political system to demands arising from the environment, which are conditions or circumstances outside the boundaries of the political system. Forces arising from the environment and affecting the political system are seen as inputs to the political system. The environment consists of cultural, political, social, and economic conditions that influence the formulation of public policy (Winarno, 2012). Culture is a social heritage that is passed down from one generation to the next and thus becomes the identity of a community. Culture is just one of the many factors that influence human action or behavior. Human actions will influence policy formulation. As in the formulation of the Health Workers Bill, there are cultural values that are generally inherent in the world of health in Indonesia. It is known that since time immemorial, people have recognized medicine and health care provided by shamans and paraji until it became a culture in a community.

Health policy is a strategic issue that needs to be understood. At present, various important policies in the health sector have been passed and enacted in the form of laws, including the Social Security Law (2004) and the BPJS Law (2011), the Hospital Law, the Health Law, and so on.

The policy-making process is long, complex, and often political. Different policy objectives influence the acceptance of policy by stakeholders in the health sector. There are differences in stakeholder acceptance of a policy and its process. This opposition is natural in the health community and is part of the democracy and transparency of the policy-making process. This opposition is also dynamic because there is the possibility of changing attitudes towards a policy.

In the context of the dynamics of health policymaking. It seems that various health policy actors do not understand the complexity of health policy. This can be understood because health and medical leaders in Indonesia are medical or public health graduates who do not receive formal

education or in-depth training in health policy. Various aspects, including policy, need to be understood by leaders of institutions, professional associations, and associations of health service organizations.

The existing pattern of principal-agent relationships is influenced not only by interinstitutional and interpersonal relationships but also by the personal values of political elites and actors with respect to health. These three things together can influence and disrupt the decision space in the process of health policymaking. The presence of non-political elites, namely business actors and the invisible hand, also affects the decision space. Political skill is a set of strategies and skills possessed by health policy actors to achieve the main objectives of public health and is not at all related to the practical political behavior possessed by health policy actors that guides policy making according to normative health objectives.

The health sector is an important part of the economy in several countries. Some argue that the health sector is like a sponge, absorbing large amounts of national resources to pay for a large number of health workers. Others argue that the health sector is like a generator of the economy, through innovation and investment in biomedical technology, the production and sale of pharmaceuticals, or by ensuring a healthy population that is economically productive. Some citizens visit health facilities as patients or clients, using hospitals, clinics, or pharmacies, or as health professionals, nurse, doctors, allied health professionals, pharmacists, or managers. Because health decisions involve matters of life and death, health is privileged over other social issues. Health is also affected by a range of decisions that have nothing to do with health care: poverty affects people's health, as do environmental pollution, dirty water, or poor sanitation. Understanding the relationship between health policy and health itself has become so important to solving today's major health problems.

There is considerable evidence that the most powerful determinants of health in modern populations are social, cultural and economic factors (Garcia, 2022). These factors come from a variety of sources and are recognized by governments and international bodies (Garcia, 2022). However, inequalities in health continue to exist within countries, such as differences in socioeconomic class, gender, and ethnicity. Inequalities in wealth, well-being and resources also persist (Hertzman et al., 2017).

Policy itself is often defined as a set of decisions made by the state, which is responsible for certain policy areas, particularly in the health sector. The people who make policy are called policymakers. Policy can be made at any level, central or local government, multinational or local companies, schools or hospitals. Policymakers are elites, a special group of policymakers who are highly placed in an organization and often have privileged relationships with senior officials in the same or other organizations.

In the simple terms, health policy analysis can be approached through a policy triangle approach. The health policy triangle is an oversimplified approach to a complex set of relationships and suggests that the four factors can be considered separately. Actors can be influenced (as individuals or as members of a group or organization) by the context in which they live and work; the context is influenced by many factors, such as: instability or ideology, in terms of history and culture; and the policy-making process of how issues get on the policy agenda and how those issues can be influenced by implementers, their position in the power structure, and their own norms and expectations. And the content of the policy reflects some or all of these parts. In this way, the triangle not only helps to think systematically about the different actors that can influence policy but also acts as a map of the solution to the problem.

The causes and predisposing factors of ill health are increasingly well understood (Bambra et al., 2005). However, many cases show that environmental factors are as important as social and economic factors in influencing health (Hertzman et al., 2017; BeLue et al., 2021). Factors such as housing, income and unemployment, and other issues are dominated by policy issues that are determinants of health and well-being. Similarly, many determinants of health and health inequalities are dependent on and external to the health sector (OECD, 2019). Because these issues are outside the purview of the health sector (the Ministry of Health, the Department of Health, and other health-related government agencies), addressing them requires policies outside the health sector to support and address them.

Health policy is influenced by a variety of things based on certain contextual factors (Human Resource, 2020). The certain contextual factors are (see also Williams et al., 2018), first, situational factors, which are conditions that are not permanent or specific and that can affect policy. Second are structural factors, which are parts of society that remain relatively unchanged. These include the political system, including the openness of the system and the opportunities for citizens to participate in policy discussions and decisions;

structural factors also include the type of economy. Third, cultural factors can influence health policy. In societies where hierarchy is important, it may be very difficult to question or challenge high-ranking or senior officials. Minority status or language differences may result in certain groups receiving inadequate information about their rights or services that do not meet their specific needs. In some countries, women cannot easily access health facilities. Fourth, international or exogenous factors that increase interdependence among countries and affect self-reliance and international cooperation in health. Although many health problems are the responsibility of national governments, some require the cooperation of national, regional or multilateral organizations.

The politics of health or the politics of welfare is an interdisciplinary field of study that examines the influence of social and political issues on the health of individuals (Nashif, 2022). The focus of this study is to analyze how political power plays a role in determining a person's health status. Our current health policies do not favor the poor, nor do they reach people in remote villages. However, in Indonesia inequalities in health care still exist (Mulyanto et al., 2019; Haemmerli et al., 2021). There are enough doctors in Indonesia, but they are concentrated in big cities and certain provinces, she said, noting that Jakarta is the province with the best doctor-to-population ratio, with one doctor for every 608 people. Meanwhile, West Sulawesi is the province with the lowest ratio, with one doctor serving 10,417 residents. According to the World Health Organization (WHO), vulnerable groups are defined as homeless people, people living in inadequate housing, migrant workers, people with disabilities, people living in remote areas, people living in poverty, people affected by vulnerability, and people affected by the digital divide, whose health rights have not yet been fulfilled. The definition of vulnerable groups in Law No. 39 of 1999 is still limited to certain groups and should be updated. Some of the vulnerable groups that still do not receive optimal attention include indigenous peoples or remote indigenous communities, people living with HIV/AIDS, and migrant workers.

Strengthening the political priority of health policy development for vulnerable groups is necessary because it can force policymakers to increase their political will to invest energy and effort in achieving their policy goals. This is in line with the key objectives of the 2030 Sustainable Development Goals (Turcea & Ion, 2020). A predictive model for strengthening political priorities in health policy development, adapted to the context of Indonesia. The complexity of the dynamic situation in Indonesia makes it impossible to describe health policy development using only the existing standard framework or model. Adaptation and contextualization of the previous framework are needed to analyze and understand the situation that is occurring.

CONCLUSION

Based on the results of the research on calculating the unit cost of dental health services using the Activity Based Costing (ABC) method in the JKN era conducted in Padang City, several conclusions are obtained, namely, there are four services in the supporting unit for dental health services namely, RM and counter services, cleaning service services, administrative and management services, and pharmacy services. Beyond the nine dental health services guaranteed by BPJS, only six, namely consultation, permanent tooth extraction, primary tooth extraction, GIC filling, pulp capping and premedication, were performed at Alai Health Center. The unit cost of dental health services in 2018 is as follows: consultation Rp 75,219, permanent tooth extraction Rp 129,659, primary tooth extraction Rp 81,737, GIC filling Rp 149,580, pulp capping Rp 123,257, and premedication Rp 68,833. The average unit cost of dental health services was Rp 104,714. Using the Activity Based Costing (ABC) calculation method, it can be seen that the largest cost of dental health services at Puskesmas is the cost of staff both at the unit level and at the batch and facility level. The amount of unit cost per action and the overall average compared to similar studies in previous years are due to differences in the amount of salary and number of employees, as well as an increase in the price of dental tools and materials needed.

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