Role of local government officers in the implementation of national health insurance for poor peoples

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Abstract This study explains the performance of the local government in implementing the Indonesian national health insurance policy model for the poor. This study used qualitative research methods. In addition, in-depth interviews, observations, and document studies were used for data collection. The data analysis consisted of data reduction, display, conclusion drawing, and verification. The study results revealed the performance patterns of local government officials, such as local government officials' capabilities, bureaucratic culture, political interests, principles of universality, and financing of health coverage. Implementing a national health insurance policy for the poor people in Bandung City, West Java, Indonesia, has implications for a broader dimension, such as political, legal, economic, social, and cultural research, which has implications for the development of health resources, improvement of the population administration system, financing and quality, and cost control.

Keywords: local government officers, policy model, health insurance covered, poor people

1. Introduction

In Indonesia, the National Social Insurance System was formed with the primary consideration of providing comprehensive social security for all Indonesian people based on Indonesian Law Number 40/2004. The law determines five types of social security programs, namely, health insurance, work accident insurance, old-age insurance, pension insurance, and death insurance, for the entire population. Participation in the social insurance program only covers a small portion of the community, while the majority of the community has not yet received adequate social security. Indonesian Law Number 40/2004, also concerning the National Social Insurance System, determines that the social insurance program implemented by several organizing bodies can gradually reach wider participation and provide better benefits for each participant. Through the implementation of a wider social security program, it is hoped that all residents will be able to meet the basic needs of a decent life, including those belonging to the poor and needy. Article 14 paragraph (1) of Law Number 40/2004 concerning the National Social Insurance System states that "the government is gradually registering the recipient of contribution assistance (beneficiaries) as a participant to the Social Insurance Administration Organization". In addition, in article 17 paragraph (4), it is determined that "contribution to the social insurance program for the poor be paid by the government". According to Friedman, poor people are defined as people with a small opportunity to accumulate a social power base, which includes the following matters: 1) productive capital such as land, housing, and equipment; 2) financial sources such as income and credit facilities; 3) social and political organizations to achieve shared needs; and 4) social networks to obtain goods, knowledge, information, and skills (Suteki & Putri, 2019). Therefore, the task and responsibility of the government is to cover and pay for health insurance for poor people. This is related to paragraph (5) in Law Number 40/2004, which states that "in the first stage, contributions, as referred to in paragraph (4), are paid by the Government for the health insurance program". Furthermore, in paragraph (6), it is determined that "the provisions referred to in paragraph (4) and paragraph (5) shall be further regulated by Government Regulation".

In their study of health insurance for poor people in Ghana, Alesane and Anang (2018) found empirical evidence of factors that inhibit registration in many developing countries, including Ghana, which is rare. The findings of their study showed that insurance activation was greater among younger individuals but lower among women. Compared to older men, more elderly women prefer health insurance. Furthermore, this research shows how to boost insurance by increasing education and increasing the size of the household. Small sociodemographic characteristics such as age, gender, literacy rate, and household size may influence the ability of registers to learn more about premium payments in Ghana. Some of the steps needed to improve insurance safety in Ghana and other developing countries include sufficient community awareness of pension benefits and age reduction for exemption from premium payments, mostly in rural areas. Therefore, increasing
community-based health insurance is a growing alternative tool for financing health care in developing countries. Health insurance is an important mechanism that, in general, helps people, states, and nations. Many variables affect the attitude of individuals toward a health insurance policy, and variables affect the decision to renew their health insurance policy when it expires. A study conducted by the World Bank (2004) in Ghana also showed that 61.1% of respondents were currently registered with the NHIS, 23.9% had not renewed their insurance after registration, and 15% had never registered. Poor service quality (58%), lack of cash (49%), and taste from other care sources were reasons cited for not renewing insurance (23%). Therefore, all stakeholders, including the community, must make efforts to educate people about the benefits of health insurance to ensure that everyone has optimal access.

For example, in rural Senegal, Johannes (2002) says that the poor have better access to health care than nonmembers by becoming members of reciprocal health insurance coverage and that members have a greater rate of use of inpatient services compared to nonmembers, and they need treatment to buy more of their compilations. This research has consequences that require the community to have the potential to enhance the management of the home. Reinsurance policies, subsidies for the poorest, and the development of links to the private sector through the promotion of group insurance policies must be appropriate tools for further publication. All tools provide better health needs for populations than public health problems. In the context of Jamaica, Bourne (2009) identified health insurance as an indicator of healthcare-seeking behavior. However, no study in Jamaica has examined the variables that determine the coverage of private health insurance. This study bridges the literature gap because it seeks to determine the correlation between the coverage of private health insurance. This research aims to understand those in Jamaica who have health insurance coverage so that it can help formulate public health policy. Sociodemographic variables (such as area of residence, education, marital status, social support, social class, gender, and age) and economic factors can predict health insurance coverage (consumption and income). Interestingly, poor health status was not correlated with insurance coverage for private health. Urban areas are responsible for more health insurance coverage than other urban or rural residents. Sociodemographic variables (such as area of residence, education, marital status, social support, social class, gender, and age) and economic factors can predict health insurance coverage (consumption and income). Interestingly, poor health status was not correlated with insurance coverage for private health. Urban areas are responsible for more health insurance coverage than other urban or rural residents. The alarming aging trend in China has attracted a great deal of attention at home and abroad. The New Cooperative Medical Scheme (NCMS) was launched in 2003 by the Chinese central government to solve uneven health problems in areas with inadequate infrastructure and relative poverty. The main beneficiaries of this policy are rural seniors; exploration is required to improve their health through a health insurance policy. During a subsidized 3-year scheme based on public health insurance (CHI) in rural China, Zhang & Wang (2008) examined adverse selection changes from time to time. People with a history of chronic conditions, fair health, and poor health are more likely than those without chronic conditions and with good health status to be registered in the system. Furthermore, we found that the health status variable and the CHI wave variable were not significant in almost all interaction terms, indicating that the adverse selection effect did not change significantly over time. Furthermore, middle-income and high-income individuals are more likely than low-income individuals to enroll in the scheme. This shows that in the subsequent registration of the CHI scheme, even with government subsidies for premiums, adverse selection remains.

The provision of health services to elderly people is a major challenge for decision-makers, unlike in Thailand, where dramatic changes occur in the age structure of the Thai population. According to Kananurak (2014), under the Social Health Insurance (SHI) scheme, the number of elderly people in Thailand will increase, along with the number of retired workers, and there will be unmet needs for the use of health services after retirement. After retirement, the SHI scheme does not cover workers unless they can use free elderly health services. Moreover, concerning universal health care support and long-term care services for all elderly people, the government budget is very tight. Therefore, by facilitating voluntary health insurance, the government can support retirees who can pay. The two faces of the same coin that make the already poor are risk and uncertainty. Several possibilities often hamper their lives. Insuring these risks enables individuals with small and regular payments to bear large uncertainties, thereby reducing their vulnerability. Recent innovations in loan contracts for microfinance groups have reduced imperfect information and transaction costs for insurance product suppliers and purchasers. For example, Shetty and Veerashekharappa (2009) examined the innovations of microfinance institutions (MFIs) in improving and accessing (including) microhealth insurance (partner-agent models) for the poor in India, particularly in Karnataka State. The main survey was conducted in 10 villages in Karnataka, India, and included 106 self-help groups (SHGs) and 318 member households. The results indicate that microfinance groups have played an important role in supplying microinsurance products to poor rural households that have been excluded for a long time. The study also revealed that the accessibility of microhealth insurance schemes is poor-focused and includes poor rural people with multiple risks. Policy recommendations argue that, with limited transaction costs and minimal information imbalances, microfinance groups are the most reliable and convenient way to deliver microhealth insurance products to poor communities in rural regions.

Since January 1, 2014, Indonesia has recorded a new history within the National Social Insurance System, namely, the operation of the Health Social Insurance Administration Organization. The implementation of Law No 40 of 2004 relating to the National Social Insurance System, following the decision of the Constitutional Court on case Number 007/PUU-III/2005,
provides legal certainty for the establishment of the Social Insurance Administration Organization for implementing Social Insurance programs throughout Indonesia. Article 1 paragraph 1 of Law Number 24/2011 concerning the Social Insurance Administration Organization states that the Social Insurance Administration Organization is a legal entity established to conduct social insurance programs. It must be understood, according to Thabrany, that the Law on the National Social Insurance System was drafted as much as possible, approaching the ideal as a direction for the development of social welfare in Indonesia. Health insurance is one element of social welfare. A reform of the social security system, including social health insurance, is the law of the National Social Insurance System. Furthermore, each region in Indonesia has the right to develop a social insurance system as part of its development. Following the decision of the Constitutional Court of Indonesia concerning the judicial review of Article 5 of Law No 40/2004 on the National Social Insurance System, that authority is a form of implementation of the Regional Government Law, in particular Article 22 h, requiring regions to develop social security systems, including health insurance (Muki, 2007).

For the implementation of the National Social Insurance System, Bandung city is a trial area. Since July 2013, the Bandung City Health Office has prepared for the implementation of the Indonesian National Health Insurance by drawing up a roadmap for the preparation of the Indonesian National Health Insurance in Bandung for this purpose. Aspects of the membership database, regulations, mapping of health facilities, and funding are mainly related to the preparation for the implementation of the Indonesian National Health Insurance. The results of the study clarify many problems faced by Indonesia's public bureaucracy, including the uncertainty of time, cost, method of service, and discrimination in service. Indonesia's public bureaucracy has not been able to become a service provider that treats all citizens of the country equally, regardless of the characteristics of subjectivity. In addition, research results were obtained by revealing a long hierarchy of services, complicated public service procedures, and very high uncertainty of service that has increased intermediary service sellers in the practice of public service delivery (Dwiyanto, 2012). The objective of this research, by the above description, is to explain the model for the construction of the Indonesian national health insurance policy for the poor and the theoretical and practical implications for implementing the Indonesian national health insurance policy for the poor.

2. Materials and Methods

This study used a qualitative research design. Qualitative research occurs in a natural setting where the researcher is an instrument for data collection (Creswell, 1998). The sampling method used in this study was purposive sampling. As previously mentioned, purposive sampling is a nonprobability form of sampling. The determination of the subjects in this study involved the use of nonprobability sampling in a purposive manner. However, "most sampling in qualitative research entails purposive sampling of some kind" (Bryman, 2008). The results of this research are then analyzed using the data analysis workflow model of Miles and Huberman consisting of three concurrent flows of activity: data reduction, data display, and conclusion drawing and verification. These data were collected via in-depth interviews, observations, and document studies. In detail, the analysis of the data, especially the interviews, involved four types of coding, namely, initial coding, focused coding, axial coding, and theoretical coding. In the initial phase of coding, the researchers perform the coding manually by looking at the transcript of the interview word for word, line-by-line, sentence-per-line, per incident, or incidents to define what is happening and what it means. Therefore, at this stage, researchers attempt to capture a variety of codes, abstract ideas, or concepts that are emerging (Charmaz, 2006). Then, the next phase is focused coding. According to Glaser, the coding is more focused, selective, and conceptual. Furthermore, in the axial coding stage, researchers link categories and subcategories, detailing the dimensions or attributes of a theme or category and synthesizing various narratives or excerpts of the data to fit or coherence with a framework of analysis that appears. Finally, theoretical phase coding aims to make a more specific range of possible relationships between categories created on a dedicated stage coding. By using the term Glaser, this stage seeks to knit back a story crumbled into a conceptual or theoretical building intact.

The informants of this research are the head of the health office of Bandung City, Indonesia, and the head of the Health Social Insurance Administration Organization of Bandung City, Indonesia. The informants were those who understood and experienced directly related Indonesian national health insurance policies in the city of Bandung. The criteria for selecting informants were leaders in these institutions who had a minimum of 3 years of working experience. The topics addressed in the in-depth interviews were Indonesia's national health insurance, Indonesia's national health insurance policy, preparation for the implementation of Indonesia's national health insurance, and the implementation of Indonesia's national health insurance. All respondents have provided consent for the research to be conducted. The documents studied are Indonesia's population, the number of poor people, regulations on Indonesia's national health insurance, and the Health Social Insurance Administration Organization.

3. Results

3.1. Performance Patterns of Local Government Officials in Implementing National Health Insurance for the Poor

The resulting research themes are normative attitude, imperative attitude, bureaucracy culture, performance patterns, able people and agile process, capabilities, external practices and political interest, and future uncertainties.
3.2. Normative Attitude

The pattern of performance of local government officials in implementing national health insurance for the poor is shown by normative and imperative attitudes. A normative attitude is an attitude that is based on applicable laws and regulations. Local government officials carry out work based on applicable laws and regulations as a guide and direction for the implementation of work. Meanwhile, the imperative attitude is an attitude that is based on instructions. They do the work according to the instructions of their superiors. For example, for the Recipients of Contribution Assistance (beneficiaries), the informant said:

“The Recipients of Contribution Assistance (beneficiaries) refers to the Government Regulation of the Republic of Indonesia Number 101 of 2012 concerning the Recipients of Contribution Assistance (beneficiaries)” (Mr. T.).

In addition to the Government Regulation of the Republic of Indonesia Number 101 of 2012 concerning the Recipients of Contribution Assistance (beneficiaries), which can be used as a reference for the implementation of health insurance, it also refers to Law Number 24 of 2011 concerning the Social Insurance Administration Organization as one of the main legal bases for the administration of social insurance. Another important legal basis is related to the acceleration of the registration of Non-Wage Recipient Workers as recommended by the Constitutional Court from the results of the judicial review as confirmed by the informant.

“with a judicial review in the Constitutional Court of Law Number 40 of 2004 concerning the National Social Security System. One of the decisions of the Constitutional Court accelerated the registration of Non-Wage Recipient Workers” (Mr. T).

Nonwage recipient workers are workers who carry out economic activities independently to earn income, who are workers outside of an employment relationship, or who are independent. In the context of membership, they can register at the Office of the Social Security-Health Administration. However, with a large number of registrants every day, it is often difficult for the Office of the Health Social Insurance Administration Organization to provide services to prospective participants of the Health Social Insurance Administration Organization from the element of Non-Wage Recipient Workers. The normative attitude was also conveyed by Mr. T, who essentially stated that the regulation must be obeyed by policymakers, particularly by the Health Social Insurance Administration Organization and the Health Office of Bandung City, as follows:

“Some rules must be obeyed now, both by the Health Social Insurance Administration Organization itself and us. We want to prove that we support the Indonesian National Health Insurance Program. ” (Mr. T).

Compliance in question is compliance in paying dues for participants of the Recipients of Contribution Assistance. The payment of dues made by the Bandung City government should not be late. This is proof that the Bandung City government supports the Indonesian National Health Insurance Program. The sustainability of the Indonesian National Health Insurance program should be supported by available funding. Compliance with the payment of members of the Health Social Insurance Administration Organization for Recipients of Contribution Assistance is an important matter, whether carried out by the Bandung City government or the private sector and the community as independent participants of the Health Social Insurance Administration Organization.

3.3. Imperative Attitude

In addition, there is an imperative attitude in the socialization of the Indonesian National Health Insurance Program and the process of paying contributions for the Recipients of Contribution Assistance. The imperative is directing or ordering someone else to do something. In other words, imperatives are instructive, meaning that they give orders often without a dialog process in carrying out their work. The imperative action of the local government apparatus can be seen in the following statement of the informant Mr. T.

“Socialization is carried out in collaboration between the Health Office and the Health Social Insurance Administration Organization. Our job (Health Office) is service—the Health Social Insurance Administration Organization from the marketing side. The Health Office also assigned the Community Health Center to the area and the household to the subdistrict to carry out socialization” (Mr. T).

Although there is a process of collaboration and division of labor between the Health Office and the Health Social Insurance Administration Organization regarding the socialization of the National Health Insurance program and health services, the Health Service is responsible for health services, and the Health Social Insurance Administration Organization has duties, among others, in terms of socializing the National Health Insurance program; however, in reality, the Health Service also conducts socialization. Thus, the socialization of the National Health Insurance program is a shared responsibility between the Health Office and the Health Social Insurance Administration Organization.
In addition, local government officials have an instructive attitude in terms of implementing the socialization of the Indonesian National Health Insurance program, namely, in the form of assignments from the Office of Health to the Community Health Center, without any dialog between the Office of Health and the Community Health Center. This shows the imperative action from superiors (the Office of Health) to subordinates (the Public Health Center). The approach applied is top-down. The top-down approach is coercive and not aspirational toward the needs of the community, including the need for health services. The top-down approach has many weaknesses due to the centralization of decisions, financing, and management, including in terms of health services.

On the other hand, the approach that should be taken is a bottom-up approach, namely, an approach that gathers basic ideas from the lower classes of society, in this case, the poor and underprivileged. Poor and underprivileged individuals should not only be seen as objects of health development but also as subjects of health development. Thus, there needs to be a shift in approach from top-down to bottom-up to gather basic community ideas in the process of development, planning, and management. The role of the community in the development process should be carried out with a participatory approach.

The imperative action of local government officials is shown in the payment of premium contributions for the poor and underprivileged, where the government pays the premium for them. Regarding this, Mr. F said:

“Therefore, there is no individual registration for the Recipients of Contribution Assistance because the contributions are not paid by them but rather by the government. Because the contributions are paid by the government, the flow is through the government” (Mr. F).

The statement “because the contribution is paid by the government, the flow is also through the government” actually shows the government’s imperative action. The government has the right to regulate the payment of premium contributions, the determination of the number of premium contributions, and the mechanism for submitting the participation of the recipients of contribution assistance. Meanwhile, the poor and underprivileged must obey and follow government regulations and instructions.

4. Discussion

4.1. The Construction Model of the Health Insurance Policy for Poor Peoples

Indonesian national health insurance is a system implemented by the government to meet the basic needs of proper health for all Indonesian people. One of the targets of the Indonesian National Health Insurance Program is poor people. The government contributes to this community group. In the health insurance membership, this group is called the recipients of contribution assistance (beneficiaries). The model of the Indonesian National Health Insurance Policy Construction for Poor People can be described as follows:

![Figure 3 The Model of the Indonesian National Health Insurance Policy Construction for poor people.](https://www.malque.pub/ojs/index.php/mr)
The first is bureaucracy culture. The performance of the apparatus in the application of Indonesian national health insurance is shown by the following bureaucracy culture: (1) pragmatic relating to the interests of the government, (2) bureaucratic in the mechanism for submitting the Health Social Insurance Administration Organization - membership of recipient of contribution assistance (beneficiaries), (3) rigidity in the interaction of tasks or occupation, (4) non-participatory data collection on the participation of members of the recipient of contribution assistance (beneficiaries), and (5) short-term orientation in achieving the target of participation in the Indonesian national health insurance program. This apparatus performance culture influences apparatus performance patterns (normative and imperative attitudes), able people and agile processes, apparatus capabilities (thinking ahead, thinking again, and thinking across), and adaptive policies. These concepts are interrelated with one another. From the perspective of the theory of dynamic governance systems, bureaucratic culture is very important and therefore has become the initial part of discussing the dynamic governance system. Able people and agile processes are the key drivers for the development of the three dynamic governance capacities of thinking ahead, thinking again, and thinking across, which are then embedded in the paths of chosen strategies, policies, and programs. Their approaches to the paths differ according to which dominant dynamic capability is being utilized (Neo & Chen, 2007).

The second factor is performance patterns. The normative performance pattern of the apparatus can influence able people. The normative performance pattern of the apparatus is not in conflict with the laws and regulations. On the other hand, the authorities can use regulations as a reference for transforming the Indonesian National Health Insurance Program. Principally, aspects of the Indonesian national health insurance policy have been known by the authorities in implementing the Indonesian national health insurance program. With the existence of laws and regulations that specifically handle Indonesian national health insurance, the public can understand and realize the importance of the Indonesian national health insurance program. However, there are still obstacles to the socialization of Indonesian national health insurance. The socialization of Indonesian national health insurance still needs to be intensified intensively so that the community, especially the poor, can understand the Indonesian national health insurance program. The normative performance pattern of this apparatus can also affect agile processes. Normative attitudes can realize agile processes; they require the development of human resources, especially the development of innovation and creativity, in describing Indonesian national health insurance policies, especially the growing awareness of the apparatus of the importance of health for poor people. The imperative apparatus performance pattern can also affect able people. Social policy has the nature of directing and developing initiatives in the implementation of the Indonesian National Health Insurance Program. Finally, committing to the institution and the institutional consequences themselves can lead to institutional consistency in the legislation and reduce the turmoil that may arise, especially regarding membership, budget, and services. Imperative apparatus performance patterns can also affect agile processes. An imperative attitude can have a positive effect on the performance of current and future officials. An imperative attitude can lead to quick work, both individually and organizationally. An organization, both in type and form, cannot be separated from the imperative element because of the end of the position because there is authority inherent in the position. This imperative attitude also depends on the leadership style that involves the authorities, which can lead to new ideas and fresh perceptions in implementing the Indonesian National Health Insurance Program.

The third category includes able people and agile processes. Able people can influence thinking ahead, thinking again, and thinking across. The implementation of Indonesian national health insurance and able people are manifested in the commitment of the apparatus to the service of the poor. Able people in the apparatus' commitment to the service of the poor can influence thinking ahead. Thinking ahead is realized in the roadmap for preparation for the implementation of Indonesian national health insurance, officials' perceptions of Indonesian national health insurance success, and planning for the quality of health services. Officials who are committed to serving poor people can think ahead in preparing for the implementation of health insurance, such as preparing a roadmap for the implementation of Indonesian national health insurance, having a perception of Indonesian national health insurance success, and planning to improve health services. The commitment of the apparatus can also make the apparatus able to think again, namely, in understanding problems and problem-solving methods, setting up a referral system, forming a team, and carrying out monitoring and evaluation of the Indonesian National Health Insurance implementation. In addition, the commitment of the authorities can also give them the ability to think across, namely, in implementing institutional and program transformation, coordinating poverty reduction, and innovating health services. Agile processes are demonstrated by transparency and accountability, both internal and external to the organization. Health human resources and health facilities are needed to serve patients with excellent service. Human health resources must have the mentality of wanting to compete. The authorities should be able to review that health facilities are not related to the structuring of the referral system; they must also meet the challenges of future needs. Health human resources must have a vision for the future and have innovations and be able to implement these innovations to facilitate and accelerate health services and make patients comfortable.

Fourth, capabilities. Thinking ahead, thinking again, and thinking across can affect adaptive policies. The apparatus that can think ahead, think again, and think across causes policymakers to adopt adaptive policies, such as readiness for participatory data collection, bureaucratic readiness, budgets, human resources, and health facilities.
The fifth factor includes external practices and political interests. In addition to the culture of apparatus performance, political interest factors; external practices, such as social justice, political justice, and procedural justice; and future uncertainties, namely, financing health coverage, also affect the dynamic governance system. This shows how a dynamic governance system is a very broad system because there are many factors associated with it.

Sixth, future uncertainties. All these components are designed to achieve a goal, namely, the Universal Health Coverage (UHC) and the Indonesian National Health Insurance Policy Model for the Poor. The UHC indicators are related to membership, services, and financing. These three UHC indicators are targets for the implementation of the Indonesian National Health Insurance Program. The three UHC indicators must receive central and regional government attention and need support from various stakeholders so that the UHC target can be achieved. Without serious attention from the government and strong stakeholder support, achieving the UHC target is difficult. National health insurance is a component of social protection that has been developed in Indonesia to achieve UHC. This includes protection for the poor in Indonesia, whose numbers are still very high. However, poor people must receive adequate social protection, not least social protection in the health sector. This is in line with Conway, Haan, and Norton (Barrientos & Santibáez, 2009). Social protection refers to “public actions taken in response to levels of vulnerability, risk, and deprivation, which are deemed socially unacceptable within a given polity and society”. In Indonesia, health insurance, which was originally in the form of social assistance, has evolved into insurance. Therefore, social protection programs in Indonesia have evolved as stated by the evolution of state social protection, from assistance and insurance to potential development (Garcia & Gruat, 2003)

4.2. Theoretical and Practical Implications

The Indonesian national health insurance policy for the poor is understood in a broader and multidimensional context: political, legal, economic, social, and cultural. Politically, it is related to the political interests of the power elite. By law, it is in contact with the laws and regulations that serve as a reference in regulating the implementation of Indonesian national health insurance. Economically, this is related to the financing and sustainability of the Indonesian National Health Insurance Program. Socially, it touches on the protection dimension for the poor. Culture is related to the bureaucratic culture or culture of apparatus performance. The reality of this research touches on the philosophical dimension, which is basic to humanity, namely, civil rights, political rights, and the social rights of citizens. The Indonesian national health insurance policy for the poor must be able to free them from poverty and obtain justice, participate in political power, and achieve social welfare. Civil rights are rights needed for the freedom of everyone; freedom of speech, thought, and belief; the right to free oneself from poverty; and the right to justice; political rights are the right to participate in political power, as members of an entity invested with political authority or as voters of the members of these bodies; and social rights are the right to achieve economic prosperity and security. Accessibility from the perspective of social work is one of the functions of social services, an important part of which needs to be discussed. It concerns not only the accessibility of poor people in health services but also the accessibility of poor people in other social services, such as education, employment, housing, social security, transportation, and advocacy.

This research further confirms that policymakers can invest in human resources and health facilities by providing and developing human resources and providing, improving, and developing health facilities to realize quality and professional health services. The results of this study require improvements to the population administration system, specifically the data collection of poor people, to make it easier for poor people to have access to health services. The government must have an accurate and accountable data system that can be accessed easily and quickly. Therefore, the government needs to build a complete and accurate database through the statistics of Indonesia. At the grass-roots level, data collection activities need to be involved. With an accurate and accountable database, it is easier for poor people to have access to health services. The government must provide sufficient funding for the continuation of the Indonesian National Health Insurance Success Program, especially for poor people. In general, this illustrates the limited role of the state in optimizing social policy in Indonesia, including a public health system that is not adequately funded and unable to provide qualified services to all citizens. Finally, the implementation of the Indonesian National Health Insurance Policy requires quality and cost control at each level of health services. Quality control is carried out to improve technical competence, access to health services, effectiveness, human relations, sustainability of health services, and comfort. Moreover, cost control is needed for efficiency and to prevent wasteful health budgets.

5. Final considerations

Universal health coverage (UHC) indicators are related to membership, services, and financing. These three UHC indicators are targets for the implementation of the Indonesian National Health Insurance Program. The three UHC indicators must receive central and regional government attention and need support from various stakeholders so that the UHC target can be achieved. Without serious attention from the government and strong stakeholder support, achieving the UHC target is difficult. Furthermore, this research has implications both theoretically and practically. Theoretically, the Indonesian National Health Insurance Policy has implications for broader dimensions, such as political, legal, economic, social, and cultural.
dimensions. In addition, it touches on a philosophical dimension concerning the rights of citizens, such as civil rights, political rights, and social rights. Moreover, practically, it is related to the development of health resources, improvement of the population administration system, financing, and quality and cost control.

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Ethical considerations

All respondents have provided consent for the research to be conducted.

Conflict of Interest

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