

Policy Analysis

A Health Policy Analysis of the Dottorota Homecare Program



Ni Made Diah Pusparini Pendet^{1*}

¹STIKES Kesdam IX/Udayana, Denpasar, Indonesia

Article Info	Abstract
Article history: Received: 24 March 2022 Accepted: 30 March 2022	<i>Introduction:</i> Poor health access had initiated the innovation of a homecare program in Makassar. Dottorota Home Care Program is a local program presented to improve the coverage of health care access in Makassar City, contributing to better community health status. This manuscript aimed to provide a health policy analysis of the Dottorota Home Care Program in Makassar City through the policy analysis triangle.
Keywords: health policy, homecare, Dottorota, policy analysis triangle	<i>Methods:</i> This study enrolled the framework of policy analysis triangle to explore the Dottorota Home Care program as formulated on the Mayor of Makassar Regional Regulation Number 6 of 2016 on Twenty-Four-Hours-Home Visitation Services (Homecare) in Makassar City. <i>Results:</i> The policy content confined the general requirement of aims and principles; scopes; home visits (home care); rights and responsibilities of the health professionals; rights and responsibilities of the patients; coordination and collaboration; guidance and supervision; funding and closing requirement. Legal and non-legal authorities played a role as actors in the policies formulation. The legal parties consist of the Mayor of Makassar, Makassar Local Authorities, Makassar Health Department, Public Health Centers, National Government, and South Sulawesi Regional Government. Hospitals, universities, and the community played the role of non-legal parties in the policy formulation. The context of the policy comprised political and legal, social-cultural, technology development, and economic aspect. The process identified were issue identification, policy arrangement, preparation, implementation, and evaluation. <i>Recommendation:</i> We suggest intensive information dissemination of the program introduction and its procedure to the community.

*Corresponding Author:

e-mail: madediahpendet@gmail.com



This work is licensed under a Creative Commons Attribution 4.0 International License.

INTRODUCTION

Currently, homecare service recognizes as a popular form of health care. Bukit (2008) elaborated the fundamental concept of homecare as comprehensive health care delivers to the client, an individual or family, in their home that intent to encourage community resilience of health maintenance, health status improvement, diseases prevention, disease recurrence prevention, and health rehabilitation. To properly respond to the trend of homecare care or businesses, varied health policies had emerged to protect and provide adequate legal forces binding the implementation of the homecare services [1]. National Patient Safety Goals for the Homecare Program by the Joint Commission, Aged Care Act 1997 in Australia, and Service Requirements for Home Care Services Guideline in Singapore had been acknowledged as homecare health policies issued for the safety of home care practice and protection from right violation. In fact, Indonesia also had issued several policies that also put the homecare service in its discussion. Regulation of the Minister of Health Number 26 of 2019 of Act Enforcement Regulation Number 38 of 2014 on Nursing had mentioned the need for health care continuity enactment by performing decent health care in client's home.

Makassar City has been proclaiming their interest in home care service as an essential complement of health care service in their area. The local stakeholders also had provided and disseminated the Dottorota Homecare Program development plan in the year 2022 [2]. Dottorota Homecare Program

is mentioned in the Mayor of Makassar Regional Regulation Number 6 of 2016 on Twenty-Four-Hours-Home Visitation Services (Homecare) in Makassar City. This regulation was issued to manage the enactment of the Dottorota Homecare Program in Makassar City. The Makassar City Mayor initiated the program implementation in January 2015 to deliver equal health service across the city area [3]. This program employs physicians, nurses, physical therapists, and speech pathologists to deliver 24-hours health service to the community in Makassar City, involving the integration of technology application with the care [4].

Dottorota Homecare Program is an appealing innovation for health care coverage improvement in Makassar City. We were intrigued to identify the content of the policies, their formulation, and the power incorporated into their formulation. The policy analysis triangle is a simple framework that assists the health policy analysis. Hence, this manuscript sought to explore the health policy analysis of the Dottorota Homecare Program in Makassar City by the policy analysis triangle.

METHODS

Qualitative analysis enrolled to analyze the content of Mayor of Makassar Regional Regulation Number 6 of 2016 on Twenty-Four-Hours-Home Visitation Services (Homecare) in Makassar City. Study data then obtained by gathering the secondary data from the previous studies to support the policy analysis triangle: content, actor, context, and process of the Home Care

Program (Dottorotta) in Makassar.

RESULTS

The result from policy analysis triangle were elaborated as follow:

Content

Content of the policies of the Home Care Program (Dottorotta) referred to the Mayor of Makassar Regional Regulation Number 6 of 2016 on Twenty-Four-Hours-Home Visitation Services (Homecare) in Makassar City that involved components of content, actor, context, and process. The policy content encompassed the general requirement of aims and principles; scopes; home visits (home care); right and responsibility of the health professionals; rights and responsibilities of the patients; coordination and collaboration; guidance and supervision; funding and closing requirement. Further, clause 1 article 1 on chapter 1 mentioned the definition of homecare as comprehensive and sustainable health care delivered to an individual or family in their home to improve, maintain, or enhance their independence level and reduce the impact of diseases without any payment due.

Three articles emphasized the objective of the Mayor of Makassar Regional Regulation Number 6 of 2016 on Twenty-Four-Hours-Home Visitation Services (Homecare) in Makassar City: (a) ensuring the fulfillment of community basic need of health to improve, maintain, or enhance their independence level and reduce the impact of diseases, (b) providing protection for the community and health professional during the care, and (c)

improving active contribution and support from the family, community, and local authorities on the local health development.

Dottorota is managed by Makassar Health Department coordinating with 46 public health centers in 15 districts in Makassar City. The difficulties of health care access had provided heavy burden and pushed the stakeholders to cope with this issue immediately. Hence, Dottorota mainly directed for a better access of health care and affordable to free medical treatment for community in Makassar. Dottorota initially designed as a home visitation program, the ambulances and care could be accessed by calling 112 or nearest Public Health Centers. With proper implementation and management, an equal coverage of health care and easier access of care potentially accomplished by the implementation of Dottorotta.

Actors

Actors on the Home Care Program (Dottorotta) in Makassar City are majorly classified into two groups: legal and non-legal parties. Local, regional, and national stakeholders considered as the part of legal parties of policies formulation. They had legal power and authority over the program. Non-legal parties identified in the program formulation were interest groups and the individual citizen.

The legal parties specifically elaborated into several bodies, according to the institution and authority: Mayor of Makassar, Makassar Local Authorities, Makassar Health Department, Public Health Centers, National

Government, and South Sulawesi Regional Government. The Mayor of Makassar City was the highest authority of the city who initiated, organized, and set the policies, also guided and supervised its implementation. It also had been well documented on the Mayor of Makassar Regional Regulation Number 6 of 2016 on Twenty-Four-Hours-Home Visitation Services (Homecare) in Makassar City. This regulation would provide the legal foundation for the program's execution. Makassar Local Authorities on the Makassar City Working Units employed to provide assessments, judgment, input, and support of program planning to implementation. They were also accountable for program funding, originating from the Local Revenues and Expenditures. The Local Health Department mainly contributed to the program implementation. They were responsible for health care delivery and health professionals' protection. On the other hand, public health centers had been enrolled to manage the program. They supplied physicians, nurses, and other medical staff for the program. They should run a sustainable evaluation to ensure proper program implementation. Regional and National stakeholders mainly contributed to program supervision and authorization.

Hospitals, universities, and communities in Makassar City were the non-legal parties of the policy formulation. Hospitals mandated to support the health service delivery from the programs. As referral health providers, they directed to provide more advanced health care for the patients admitted to the program. Collaboration between the hospital and the program aimed to provide more advanced care for the patients, especially those who

couldn't do regular visits to the hospital. State or private universities contributed to updating knowledge and homecare practices. Their discovery would contribute to innovation, fresh ideas, and advance finding to expand the program. The sustainable scientific review would help the stakeholders to identify relevant hindrances of program execution. Hence proper recommendations could be suggested for better health care delivery in the program. Supervision function could be well delivered by the main target of the program, the community. They would be an essential source of information on the hindrances, violations, and weaknesses of the program. This information would be crucial for program development.

Context

Makassar City had proposed a fresh breakthrough and innovation to improve health care service access in their area. This program initially driven by wide scope of area in Makassar City that possibly impact the inequality of health care access. The key success indicator of the program implementation was the high access of Home Care Program (Dottorota) in Makassar City. To achieve the targeted goals, an intensive information dissemination of the program was directed.

The establishment of Mayor of Makassar Regulation Number 6 of 2016 on Twenty-Four-Hours-Home Visitation Services (Home Care) in Makassar City considered as a vital factor on the political and legal aspect of the program invention. Moreover, Makassar City also set a vision and mission for city health

development in 2014 to 2019: improving health care accessibility through 24-hours visitation. This commitment also clearly documented on the Regional Regulation Number 5 of 2014. Departed from the regulation, vision and mission, and the regional regulation, the local stakeholders then formulated the Home Care Program (Dottorota). The funding of the program originated from the Makassar City Revenue and Expenditure. Health professionals enrolled on the program are protected by the regulation, law, and constitution to deliver the care as mandated on their professional code of ethics and regulation. Their income would be given according to their service performance as scripted on the regulation.

Social-cultural aspect that may influence the invention of the Home Care Program (Dottorota) was the tendency to seek help from health provider without considering health care system flow procedure, referring to a method introduced by Social Health Insurance Administration Body [3]. This situation was in line with the statement from the Head of Makassar City Local Health Department that expressed his disappointment of poor utilization of health care services from the public health centers. Further, he declared that the pattern of health care seeking behavior to bigger hospital had been deeply rooted and became a habit. Home Care Program (Dottorota) was expected to provide easier access to health care services from the public health center and to make the effective use of public health center as primary health provider. To engage public health center on the program, call center 112 involved on the program to track patients'

location and situation in the Makassar area. This call center linked the patient's location with nearest public health centers. Public health center then expected to adequately response, serve an essential position in deciding the need of care, and deliver precise medical procedure through the direct visitation.

Rapid technology development also influenced the policy formulation. Technology had been an unseparated part of our daily life. Development in the field of technology improves the quality of public services towards a more effective, efficient, and transparent. Health services are also following the trend by shifting from conventional to modernized care. This situation would affect the technology adoption of the Home Care Program (Dottorota). Health services provided by Dottorota applied technology to enhance the quality of services delivered. The utilization of monitors on the ambulance, smart card, and patient location tracking device on the program were examples of technology adoption in this program [3].

Low-socioeconomic status identified as factors affected the policy formulation on the aspect of economics. The majority of households with low income had reported difficulties in accessing health services. This situation had motivated the initiation of the Home Care Program (Dottorota). This program is designed to provide free health services in Makassar City. Health services expected to be equally distributed with no discrimination. This program also had equipped with free ambulance services that claimed to be capable of accessing various

types of topography and land situation in Makassar [3]. It signified the potential of equally distributed health care and fair access of care.

Processes

Home Care Program (Dottorota) invented through several steps. Health issues in the area of Makassar City identified in the first step as the fundamental data for policy formulation. Poor health access was recognized as common issues encountered by the community. This situation may associate with the remote location, low private transportation ownership, and poor access of public transportation [3]. Poor utilization of public health center services also initiated the program formulation.

Policy formulation then conducted in the second step. Issues identified in the first step applied as essential information for adequate policies invention. Policies also formulated to manifest the values embodied on Makassar City's Vision and Mission for health development in 2014 to 2019, as also written on the Regional Regulation Number 5 of 2014: improving health care accessibility through 24-hours services. Based on the issue and regulation, the local stakeholders then formulated policies to cope with the poor health access and health care coverage.

The third step was preparation. The identification of eligible health providers, funding, facilities and supporting tools, and the method of evaluation required prior the program execution. The preparation required had been well written on the Mayor of Makassar Regulation Number 63 of 2015 on

Twenty-Four-Hours-Home Visitation Services (Homecare) in Makassar City (revised by the Mayor of Makassar Regulation Number 6 of 2016 on Twenty-Four-Hours-Home Visitation Services (Home Care) in Makassar City. Mayor of Makassar City, local stakeholders, and Makassar Health Department then issued a decree for the public health centers and their health professionals for the program execution. The letter instructed their participation as major health providers and staffs on the homecare program. Further, it also added the responsibility of the hospital to manage referral cases. A collaboration agreement between hospitals and public health centers also directed to enhance the inclusiveness and sustainability of the program. Information dissemination about the Home Care Program (Dottorota) in Makassar City also conducted to introduce the program, its facilities, and its procedure.

The fourth step was program implementation. Health care in Makassar City had been delivered according to the criteria, type, and procedure set by the Mayor of Makassar Regional Regulation Number 6 of 2016 on Twenty-Four-Hours-Home Visitation Services (Homecare) in Makassar City. Health professionals, as the caregiver, and the community, as the patients, has unique rights and responsibilities as documented on the regulation. This program would deliver free health care services for the Makassar community. The call center also intensively involved in the program. Public health centers enrolled to provide proper care for homecare patients. Patients would be referred to the nearest hospital or public health centers for more advanced care. Monitor and medical

tools in Dottorota care designed to be directly connected to the referral health providers system to identify the health issue faster and provide spaces to prepare for proper medical procedures before patients arrived at the health providers.

The fifth step was the evaluation. The evaluation delivered by ensuring the program implementation was running according to the plan. This step should have been directed by the policy manager, the benefit recipient, and the interest group. The policy manager and initiator of the program were the Mayor of Makassar City, local stakeholders, local health department, public health centers, national stakeholders, and regional stakeholders (South Sulawesi). The community is the benefit recipient of the program. The interest groups were universities in the Makassar City area. Findings from the evaluation would provide a significant contribution to program improvement.

Instead of appreciation, the initial period of the program was reaping skeptical and harsh critics. The limited capacity of ambulance services in a day drove unsatisfaction responses from the patients. Further, the expectation of 24-hours services could not be fully realized during that period. Patients were only able to receive the medical treatment or care after 12 a.m. Other issues recognized were the poor information dissemination of the program.

CONCLUSION AND RECOMMENDATION

Home Care (Dottorota) Program formulation as documented on the Mayor of Makassar

Regional Regulation Number 6 of 2016 on Twenty-Four-Hours-Home Visitation Services (Homecare) in Makassar City involved components of content, actor, context, and process in the policy analysis triangle. The policy content encompassed the general requirement of aims and principles; scopes; home visits (home care); rights and responsibilities of the health professionals; rights and responsibilities of the patients; coordination and collaboration; guidance and supervision; funding and closing requirement. Legal and non-legal authorities played a role as actors in the policies formulation. The legal parties consisted of the Mayor of Makassar, Makassar Local Authorities, Makassar Health Department, Public Health Centers, National Government, and South Sulawesi Regional Government. Hospitals, universities, and the community played the role of non-legal parties in the policy formulation. The context of the policy comprised political and legal, social-cultural, technology development, and economic aspect. The process identified were issue identification, policy arrangement, preparation, implementation, and evaluation.

Instead of appreciation, the initial period of the program was reaping skeptical and harsh critics. The limited capacity of ambulance services in a day drove unsatisfaction responses from the patients. Further, the expectation of 24-hours services could not be fully realized during that period. Patients were only able to receive the medical treatment or care after 12 a.m. Other issues recognized were the poor information dissemination of the program. To cope with these issues, supporting facilities, such as ambulances and other supporting medical

tools were added. They also recruited more health professionals for the program [2]. Information dissemination about the program was also conducted more intensively. Sustainable evaluation and innovation have been conducted to ensure the benefit of the program for the community.

REFERENCES

- [1] I. Suswati, F. E. B. Setiawan, Y. B. Prasetyo, & A. Tilaksa, *Interprofessional Education IPE Panduan Tutorial dan Homevisit Kesehatan Keluarga*, Malang: UMM Press, 2018.
- [2] Kamsah, "Walikota Makassar Aktifkan Kembali Program Homecare Dottorota," [Online]. Available: <https://makassar.terkini.id/wali-kota-makassar-aktifkan-kembali-program-home-care-dottorota>
- [3] Kementerian Kesehatan Republik Indonesia, "Dottoro'ta, Era Baru Layanan Dokter Bergerak," [Online]. Available: <https://sehatnegeriku.kemkes.go.id/baca/daerah/20170288/3520045/dottoro-ta-era-baru-layanan-dokter-bergerak>
- [4] R. A. Maulana, "Pelaksanaan Program Homecare Dottoro'ta di Kota Makassar," Makassar, Universitas Hasanuddin, 2021.