

An Integrated Public-Private Partnership System for Covering Narcotics Addiction Treatment Centre: A Case Study of Anti-Narcotics Zones in Indonesia

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Abstract—Indonesia declared an ‘extreme narcotics emergency situation’ in July 2017. President Jokowi Administration has taken tough drug stance due to its public health alert that comes together with damaging social economic issues. A survey by Indonesian National Narcotics Board estimated 3.36 million Indonesians suffer narcotics addiction likely in their productive age [2]. Even more so, it is assumed that drug abuse contributes to the death of thirty people daily in Indonesia. The estimated socio-economic cost of treating the abuse could reach up to eighty billion rupiahs yearly [2]. The long term treatment it takes for the government to assist those with addiction demand comprehensive approach to be successful [16; 20; 21; 22] This study puts forward a claim that a proper cross boundary, intergovernmental health cover system is vital to cope with the social economic damage of the issue. The government’s hard line for drug convicts should be in line with the public health assistance for those wanting to get out of addiction cycle as mandated in law no 35 year 2009 on narcotics. The research aims at providing discourse on critical systemic thinking [23; 24; 14] with respect to how and why public-private health partnership model could come up with strategic innovation in terms of providing drug abuse rehabilitation in community service through the partnership with private sector.

Keywords—*Narcotics, Intergovernmental, rehabilitation Partnership.*

I. INTRODUCTION

The purpose of this research is to find a model in implementing community rehabilitation in vulnerable areas by developing a funding system with integrated public and private methods. This research can be used as a reference for policy makers in the field of rehabilitation carried out in the community. The scope of the study will be taken data from the rehabilitation sites in the community and have carried out these activities.

According The World Drug Report 2019 estimated “number of narcotics abusers in the world (ages 15-69 years old) amounted to 255 million with a mortality rate, 190.000 die per year or 512 addicts die per year” [19]. The majority of addicts (74%) are on cannabis together with 800 new types of narcotics trafficked world widely [16]. In Asian countries, the number of opioid users last year considered higher than the estimation, namely 29.5 million, from a previous estimate around 13.6 million. A survey by Indonesian National Narcotics Board and Health Research Center of Universitas Indonesia in 34 provinces in Indonesia showed the prevalence of narcotics abuse is 1.77% of estimated around 3.36 million Indonesians including productive ages ranging from 10 to 59 years old, 30 people are died of narcotics, abuse daily [2].

United Nations Office on Drugs and Crime (UNODC) reported approximately 10% of all drug users are addicts [17]. As a case in point, UNODC estimated 23.5 million Americans are alcohol and drug addict and so cal for government support services. Unfortunately, there is merely one of 10 people (2.6 million of 23.5 million) have access to public service, creating, a treatment gap. The gap is due to lack of inadequate public health insurance coverage with which is related to lack of public health insurance system covering such addiction cases. Indonesian National Narcotics Board indicated just 5% of addicts access rehabilitation services, while the remaining 95% tend to access private rehabilitation services such as the Wajiba Recipient Institution Report (IPWL) and and other profit-based rehab services simply because they have to [2]. Those having no access to public rehabilitation services mostly live in drug-prone areas.

The distribution of addicts in Indonesia which is divided into 3 environments, namely: 59.3% work

environment (\pm 2 million addicts), 23.7% education environment (\pm 800 thousand addicts) and 17% community environment (\pm 573 thousand addicts). Of these, the majority abused cannabis narcotics (44.7%) and religious types of New Narcotics that were known amounted to 71 types of NPS [2]. The three environments are outlined in the 2015 deputy community empowerment planning document by establishing 698 vulnerable areas. The handling of drug abusers in Demand Reduction based on 2015 UNODC recommendations as best as community rehabilitation [16], and in several countries has been supported by various policies and financing systems involving the government and insurance, but in Indonesia rehabilitation policies are still focused on government-owned rehabilitation with a policy and financing system which is still borne by the government [3; 4]. Indonesia's Total Health Expenditure (THE) continues to increase from year to year, where health spending is IDR 436.5 trillion in 2017 (an increase of 106% compared to 2010), with health spending valued at IDR 1.6 million / capita / year [11]. The funding for rehabilitation of narcotics abusers includes medical rehabilitation ranging from 4 million rupiah per person / person, while non-health costs range from 10 million rupiah times / person, can be seen the amount of costs needed in rehabilitation programs that exceed per capita health spending per year [2]. Since 2014, 5 years after the national health insurance program (JKN) was launched it has benefited the wider community. With the coverage of program membership continues to increase. In 2018, the largest proportion of membership came from the PBI (APBN) segment of 44.26%, can be seen the amount of costs needed in rehabilitation programs that exceed per capita health spending per year [2]. Since 2014, 5 years after the national health insurance program (JKN) was launched it has benefited the wider community. With the coverage of the membership program continues to increase. In 2018, the largest proportion of membership came from the (APBN) segment of 44.26%. However, the most significant growth of participants from year to year occurred in the non-PBI segment. As of the end of 2018, JKN/KIS (Indonesian health insurance) membership coverage had reached 208.1 million. In 2018, the Minister of Social Affairs determined the poor and poor people based on an integrated database of 92.4 million people based on Decree of the Minister of Social Affairs Number 5 / HUK/2018 [6]. However, in the SJN system and ministerial decree it does not regulate the costs for rehabilitation of narcotics abusers. In fact, as explained, that the recovery process requires a long time and results in the cost required.

Financing for drug rehabilitation program in Indonesia had been regulated by Presidential Regulation No. 82 of 2018 about Health Insurance (Peraturan Presiden No. 82 Tahun 2018 tentang Asuransi Kesehatan) [13]. Part of the regulation states that, "Some of the services that are not covered are health problems/diseases due to drug and/or alcohol addiction and traffic safety due to intoxication." The regulation used by health insurance as their justification which

can't cover the costs of drug abuse rehabilitation programs, for example BPJS-Kesehatan (Indonesian health insurance). This conditions is also stated in the results of the study that funding for drug addiction patients occupies quite high numbers due to various other diseases that are also caused [9].

Hawari stated that the rehabilitation program had been implemented by a different financing system according to the organizer [4]. Indonesia has at least three types of rehabilitation institutions including community-based (Madani Mental Health Care-An Integrated System), behavioral approach-based (National Narcotics Board), and hospital-based (ex : MH Thamrin Hospital). Community-based institutions providing program that are paid monthly about 10.5 million rupiah, behavioral approach-based providing programs at a cost of 5 to 8 million rupiah, and hospital-based with the usual range of 0.5 million rupiah per day.

In ASEAN, some countries have different financing systems. Myanmar through their health ministry allocated funds amounting 47.20 million Ks [3; 5]. The national financing system is adopted by hospitals and all rehabilitation institutions [5]. Myanmar's health ministry also accepts donations from the private sector. The main problem in financing system in Myanmar is the limited allocated of funds for drugs and rehabilitation programs. In addition, thailand has program that is considered quited strong because it involves the public and private sectors to collaborate [3]. The ministry of health and finance also collaborates in providing funding for it [5].

II. CONCEPTUAL FRAMEWORK

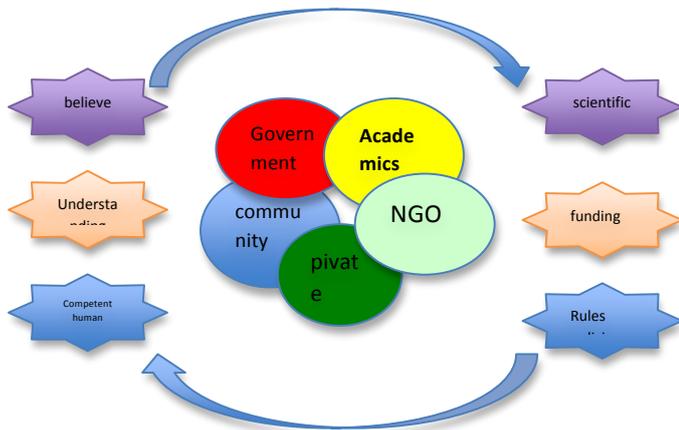
Effective prevention of drug involves integrated holistic between policies and actions, which takes into accounting of risk factors for drug use, such as substance abuse by parents, family circumstances, peer pressure, school or work life, lifestyle reasons and socioeconomic factors. Promote a joint approach of government policies and strategies that might influence risk factors for substance abuse important in this context [1].

UNODC has issued a Guidance Document for Southeast Asian countries that outlines the main features and principles of community-based treatment, in the context of a joint approach to the community [17]. The State of Switzerland issued a policy of combining partial decriminalization with investment in health services and mitigation of adverse impacts. There is voluntary care for narcotics and alcohol cases and welfare services in the community. Treatment for dependency cases is included in the health insurance scheme. China has abolished criminal penalties for drug use, the current administrative sanction system remains very strict. There is voluntary care for narcotics and alcohol cases and welfare services in the community. Treatment for dependency cases is included in the health insurance scheme. China has abolished criminal

penalties for drug use, the current administrative sanction system remains very strict. China's 2008 Anti-Narcotics Law provides 'community-based treatment' and 'mandatory detoxification isolation'. There are strict requirements for registering drug users for monitoring by the police. However, the strict nature of 'community medicine' and 'mandatory isolated detoxification' reduce the effectiveness of the policy from the point of view of the health response [8]. A policy decision in Vietnam in 2013, known as the Renovation Plan on Drug Treatment, confirms the transition to community-based treatment. 80 of the 107 detention centers will be changed to provide voluntary community-based treatment, social services and employment, including psychological support and post-treatment along with narcotics therapy services such as detoxification, OST and relapse prevention [15].

The strategic policy of the war against drugs with the implementation of Presidential Instruction number 6 of 2018 on the National Action Plan for P4GN was issued in mid-2018 [12]. This instruction integrates Government, community and private sector. BNN in this case establishes more than 600 drug-prone areas. This area is a high demand for narcotics abuse and at the same time vulnerable to poverty. P4GN synergy is needed from across ministries and government agencies as well as the public and private sector in from the central level to the regional level to reduce the level of regional vulnerability.

Community-based rehabilitation targets demand reduction as one of the strategies in P4GN with the concept of partnership from all related elements in one community. The concept uses the concept of pentahelix [10].



This method is used to find an accommodating model like the concept above be able to perform community rehabilitation services that are integrated in public and private sectors. The following is description of the concept of rehabilitation services.

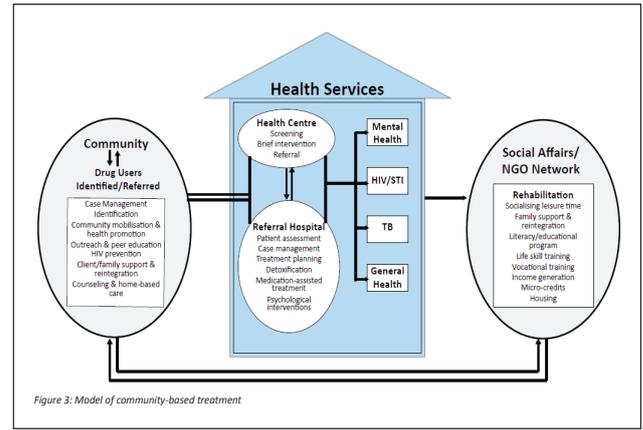


Figure 3: Model of community-based treatment

Resource: UNODC-WHO International Standard for Treatment of Drug Use Disorder [19].

Health services can't be separated from the role of government in governance. So it's necessary to know the definition and role of the government in governance clearly. Government has been assumed to be central to governance. Kourula et.al stated that, "... government as an institution in the boarder context of the governance of bussiness conduct [...] review the longevity and heterogenity of governmental actors along with, and in relation to, the evolving role and place of bussiness and civil society actors under the double challenge of privatization and globalization over the last three to four decades [...] the evolution of government's primary governance roles. 'governments' have the capacity, within their jurisdictions, to impose legally binding constraints and sanctions over non-governmental actors, whether in politics, society, or market [7]. By 'government' refer not to corporate governance, but to the wider concept of societal governance, that of the collective means to give "direction to society" [7]. The government also means governance actors who gives direction to society's politics and markets. The new role of government is not just a regulator of 'markets', but the role of government has evolved to be a beneficiary of the market domain that fills in the public affairs slot which has so far had been dominated by the 'government domain' such as public health covers, public transport, and public waste removal [7].

III. METHODOLOGY

Research will be carried out with case studies on the CBU service model of the input order (financing, facilities and infrastructure, human resources, rules and policies), the process order (including rehabilitation flow / process and rehabilitation methods), the outcome order (recurrence and productivity) and client characteristics. Design research with mixed methods between qualitative and quantitative approaches. Using the Critically heuristic boundary questions method Quantitative approach to assessing the costs, facilities and infrastructure, human resources, rehabilitation methods, rehabilitation flow / process. A qualitative approach to look at coverage, recurrence, productivity and financing characteristics and policies.

This research was conducted in DKI Jakarta Province. The participatory action research (PAR) public and private integration in community rehabilitation services in vulnerable areas (critical ethnographic case studies in DKI Jakarta).

IV. FINDINGS

The researcher has background as an employee in National Narcotics Agency since 2005. The following are his educational background, courses and job positions.

| | |
|-----------------------------|---|
| Education | <ul style="list-style-type: none"> - Bachelor program of Medical Education, Faculty of Medicine, Universitas Trisakti, 2003 - Master Program of Hospital Administration Study, 2008 - Pulmonology Specialist Education, Faculty of Medicine, Universitas Indonesia, 2012 |
| Employment | <ul style="list-style-type: none"> - Doctor at Puskemas Pondok Jagung (Indonesian Regional Community Health Center), Tangerang Regency, 2013 - Medical staff at The Therapy and Rehabilitation Laboraroty Center (Puslab T&R), 2005 - Head of inancial Planning and Administration at The Therapy and Rehabilitation Laboraroty Center, BNN (2006) - Head of Section Strengthening government institutions, sub-division strengthening the post-rehabilitation directorate deputy agency rehabilitation center BNN (2014) - Head of Sub Directorate for Strengthening the Directorate of Post-rehabilitation Agency Deputy for Rehabilitation of BNN (2015) - Analyst of deputy community participation in BNN's community empowerment (2017) |
| Training and courses | <ul style="list-style-type: none"> - Medical <ul style="list-style-type: none"> a. Stop smoking counseling b. ILO chest X-ray c. Pulmonology intervention d. Thoracic ultrasonography (USG) e. TB DOTS f. TB MDR - Position <ul style="list-style-type: none"> a. PIM Training IV b. PIM Training III - Courses <ul style="list-style-type: none"> a. Procurement of goods and services b. Middle auditor c. IPWL d. Curriculum counselor e. Cognitive behavioral therapy f. Motivational intervention |

Based on the background above, the researchers obtained preliminary findings from this study as set out in the table below:

| The 12 cirtically boundary questions in ‘is’ mode (actual fact finding in the field) → “actually” | The 12 critically heuristic boundary questions in the ught ‘ought’ mode (what should happen at the ideal level) → “Should” |
|---|---|
| <p>In fact, BNN is an institution that is a policy maker within the scope of rehabilitation issues. In article 54 of Indonesian Law No. 35 of 2009 (UU No. 35 Tahun 2009) it contains the obligation to carry out rehabilitation for narcotics abusers both medically and socially. Medical rehabilitation of addicts, abusers and victims of narcotics abuse that has been decided by the court is held in government, regional government or community medical rehabilitation facilities. As the implementation of Article 54 of Government Regulation No. 25 of 2011 (PP No.25 Tahun 2011) concerning IPWL and Permenkes No. 37 concerning procedures for reporting must be published. The Ministry of Social Affairs with social ministrial regulations (Permensos) No. 22 of 2014 regulates social rehabilitation standards. National Narcotics Ageny issued National Regulation No. 11 of 2014 concerning medical and social rehabilitation. Total combined rehabilitation capacity of BNN- Ministry of Health - Ministry of Social Affairs 18000 TT. So that still leaves much of the need for 1.8 million narcotics addicts in the community. Funding carried out sourced from the state budget. So that the implementation of rehabilitation depends a lot on the government. The rehabilitation and recovery period requires a long time so it requires a large cost while the government budget is limited. Whereas the financing with the BPJS system has not been included in the proposal of the minister of health ministry. The types of NPS that continue to develop also require changes in the form of rehabilitation. While the results of rehabilitation activities were not exposed by the media.</p> | <p><i>Who or who should be the stakeholders of the policy to be formulated or reviewed? In line with the above question, the same argument can be used in point one of 'ought mode' : Who or which party should be factually a stakeholder in a policy issue ?; Which party, within the scope of the problem, whose voice - interests represent or is represented [...]</i></p> <p>In Indonesian laws and then followed by a presidential regulation on the authority of the National Narcotics Agency, especially in the field of rehabilitation, still working with the ministry of health and social ministry, it should be involved in this matter in the ministry of the interior and the ministry of law and human rights and BPJS. The Ministry of Social Affairs can include abusers in the community or in community institutions with the criteria of being unable to be registered in the PBI recipient list. The Ministry of Health can set service standards so that BPJS can cover health insurance. The Ministry of Home Affairs can arrange budgets for regions that will carry out community rehabilitation and encourage the private sector. The police and prosecutors can play a role in overseeing the process in the community.</p> |
| <p>The purpose of the policy was made so that the user is not</p> | <p>In the report it has been explained that the</p> |

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|---|---|---|---|
| <p>criminalized, narcotics abuse based on DSM IV is included in chronic mental illness, so the therapy is considered as a separate part from criminal, so that it is not in prison but in rehabilitation. The drug abuse is main target market in this business, so in terms of reduction demand, reducing the number of markets by rehabilitation is one of the strategies in P4GN</p> | <p>recommended rehabilitation is community-based. Implementation of rehabilitation carried out based on court decisions can be accommodated to be carried out within the community. Supervision for them in the community should also be carried out continuously</p> | <p>Ministry of Social Affairs with a self-financing system. So the costs incurred cannot be controlled by the government. The media has not been fully involved in this implementation. Began to engage companies in rehabilitation activities using CSR funds.</p> | <p>into the PBI recipient list, the BPJS provides health services, the media preach to eliminate stigma and facilitate access, academics and practitioners are involved in their expertise.</p> |
| <p>The benchmarks of each rehabilitation policy are recovery, no drugs, productivity</p> | <p><i>The benchmarks of a rehabilitation policy should not only be individual but should also have elements of family and community in them so that they become healthy families and decrease vulnerable areas.</i></p> | <p>In the current rehabilitation policy formulator are BNN, the ministry of health and the ministry of social affairs.</p> | <p>Not only ministries or state institutions but also the public and service recipients as well as private institutions and academics should be involved</p> |
| <p>Benchmarks for the success of the rehabilitation program depend on BNN policy, the ministry of health and the ministry of social affairs</p> | <p><i>BNN as the leading sector should be the benchmark for this policy</i></p> | <p>Like proper policy-making certainly involves several expertise including addiction counselors, psychology, NGOs engaged in rehabilitation services, psychiatric doctors, social workers.</p> | <p>Addiction counselors, social workers, doctors, administrative or policy experts, psychology, communication science,</p> |
| <p>Coordination between ministries and institutions within the framework of the rehabilitation program has been stated in Presidential Decree No. 6 of 2018. In the field of rehabilitation of BNN as a joint coordinator with the Ministry of Health and Ministry of Social Affairs. Implementation of rehabilitation in prisons is carried out with the coordination of kemenkuham. Funding is regulated by each institution with the amount of rehabilitation costs in accordance with ministerial regulations made.</p> | <p>BNN as the leading sector must have authority in the distribution of tasks and authority in the relevant ministries or institutions in implementing community rehabilitation.</p> | <p><i>The involvement of these experts was based on educational competence and experience in the rehabilitation sector</i></p> | <p>International or regional international bodies can be used as guarantors of the quality of the policy</p> |
| <p>The condition that occurs at this time is the rehabilitation standard implemented by the government in this case the National Narcotics Agency, the ministry of health, the social ministry and the Ministry of Public Security has been made with the SOP standards that have been set. Regarding the financing set by each ministry.</p> <p>Community-based rehabilitation has been made by BNN and the</p> | <p>BNN should regulate the authority of each institution in the rehabilitation of this community so that the role of each ministry and institution and the community can synergize in its implementation. The setting of health service standards by the ministry of health, the ministry of social setting up social rehabilitation services standards in the community and including poor abusers</p> | <p><i>The involvement of counselors and the community is part of those who will be affected by this policy regulation. Counselors are considered as people who have experience in drug abusers.</i></p> | <p>Counselors and communities in vulnerable areas that can be represented by NGOs must be involved</p> |
| <p>The involvement of counselors and the community in the formulation of community rehabilitation policies is to assess the impact of these policies on the community</p> | | | <p>The involvement of counselors and the community in this policy starts from the planning, policy formulation, implementation and monitoring and evaluation stages.</p> |
| | | <p><i>Prevention and eradication of illicit drug trafficking with sustainable rehabilitation to improve the survival rate</i></p> | <p><i>How can the State be present in protecting drug abuse by the presence of a system in the community that can provide rehabilitation and financial guarantees in an integrated manner so that it impacts on the decrease in addiction rates, increased recovery and increased productivity.</i></p> |

*Resource : Riswanda, 2018 [14]

This Research will involve some informan below:

| Type of informant | Name of Informant | Interview location |
|-------------------|---|--|
| Policy makers | Informant who holds the policy execution authority from National Anti-Narcotics Agency, Ministry of Youth and Sports, Attorney General, Ministry of Home Affairs, Ministry of Justice and Human Rights, Ministry of Health, and Ministry of Social. | Central sector institutions written informants |
| | Informant of the field policy executor from local government, Indonesian National Police, Local Anti-Narcotics Agency, Department of Health, Department of Social, and Department of Sports. | Local sector institutions written informants |
| Users | 3 communities : Rekan Sebaya Foundation, Pelita Ilmu Foundation, Charisma Foundation | Each office |
| | Professional organizations : IDI, PDSKJ, counselor, psychologist | Central |
| | Families of drug victim (FSG) | Central/local |
| | Religious leaders (interfaith scholars) | Central/local |
| | Researcher in University | Central/local |
| | Stated-Owned Enterprises/Regionally-Owned Enterprise/private sector | Central/local |
| | Media | Central/local |

V. CONCLUSION

The conclusion is the study should be continue with involving all of stakeholders to get a service model as like as this study purpose to improve health service.

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