Driving Factors and Obstacles in the Implementation of National Health Insurance among In-patient Utilization in Indonesia: A Critical Review towards Top-down Policy

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Abstract

The implementation of National Health Insurance (Jaminan Kesehatan Nasional, JKN) policy was carried out to provide in-patient care coverage for all people in Indonesia. This study examined the driving factors and obstacles in in-patient care in South Sulawesi Province with highest utilization rate and Maluku Province with the lowest rate from the perspective of top-down policy according to the theory of Edwards III. Data collection conducted by doing in-depth interviews with national and local government in Jakarta, South Sulawesi and Maluku provinces in 2016 includes Health Ministry, Health Providers, and Social Security Agency and we analyze the influencing factors with literature review on previous studies and statistical data. The driving factors found in JKN implementation are ease of access to health services, rising number of participants, referral destination, growth number of medical facilities, and commitment support from the local government. In contrast, the main obstacles found were geographical challenge, disparity of health workers, and lack of adequate health service facilities. This finding shows that the cooperation of community as a stakeholder (gotong royong) took a major role in determining the goals of JKN implementation. The value of gotong royong found in the JKN policy is a bottom-up perspective which is a novelty in this policy but not covered in Edwards III’s theory.

Key Words: Top-down Policy Edwards III, JKN Indonesia, In-patient Utilization

1. Introduction

Indonesia started to implement healthcare integrally through BPJS Health on January 1, 2014.
Gradually, this healthcare participation, which is called *Jaminan Kesehatan Nasional* (JKN), is expected to provide coverage for all Indonesian people by 2019 (Universal Health Coverage/ UHC) (Harimurti, Pambudi, Pigazzini, & Tandon, 2013). The implementation of JKN is based on the mandate of Regulation Number 40 of 2004 about National Social Security System (*Sistem Jaminan Sosial Nasional*) and Regulation Number 24 of 2011 about Social Security Agency (*Badan Penyelenggara Jaminan Sosial/ BPJS*).

At the beginning of the implementation in 2014, the number of JKN participants reached 121.6 million lives (49% of the population) with a target of 257 million lives by 2019 (100% of the population). Up to May 2017, JKN participation has reached 176.738.998 lives or equal to 69% of the total population of Indonesia. This number keeps increasing every month until it reaches the target of the entire Indonesian population in 2019. Of all the participants who are registered, participants from the segment of Premium Support Receiver (*Penerima Bantuan Iuran*, PBI) is the dominating participant, as much as 62% or 108.986.892 lives of the total of registered participants. PBI participants are those whose premium is covered by Central Government supported by Local Government (Badan Penyelenggara Jaminan Sosial (BPJS) Kesehatan, 2017).

JKN participants who pay the premium are covered for all health service expenses which are divided into three groups of services which are first degree out-patient expenses (*Rawat Jalan Tingkat Pertama*, RJTP), advanced out-patient expenses (*Rawat Jalan Tingkat Lanjut*, RJTL), and advanced in-patient expense (*Rawat Inap Tingkat Lanjut*, RITL). The benefits that are obtained by JKN participants are more comprehensive compared to the benefits and scheme of Regional Healthcare (*Jaminan Kesehatan Daerah*, Jamkesda) which existed prior to JKN. This coverage of health service benefit includes coverage for catastrophic illnesses that are often very costly. Other than that, the recipients of the JKN benefits have access to services in every medical facility (*Fasilitas Kesehatan*, Faskes) owned by both the government and private sector which cooperate with BPJS Health, both in the category of First Degree Medical Facilities such as Community Health Center (Puskesmas) and clinics as well as advanced medical facility (hospitals). Other than that, JKN is an effort by the government to give equal opportunity to the poor in obtaining health services from available medical facilities. This is different to the condition of health services in 2004-2005 as mentioned in a study in Yogyakarta (Indonesia) that the poor tend to buy over the counter medicine for flu, fever, diarrhea and breathing difficulty rather than going to a medical facility (Seeberg, Pannarunothai, Padmawati, Trisnantoro, Barua, & Pandav, 2014).

The benefits that are received by JKN participants are quite comprehensive compared to several other *Jamkesda* schemes. The benefits of JKN are comprehensive for all illnesses. This is in line with the assumption than JKN has fulfilled the UHC dimensions which includes: health coverage for everyone (the first dimension), coverage of all illnesses (the second dimension), and a minimum cost burdened to the people, for pre-determined selection of services (Nugraheni, 2015) (Boerma, Evans, Kieny, Eozenou,
Evans, & Wagstaff, 2014). This condition is in line with the goals of UHC that everyone can access high quality health services, to protect everyone from public health risk, and to protect everyone from becoming poor from being sick as a result of paying the cost from personal income (Maeda, Araujo, Cashin, Harris, Ikegami, & Reich, 2014). JKN services also bear the services up to health services for catastrophic illnesses. This bearing of the cost of catastrophic illnesses is the advantage of JKN which is a service that protects everyone in every health condition (Thabrany, 2015). This condition describes the effort of fulfilling health rights for all regardless of their social economic status to obtain health services that they need. The implementation of JKN policy shows that there is an increase of national utilization, but there are still disparities in many areas which are highly varied. These disparities are influenced by among others geographical conditions, availability of resources and medical facilities which become a challenge in implementing JKN in Indonesia.

By considering the background above, there needs to be a study that analyzes the factors that can influence the implementation of JKN policy in achieving UHC target, especially in utilization of in-patient care in Indonesia. This study is aimed to discover the driving factors and obstacles in implementing JKN policy especially in-patient utilization in line with top-down policy perspective of Edwards III’s theory which emphasizes four variables which includes communication, bureaucratic structure, resources and disposition.

2. Materials and Method

This study used a qualitative approach, in which data was collected through in-depth interviews and literature review on previous studies and statistical data. In-depth interview was conducted in three cities: Makassar (South Sulawesi Province), Jakarta (DKI Jakarta Province), and Ambon (Maluku Province). Based on National Social Economy Survey 2015 (Susenas), after one year of the implementation of JKN, South Sulawesi is the province with a high value of in-patient utilization, which is above the national average, while Maluku has the lowest rate. In-depth interviews were done in South Sulawesi and Maluku in 2016. The informants of the study were employees of the Health Ministry, Local Government, Health Services, hospitals and Healthcare and Social Security Agency in Makassar, Ambon, and Jakarta. List of the informants are mentioned in Table 1.1

<table>
<thead>
<tr>
<th>Informants</th>
<th>National Level</th>
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<tbody>
<tr>
<td>Head of Human Resource Department, Ministry of Health Republic of Indonesia</td>
<td>Governor of Maluku Province in Ambon</td>
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<tr>
<td>Senior Advisor on Budgeting, Ministry of Health Republic of Indonesia</td>
<td>Head of Maluku Region of BPJS Health in Makassar</td>
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<td>Members of National Social Security Council</td>
<td>Head of Department of Health Maluku Province</td>
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3. Result and Discussion

Driving Factors & Obstacles in the Implementation of JKN

The discussion of implementation of healthcare in the scheme of JKN in terms of in-patient service, seen from aspects of the executing institution, instruments and policy strategy, uses Edwards III’s theory of implementation as a theoretical framework. Utilization of in-patient is defined as in-patient service in public and private hospitals using examples in South Sulawesi and Maluku provinces. Susenas survey in 2015 showed that South Sulawesi has a high in-patient utilization rate compared to the national average. South Sulawesi, which is in regional 3, is recorded as an area with in-patient utilization value of 19.86, higher than national utilization value (19.64). Meanwhile, Maluku is the province with the lowest utilization value according Susenas 2015. Utilization based on area, placed Maluku in regional 5 with the lowest in-patient utilization value of 9.04 (Pusat Pembiayan dan Jaminan Kesehatan (PPJK) Kemenkes RI, 2016).

Ease in obtaining medical services was mentioned by several informants in South Sulawesi was the major factoring that increase the utility of in-patient care because the cost of treatment is guaranteed. This ease is admitted to be very influential for the poor because it makes it easy for them in getting health services without paying any expenses. Other than the poor, independent participants (those who pay the premium individually and not supported by the government) also get the benefits of health service coverage.

The increase of participant numbers in South Sulawesi also influences the increase of in-patient utility. Even though, up to now, there is a high number of participants from the PBI segment, which is a significant factor in increasing the JKN participation, people who register as independent participants also increase. This is because people are getting a better understanding of the importance of JKN. The healthcare system enables risk sharing for JKN participants so people are motivated to participate in the JKN program. Several informants admitted that the increase of JKN participants has expanded the utilization of health services, including in-patient service. The coverage of JKN participation in South Sulawesi in 2014 was 49%, while the highest participation coverage in the same year was in South Kalimantan which was 66,3% (Badan Perencanaan Pembangunan Nasional (BAPPENAS), 2015). This comparison of participation coverage shows that the JKN participation coverage of South Sulawesi is very good, considering South
Sulawesi is one of the ten most populous provinces in Indonesia. In addition, the referral system and availability of facilities in South Sulawesi, especially in Makassar, was also a factor in increasing in-patient utility in the area. Informants admitted that Makassar is a referral destination for East Indonesia area; therefore many patients from surrounding areas, including Maluku, are referred to Makassar if they are untreatable or if treatment instrument is not available in their area. This is corroborated by informants from BPJS Health Maluku that the limitation of infrastructure and doctors makes the health service in that area often has to refer the patients to other areas, for example to Makassar, Surabaya, or Jakarta.

From the point of view of availability, the increasing numbers of medical facilities that cooperate with BPJS Health in South Sulawesi has increased the chances of people in getting health services therefore the utilization rate of in-patient care also increases. This hypotheses is confirmed by an informant from BPJS of South Sulawesi that there has been an increase of medical facilities in South Sulawesi since the implementation of JKN, not just in government-owned facilities, but also private facilities that cooperate with BPJS Health in the JKN program.

“....we see a high utilization rate in South Sulawesi, this is because this province is an industrial province, a highly developed province and it also has a good medical track record in creating doctors who graduated from Hasanudin University’s hospital, which has been established for many years, from these doctor graduates, emerges many hospitals and later on clinics, therefore patients or citizens of South Sulawesi can get easy access to medical care. And geographically, there are no obstacles in reaching these medical facilities.” (An official from Wahidin Hospital)

Data from Susenas 2015 shows that after the implementation of JKN in Ambon, in-patient utilization has increased, especially among JKN participants who were admitted both as PBI and VIP patients in private hospitals. This is also admitted by informants from private hospitals. There has been an increase in utilization for all types of treatment room since the cooperation between medical facilities and BPJS Health in Ambon.

The absence of geographical obstacles is one of the driving factors for the high in-patient utilization in South Sulawesi. Informants of South Sulawesi BPJS Health expressed that there are no geographical obstacles in accessing health services; with the exception of Pangkep area. This is also supported by socialization and education programs that were carried out which increased the public’s knowledge of the program. So, without geographical obstacles, the public can easily access available services. However, socialization programs are still needed, especially for the medical workforce so they can better understand the referral system and improve claim record management. This is needed to minimize the waiting line at the referral hospital, which can influence the quality of service. Other than the lack of geographical obstacle, South Sulawesi, especially Makassar, also has an innovation, which is homecare service, health service coming to people who need free service.
Different circumstances are found in Maluku. This research has found that in-patient utilization rate in Maluku is the lowest in Indonesia based on Susenas data in 2015. This low in-patient utilization rate in Maluku is mainly influenced by geographical obstacles. Maluku is an archipelago; therefore access to health service is more difficult. Other than that, up to this point the implementation of “coming to the participant” (meaning healthcare services go to where the patients are) has not been done optimally so it is yet to solve the problem of geographical access and transportation for the patients. This limited access of archipelagic community is mainly due to problems such as high cost, time and unavailability of medical facilities. Another condition that influences in-patient utilization rate in Maluku is the gap of medical workforce availability.

Maluku consists mostly of islands; therefore access to medical facilities is more difficult. The trip to other islands in search of medical facilities burdens the people in terms of cost and time. Other than that there is still a disparity in medical workforce, for example the rarity of specialists for type C hospitals in Ambon. This condition causes some people, according to informants from Maluku Province Health Service (Dinas Kesehatan Provinsi Maluku), prefer not to seek treatment at all, thus, causing utilization rates to be low.

Still related to the disparity of medical workforce, Maluku is not the only area in Indonesia with that problem. A research conducted in the Regency of Lingga, in the Province of Riau, (another archipelagic state) found that there are not enough general practitioners and specialists available (Luti, Hasanbasri, & Lazuardi, 2012). Another research in Natuna Islands, Province of Riau, found that the role of local government is very important in the distribution and dispersion of medical workforce (Syafari, Sulistyo, & Kristiani, 2013). Data from the Indonesian Health Profile of 2015 showed that the ratio of physicians to 100,000 inhabitants in the province of Maluku is 18.86. This is higher compared to the ratio of physicians in South Sulawesi, which is 16.91 and also higher than the national rate which is only 16.06. However, this ratio is still far from the ideal target set by the Ministry of Health that has to be reached in 2019, which is 45 physicians per 100,000 inhabitants (Kementerian Kesehatan RI, 2016).

In facing this challenge, Maluku Province Government has compiled island cluster referral system but still faces problems in the implementation especially related to expensive transportations cost. In addition, medical facilities in the regency level (Kecil Island area) do not yet have the required medical equipment and workforce for treating patients.

The problem of limited access due to geographical obstacles is a research finding variable which influences accessibility in obtaining health service. Geographical obstacles and additional cost for transportation are also problems found in other parts of Indonesia. A study of tuberculosis (TB) patients at Kulon Progo Regency, DI Yogyakarta Province, found that during the diagnosis stage, the highest cost component includes in-patient costs, direct medical costs and additional meal costs, however, during the next phase, which is treatment, the cost of meals and trips became the highest cost component compared to
direct medical costs (Ratnawati, 2015).

“... based on my observation, in archipelagic states, the main obstacle is the transportation aspect, for example, when someone in the Puskesmas (local clinic) gets referred to a hospital. Especially in areas where the island does not have a hospital, the island only has the first tier of medical facility, which is Puskesmas. So, in order for the patient to go a hospital, it will take up a lot of their time and money for the transport.” (An official of BPJS Health of Makassar, South Sulawesi)

This condition shows that the annulment of health service cost in JKN scheme does not instantly increase access to health services especially in geographically challenged areas such as Maluku. Geographical obstacles compounded with limited health resources and equipment in several areas in Maluku, are some of the challenges for archipelagic areas. Delayed referrals to better medical facilities can also lower the patient’s health condition and possibly increase the number of mortality.

Access to health services in archipelagic areas is indeed a challenge in Indonesia. Informants from Ministry of Health said that the typological differences of archipelagic and land societies are extreme. For example, the island of Java is highly populated but the population is concentrated, meanwhile in areas such as Maluku the population is spread in a vast area. This means medical facility dispersion for the needs of health service must be dealt with according to the condition of each area.

Because of these obstacles, some difficulties in health services are still found such as medicine availability management. A common problem is medicines covered by BPJS Health are not available so patients must buy a different medicine and spend additional cost. The medicine availability management is admitted by informants to be influenced by the budgeting and procurement systems, especially in public hospitals which have to procure medicines at the beginning of the budget year. Therefore, when the medicine is out of stock, it can only be procured during the next budgeting period. From the in-depth interview with an employee of a health service hospital, it was found that the management of the hospital was hindered by an external factor which was the unavailability of medicine in LKPP (Lembaga Kebijakan Pengadaan Barang dan Jasa Pemerintah, Government Goods and Service Procurement Policy Institution) and the limitation of budget for health service hospitals.

Another challenge in in-patient service is limited availability of beds in hospitals. This condition shows that an increase in the number of in-patient patients is not necessarily followed by the addition of beds. Data from the Indonesian Health Profile of 2015 showed that the ratio for available beds in the province of Maluku is 1.43. This is lower than the ratio in South Sulawesi, which is 1.51. However these two provinces have a higher ratio compared to the national average, which is only 1.21 (BPJS Kesehatan, 2016). Therefore, in relation to the availability of beds, other than having a high ratio number, the quality of service must also be considered so the value of utilization will increase.
The Role of the Executing Institution in JKN Implementation

The implementation of JKN involves national institutions (Ministry of Health, BPJS Health) and local institutions (Local Government, Health Service, local BPJS Health). This study found that local government has a role in the implementation of JKN and increasing number of participants. Local government has a role mainly in the integration of Jamkesda (regional healthcare). Local government through Health Service also has a role in supporting and overseeing the implementation of JKN in relation to the referral system. In the execution of the referral system policy, there are some difficulties faced by the local government in relation to overlapping policies between local policies and central government policies. Through Health Service, the local government also has an important role in increasing the quality of health service and in socialization programs. BPJS Health and Health Service have a significant role in increasing the transfer of information from JKN policy to concrete implementation that can be understood by the public. Socialization programs are an example of an effort done to increase the clarity of goals and systems of JKN. In addition, another role that is also determined by Local Government, among others, is optimum health spending allocation in the region, which is a minimum of 10% of the total local budget (APBD). Local government is also responsible in setting up complaint channels and regulations which can oversee violations in the execution of JKN in order to improve the quality of service and ensure that there is no discrimination. In responding the inequality of medical workforce, the innovation of local government in determining additional efforts so public services can be accessed has a key role so a high quality resource is obtained in terms of skills and expertise.

Local government and medical facilities are the frontrunners of service which have key roles in the implementation of JKN, especially in in-patient service both in public and private hospitals. The commitment of local government is very dominant in supporting the increase of participation both through integration of Jamkesda and socialization of JKN in the region. This shows that local government, medical facilities and medical workforce not only have a duty as policy executors, which has a clear mandate from the central government, but are also expected to commit in giving the best service in order to successfully implement JKN policy. Elmore (1978) stated that effective policy implementation is determined not only by clear policy goals but also the performance standard of the sub unit (local government) and also by having an element of control which keeps up with the achievement of the policy goals. Different levels of government should participate in the implementation because they are the units responsible. Implementation of a policy is a series of execution carried out by responsible institution or organization (Jann & Wegrich, 2006). Government (in the national, regional, and local level) is the main institution which is responsible for developing national health policy (Navarro, 2007). Cooperation between levels of government is considered crucial to ensure social service execution in the local level (Fossati, 2016).

In addition, local government is also a governmental organization which is experienced in implementing healthcare after the era of decentralization and has the authority in health. Local government

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is an institution which has a historical record in implementing healthcare long before JKN was implemented, for example Jembrana, which is often mentioned as an area which has Jamkesda called *Jaminan Kesehatan Jembrana* (Jembrana Healthcare, JKJ) which provides healthcare for all citizens since 2003 (Aspinall, 2014) (Rosser, Wilson, & Sulistiyanto, 2011). With the development of JKN, Jamkesda, which was previously managed by the local government, is now integrated into the JKN system by giving an opportunity to the local government for cost sharing. At the beginning of the JKN transformation, Jamkesda had a role in covering the gap of people who were not covered by JKN, usually the middle class (not poor, non PNS (public servants), and not able to finance their own healthcare) or also called ‘missing middle’ (Sparrow, Budiati, Yumna, Warda, Suryahadi, & Bedi, 2017).

**Critical Review of Edwards III’s Top-down Policy Theory in the Implementation of JKN Policy for In-patient Utilization in Indonesia**

The findings of this study show that Edwards III’s theory in policy implementation has not fully covered the real condition in the study area. This is in line with Matland’s critic that a construction of a list of variables is not merely enough. Theorists also need specify the condition where the variables are important and the reason why those variables are important in a different setting (Matland, 1995).

Analysis of policy implementation is viewed through Edwards III’s theory, which considers four aspects, which are communication, bureaucratic structure, disposition and resources. The findings on the field in terms of bureaucratic structure is that synchronization of JKN implementation is needed between central and local government, especially in setting necessary derivative policies. Variable analysis that influence the implementation of JKN, especially for in-patient service at public and private hospitals, shows that the variables offered by Edwards III do not fully cover the condition of JKN policy implementation in Indonesia. First of all, Edwards III viewed policy implementation through a top-down perspective. This perspective does not cover the role of direct service to society which is performed by doctors, BPJS officers, and other medical workforce at the grassroots level of bureaucrats. This is in line with the critic towards policy implementation theories with a top-down perspective as iterated by Lipsky (1971) that a bottom-up analysis approach to policy implementation is needed. The significant influence of front line staff or grassroots level of bureaucrats needs to be considered in public service when discussing the execution of policy implementation (Lipsky, 1971).

Local government’s commitment, medical facilities, and medical workforce show that there is a political process that is not just administrative in policy implementation. A top-down implementation theory views policy implementation only as an administrative process without any regard to political aspects or efforts to overcome those political obstacles (Berman, 1978). Here, political aspect is a process that is carried out by local government in implementing the policy, which is usually influenced by the commitment...
of the leader and other necessary decisions so that policy implementation will be successful, for example the commitment to integrate Jamkesda, the initiative for budget allocation, forming an executive team, and so on. The implementation of JKN in in-patient service at public and private hospitals in Indonesia shows that this policy must have political support in order to achieve UHC target in 2019.

Other evidence strengthens that the top-down policy perspective of Edwards III’s theory must also be supported by the lower levels of executive institutions or grassroots level of bureaucrats. This shows that the perspective of top-down policy must also be complemented with a bottom-up perspective, especially for countries with a decentralized system like Indonesia, because the local government has the authority to decide health services issues. This is reflected in local and gubernatorial regulations in the field of health service and healthcare as derivative regulations of UU SJSN and UU BPJS in Indonesia, and also supported by Regulation in Local Government in 1999. Several local governments already have local healthcare systems which flourish during the implementation of JKN. That is why it is important to consider bottom-up perspective as an effort to integrate local healthcare system into the JKN system.

Bottom-up perspective shows that in a policy there must be an understanding of the role of grassroots level bureaucrats as officials who have control in the implementation process. In policy implementation, grassroots level bureaucrats are actors who interact directly with the people. Empirical evidence shows that in the implementation process, every public official who execute the policy will do it according to the regulations of the executing institution and their own personal characteristics (Hill & Hupe, 2002). A gap between the policy maker and the official who executes the policy can hinder the implementation of this policy. This study also finds that there are variables that are not covered in the top-down perspective, but can be highlighted in the bottom-up perspective, including organizations other than the executing organization (not the government). A variable found in this research but is not included in Edwards III’s theory of policy implementation is people’s participation or gotong-royong (cooperation) which is a principle of JKN policy. Gotong-royong is the principle of SJSN execution according the mandate in Regulation Number 40 of 2004 and Regulation Number 24 of 2011. Gotong-royong is a principle of togetherness among participants in bearing the cost of social security with the obligation of paying the premium according to their level of income. This condition enables people who are healthy to subsidize for people who are sick, the rich helps the poor.

Gotong-royong is in line with previous researches that said that other than grassroots level bureaucrats, other factors such as organizational implementation machinery, or in this case community organization network, can highly determine the implementation of policy (Lynn, Heinrich, and Hill 2000). This is proven by a trend of gotong-royong of a variety of stake holders in health financing. One example is an effort done by BPJS to cooperate with BAZNAS (Badan Amil Zakat Nasional, National Tithing Organization) in giving opportunity to the well-off who wants to help by donating premium to the less fortunate or the poor. The target of this program is non PBI class 3 benefit recipients who have not yet paid
of their premium for at least 3 months and are participants of PBPU category (*Peserta Bukan Penerima Upah*, participants who are not paid for by the government). BAZNAS is an official body that was established after Presidential Decree Number 8 of 2001 with the task and function of gathering and distributing *zakat, infaq*, and *sedakah* (Muslim tithing and charity) at the national level ((BAZNAS), 2017). In this case, the principle of *gotong-royong* which is based on religious values in the community can be the determinant of the success of the implementation of JKN program in Indonesia. This finding is in line with the development of the concept of government to governance. Governance emphasizes more on the role of the people both individually and as an organization in various forms in the entire process of policy from the formation until the evaluation (Brikenhoff & Johnson, 2008). That is why it is important to not only consider the government but also non-governmental actors and their interaction with the government in the process of policy implementation (Frishtak, 1994).

Cooperation (*gotong-royong*) *is not only needed* in financing, but it also needed among the stakeholders in implementing JKN. The active role of medical workforce, medical facilities, central government, local government, businesses, and public figures are highly needed in the implementation of JKN. Research results in South Sulawesi and Maluku shows that the active role of stakeholders is an important determinant in supporting policy implementation. This can be seen in the effort of socialization of JKN program which is mainly done by Health Service in cooperation with BPJS Health in South Sulawesi in delivering JKN programs.

The findings in Maluku also show that the role of non-governmental/private sector is helpful in driving the success of this program. One of the efforts done by the private sector, in cooperation with Maluku Province Local Government, is giving out scholarships to medical workforce from the region so they can work in the medical facilities built in Maluku. This can help support the effort to increase the number of medical workforce availability which is limited in that area. This active participation is also seen from the increasing number of medical facilities both public and private which are registered as partners of BPJS Health to admit JKN patients. Up to May 2017, with the number of JKN-KIS participants of 177 million lives, BPJS Health also has cooperated with about 26,000 medical facilities, both First Degree Medical Facilities (Health Centers, Pratama Clinics, Private Practice, and so on) and Advanced Referral Medical Facilities (Hospital, Pharmacy, Optician, and so on) which are spread all across Indonesia.

Participation both in Maluku and South Sulawesi shows that social organizations, religion-based social organizations, and private sectors are highly needed in supporting JKN policy. Active participation from the public is not limited to not only creating the policy but also in the implementation stage and this shows the degree of citizen power (Antoft & Novak, 1998) (Arnstein, 1969). The participation is not only in an active role in finding information but also in contributing (McGee & Norton, 2000).
4. Conclusion

This research found that driving factors influencing in-patient utilization in JKN implementation are easier access in obtaining health care and medical facilities, the increase of JKN participant number, South Sulawesi being the destination for medical facility referral in East Indonesia, the growing number of medical facilities, no significant geographical challenges, and commitment support from the local government. Meanwhile, the main obstacles that can affect the implementation are due to geographical challenge, disparity of health workers, and lack of adequate health service facilities.

Based on the critical review of Edwards III’s theory, it can be concluded that in the implementation of JKN policy, the perspective of a top-down policy in the theory cannot be applied singularly and the perspective of a bottom-up policy must also be considered. JKN policy in Indonesia is an example of a policy that combines the two perspectives by emphasizing on the factor of local wisdom in the form of cooperation (gotong-royong principle) in the execution. Therefore, in the implementation of a policy, especially one that requires the involvement of the society in a large population, additional variables needs to be considered, in this case the variable of gotong-royong which is not covered in Edwards III’s theory. The principle of gotong-royong in JKN is implemented in the aspect of financing, socialization, and health service which shows increasing trend of the public’s participation in supporting the success of this policy. This is proven by the increased number of JKN participants from 121 million at the beginning of the implementation in 2014 to 177.5 million in May 2017 from the total target of 250 million, which will be achieved in 2019 (Universal Health Coverage/UHC).

Authors Contribution

The first authors had made substantial contributions to conception, design, data collection, analysis and interpretation of data; drafting the article, revising it critically for important intellectual content; and final approval of the version to be published. The second, third, fourth and fifth author had given substantial advice to the first author in developing concept, methodology, data collection, and discussion of the content.

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References


