Contributory factors the poor unable to access the National Health Protection: A case study in Waingapu, Sumba Timur District, Indonesia

[1*)]Baiq Dewi Harnani, Yohanes K. Windi [2*)], Asnani [3]
[1,2,3] Poltekkes Kemenkes Surabaya
[*)] Corresponding Author: baiqdewihr@yahoo.co.id

ABSTRACT

Background and Purpose: Regardless of the significant coverage of the poor by the National Health Protection of Indonesia (NHPS), hundreds of thousands still need access to membership and free health care. The study investigates the underlying factor making the poor cast away from the NHPI, especially in Waingapu, Sumba Timur, Indonesia.

Methods: We use a qualitative approach to identify the contributing factors to why NHPI is inaccessible for some populations. A total of 30 residents of Waingapu who attend healthcare in two hospitals and five Community Health Centers were recruited using convenience technic. Twenty residents participated in the semi-structured interview, while ten engaged in casual conversations. We also interviewed three heads of community groups and three health cadres, for comparative information. Questions have been developed to guide the interviews and casual conversation. The interviews were audio-taped and transcribed while intensive note-taking occurred during the informal discussion or narrated the conversation immediately after the talks ended. The information was inductive, analyzed and coded to produce common information among the participants.

Results: The data analysis reveals the factors that contributed to the failure of the resident to enrol in the NHPI, such as lack of information about the registration, poor socialization of the program, the ignorance of village officers, unaffordability, and confusion about the parties responsible for the registration.

Conclusion: The study concludes that poor people are still vulnerable to access free coverage and healthcare from the NHPI. The stakeholders of the NHPI, especially the local management of NHPI and local government, need to educate the commoners about the mechanism, benefits, and contribution to the NHPI to ensure equity and equality in accessing quality healthcare.

Keywords: Poor people, access, National Health Protection

INTRODUCTION

The World Health Organization (WHO) campaigns for implementing Universal Health Coverage (UHC). The UHC aims to ensure the access of the whole population of a country to the full range of essential and quality healthcare needed and avoid financial catastrophe when seeking medication.[1] UHC is the answer for people in Low-Income Countries (LICs) and Lower-Middle Developing Countries (LMICs) to access affordable and quality healthcare. The governments must provide free health protection and improve access to quality, equality and equity healthcare.[2] Poverty is strongly associated with poor health, and medical cost draw the poor deeply to poverty.[3–6]

Therefore, governments are responsible for reducing the gap between the poor and well-off populations in accessing quality health care.

In the Indonesian context, the progress of UHC is significant [7], especially when the National Health Protection of Indonesia is officially introduced in 2104 as a measure to achieve UHC.[8] The NHPI is a substantial achievement of Indonesia in protecting the population[9], especially the low-income population. Currently, the BPJS-Kesehatan (the organizing management of NHPI) claims that 247.7 out of 276 million of the people have been enrolled as a member, and 151.7 out of 247.7 million are the Recipients of Premium Assistance (RPA) subsidized by the government[10]. The government pays the monthly plan of the RPA while the rest of the population (Non-RPA) is fully paid or partly subsidized by their employers).

Indonesia's poor and low-income groups reach 26.2 million (9.5%) of the country's total population.[11] The coverage of RPA in NHPI is 5.8 five times bigger than the country's poor population. The figures reflect that all poor people have yet to enrol in the RPA scheme and have access to healthcare. However, it needs to be clarified to what extent the poor are fully registered in RPA. Validation of the poor is weak, making this population vulnerable to being cast away from the scheme. For example, the waste pickers in Surabaya, as the representation of the urban poor group counted as 20%, were left behind from the RPA membership[12]. The Ministry of Human Research, Development and Culture reports that 10.8 million impoverished people need RPA scheme access.[13] Furthermore, 28.3% urban poor has not covered by NHP [14]

The remaining question is why and what factors hampering the people, especially the poor groups, from accessing the membership of health protection from the government. The poor cannot access health protection due to the plan's cost, and free health protection does not reach the poor.[15,16] In the case of Indonesia, this study attempts to identify the contributing factors making millions of people fail to enrol in the NHPI. We take Waingapu, the District of Sumba Timur, Nusa Tenggara Timur Province, as the research site based on some considerations, such as being classified as poor district, limited access to social welfare benefits, and being geographically far from the centre of government. The percentage of the poor population in the district is 31% from 252,704 people in 2017 [17]. The RPA paid through the annual budgeting plan of Sumba Timur District reaches 44,429 people, or only 17.6% of the district's population.[18] The statistics reflect the vulnerability of poor people in the district to access the NHP program.

Besides the financial capacity of the district to enrol its resident on NHPI, we argue that underlying factors contribute to thousands of poor people in the district being unable to access this social health plan. The study, therefore, investigates the underpinning factors that contribute to the failure of the poor residents of the Sumba Timur to unenroll in the NHP scheme. The study is vital for all stakeholders in the district to mitigate the factors and take necessary actions to improve the coverage of NHP for the poor in need.

METHODS

The study adopts a qualitative inquiry involving 30 Waingapu, Sumba Timur District residents. Using convenience procedure, we recruited the respondents attending healthcare in two hospitals and five Community Health Centers. Three heads of

community groups, including three health cadre, also participated in the interview. We collected data using semi-structured interviews and casual conversations. We approached potential respondents, and explained who we were, the aim of the study, and the nature of their involvement. A plain language statement is provided, orally presented to the respondents, and requesting their consent as proof of participation. We convinced the protect the privacy of the respondents and only appear in pseudonyms in any publication. We also asked permission to audio-tape the interviews while intensive note-taking occurred during casual conversation. The information was transcribed and narrated. We performed inductive analyzed, coded, and determined the themes.

The project has passed the Ethical Clearance issued by the Research Ethics Commission of Poltekkes Kemenkes Surabaya, with project No: EA/828/KEPK-Poltekkes_Sby/V/2022, on 18 March 2022. Before the data collection, the researchers proposed and obtained permission from the Political and Community Protection Board of both NTT Province and the District of Sumba Timur to collect the data.

RESULTS AND DISCUSSION

The qualitative data analysis identifies some factors making people, especially the poor, unable to enrol in the NHP program. Lack of information due to poor socialization of NHP, the cost of health plan, and unrecognition of the government officials responsible for the registration are identifiable factors related to failure to enrol on the scheme.

Unclear RPA enrolment process

The residents must enrol for the NHP membership regardless of whether they are classified as RPA or Non-RPA. Some interviews show that possibility of the residents (especially the RPA groups) being left behind from the NHP membership is identifiable. Being unfamiliar with the enrollment mechanism leaves the residents without health protection. The following conversation reveals the situation.

Interviewer	:	*Did you have this card?? (Showing di NHP card membership*
Umbu HPP	:	*No, I don't have one*
Interviewer	:	*Why? You can use this card for free medication*
Umbu HPP	:	*I still need the card. Some of the neighbours have the card. They said that cards should be taken when going to Puskesmas.*
Interviewer	:	*Why don't you apply for the card? It is free for people like you*
Umbu HPP	:	*I need to learn how to apply for the card. When I asked my neighbours, they told me that they got the card from the head of the community group (Ketua RT)*
Interviewer	:	*So, they did not apply for the card?*
Umbu HPP	:	*No……the Ketua RT handed them the card, told them to keep the card in a secure place and bring the card when attending health care in Puskesmas*
Interviewer	:	*Did you ask the health cadre or Pak RT (The Head of the Community group)??*
Umbu HPP	:	*I did; they just asked me to wait…….until now, I have had no*

answer from them

The conversation above clearly exposes the risk of poor people fail to receive the membership of RPA to access free health care. The mechanism of enrollment of residents needs to be better understood. According to the Regulation of the Ministry of Social Welfare No. 21/2019, poor people may access the RPA membership if they are registered on the Integrated List of Social Welfare (ILSW) in the Social Welfare Department (SWD) [19] The village office register the RPA candidate to the SWD and forwards the list to the head of district, governor, and the Ministry of Social Welfare. Upon the approval of the Ministry of Social Welfare, the applicant will be considered as the RPA.

The remaining problem is to what extent the number of ILSW is adequately validated. It seems the registration is complicated and time-consuming, making the risk of poor people unregistered in social safety net programs, including RPA [20,21]. Lack of knowledge of NHP, its benefits, and the mechanism to register lower the coverage of NHP among poor-informal workers in rural areas [22,23]. The low enrollment of social health insurance due to poor knowledge about the health protection program also occurs worldwide, such as Uganda [24], literacy level influences enrol health plans in Ghana [25],

Poor socialization of NHP

The introduction of new programs leads to intrigue and retention in society, especially when the policy is not believed as a pro-poor program [26] Likewise, the introduction of NHP in Indonesia faced challenges, political intervention, and retention from some religious leaders [27]. Poor information about the enrollment mechanism and benefits reflect the program's poor socialization. A conversation with some respondents revealed that:

> *I have never been involved in any socialization of the NHP. Not from the village office, the health department, or even the local management of NHP. The head of the kampong reminds us to bring the membership card when seeking medication. I even need to find out how I got the card while some of my neighbours do not get the card as mine. (Rambu KDD, 46 years old woman).*

A health cadre described that socialization of NHP was absent. She claimed:

> *The village officer handed me NHP cards and asked me to distribute them to the people in my working area. I told the recipient to securely store the card and take it with them when visiting health facilities. That is all information I can share with the residents. When some people came and asked about the procedure to obtain the card, I couldn't satisfy their request. As a cadre, I have never been involved in the socialization of the NHP. I initiated to ask the village officers I also failed to get the information as they told me they obtained the card from social welfare without detailed information* (Rambu TN, health cadre, 33 years old)

The statement above implies the importance of the socialization of the NHP program to the community. Lack of information prevents the resident from enrolling on the scheme. Promotion is an effective and efficient way to achieve maximum outcomes and participation in a health protection program. There is a strong association between socialization and awareness of enrolling for NHP membership and payment for the premium [28–30] Socialization of NHP only limited to becoming a member of the scheme without further detail description of the program [31]

Poor support and coordination of NHP stakeholders

The enrollment of poor people in NHP depends on the verification of the Ministry of Social Welfare based on the data provided by the local Social Welfare Department and the village office. The problem occurs when no work guideline is provided for the lower village officers about enrollment. It is complicated when residents expect the village officers to be knowledgeable about the enrollment registration mechanism when these officers need to be equipped with such knowledge.

> *The head of the community group does not know precisely the requirements for enrollment of poor people like me. We hope they can explain to us how is the registration process so we can try to do it by ourselves. But they need to give us information. Who else do we rely on?* (Rambu Hn, 47 years old woman)

To confirm the residents' complaints, we interviewed one of the heads of the community group and a health cadre. The conversation implies that information regarding the registration, benefits and responsibility of the RPA is limited. The previous head of the community group explained:

> *The village office only required us to identify the poor people in our working area. We sent almost all the residents to my area because we thought they were poor. Unfortunately, only some proposed residents get membership cards from the NHP. Honestly, we know who is needy and eligible for the program. In reality, many of them do not get the card. The village office staff needed to explain why and how to re-enrol those people. They just told us to wait*. (Umbu KLW, 68 years old)

Furthermore, a specific case described a health cadre in that they found NHP cards dumped in front of the village office after the big flood hit the village in 2021. Hundreds of the cards belong to the residents in her working area. She explained that.

> *Indeed, many residents asked me about the NHP membership. I am still trying to figure out what I should explain to them. So far, we got the membership cards from the village office staff, who asked me to distribute them. But only some of the poor people in my area called the card. Sadly, when the big flood hit the city in 2021, we found that hundreds of NHP cards were dumped because of getting wet in flood. When I sorted the cards, I found some cards belonging to the*

residents in my area. When I asked the village office staff, they explained that there was an instruction to distribute the card once the flood struck the city ((Rambu TN, a health cadre, 33 years old).

The remarks above clearly described the poor support of the village office staff or any other stakeholder regarding the registration and distribution of the NHP membership cards. The coordination among NHP stakeholders (Village office staff, Social Welfare Department, District Health Department, and local management of NHP) is least optimum [32]. Besides poor coordination, service management, the attitude of stakeholders, and limited human resources in lower-level government are impediments to the NHP implementation [33]. Thus, limited supports, poor coordination, and behaviours of stakeholders become identifiable burdens for the poor to access free health care under the protection of what is called pro-poor NHP.

The unaffordability of the health plan

The NHP is a pro-poor social health insurance subsidized by the government. The government claims that the number of the RPA exceeds the percentage of the country's poor population, but it is undeniable that millions of this group are unable to access the scheme due to weak validation of the poor [13,14]. Becoming a full-paying patient is the only way for them to access health care. Unfortunately, the monthly payment is unaffordable for these penniless people. They claimed:

I am still determining when I will get the card for free medication. Sickness can come anytime without warning us. Buying the membership is the only option. The problem is how far I can pay the premium every month. Once, I paid the plan only a couple of months and then my membership was suspended as I could not afford to continue the payment, especially during the Covid-19. Live becomes complex and paying the monthly premium is not our priority (Umbu LUT, 49 years old man)

A villager, Umbu TKG (53 years old man), a traditional hand-weaving textile in Prailiu Village, explained his difficulties in pursuing the monthly premium of NHP. The villagers are primarily traditional textile crafters, heavily depending on the tourist who visits and buys their clothes. When the Covid-19 Pandemic hit Indonesia, any means of transportation to and from the city were suspended; therefore, no domestic and international tourists visited the village. He said:

I have six people in my house, including my mother-in-law. Even though the premium is not expensive, the accumulation is a problem for me. I have no permanent job and rely on selling this ***kain tenun*** *(hand-weaving textiles). It is difficult during the Covid-19 Pandemic. There are only a few tourists have visited our gallery until now. We cannot afford to pay the premium. Providing food for my family is far more important than spending the protection plan. Sadly, the selling of* ***Kain Tenun*** *differs from what we sell in grocery stores. It is*

collectable items that need a unique buyer. Only some tourists are collectors but only interested in visiting this old-traditional village, how we make the clothes, and any other traditional customs. It is hard to sell clothes in a normal situation. So, you can imagine our condition during this Pandemic.

To what extent all the poor population of Indonesia access free health care under the protection of NHP is still an issue. The risk of the poor being excluded from the scheme remains high [13,14] Consequently, buying a health plan or living without health protection are the only options. Unfortunately, purchasing capability of the poor is low, especially during the Covid-19 Pandemic, needing adjustment of premium payment [34] The remarks above imply that the risk of poor people purchasing the health plan is high and risk their access to essential health care, especially during the Covid-19 Pandemic.
The absence of health protection pushes the poor to pay the cost of their health care, and risking them falling deeply into poverty is conspicuous. [35] Equality and equity to access affordable health care are at risk as not all populations, especially the disadvantaged groups. If the medical care cost widens the gap between the poor and economically advantaged population, the absence of free healthcare will aggravate the poor and risk their health status and well-being.

CONCLUSIONS

Poor groups, especially in rural areas, are still vulnerable to enrolling in the free health care covered by the NHP. Bureaucracy procedure, multi-stage enrollment, and validation process of the RPA are complicated and time-consuming—the poor need to be better informed regarding the enrollment procedure, requirements, and benefits of NHP. The lack of information on NHP strongly associates with the poor socialization of the program. The risk of the flawed being cast away from the NHP relates to poor coordination between stakeholders of NHP and the unaffordability of the scheme. The study suggests the necessity to validate and equip the poor with an enrollment mechanism while promoting the benefits and responsibility of the RPA.

REFERENCES

1. WHO. Universal Health Coverage (UHC) [Internet]. WHO. 2019 [cited 2019 Mar 10]. Available from: https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)
2. Ranabhat CL, Jakovljevic M, Dhimal M, Kim CB. Structural Factors Responsible for Universal Health Coverage in Low- and Middle-Income Countries: Results From 118 Countries. Front Public Heal. 2020;7(January):1–8.
3. World Bank. Health and Poverty [Internet]. The World Bank. 2014 [cited 2022 Dec 21]. Available from: https://www.worldbank.org/en/topic/health/brief/poverty-health
4. Sirag A, Nor NM. Out-of-pocket health expenditure and poverty: Evidence from a dynamic panel threshold analysis. Healthc. 2021;9(5).
5. Purba IE, Purba P, Dakhi RA. Analysis Of Inhibiting Factors For The

Effectiveness Of Public Information Policy In The Services Of BPJS During The Covid-19 Pandemic At Puskesmas Kartini, Pematang Siantar City. Iqra J Perpust Dan Inf Vol 16 Nomor 2 Oktober 2022 [Internet]. 2022;16(2):252–64. Available from: http://apps.who.int/bookorders.
6. Meessen B, Van Damme W, Tashobya CK, Tibouti A. Poverty and user fees for public health care in low-income countries: lessons from Uganda and Cambodia. Lancet. 2006;368(9554):2253–7.
7. World Bank. World Bank Approves Support to Strengthen Health Insurance, Improve Quality of Health Care in Indonesia [Internet]. The World Bank. 2021 [cited 2023 Jan 3]. Available from: https://www.worldbank.org/en/news/press-release/2021/12/16/world-bank-approves-support-to-strengthen-health-insurance-improve-quality-of-health-care-in-indonesia
8. TNP2K. The Road to National Health Insurance (JKN). TNP2K. 2015.
9. Simmonds A, Hort K. Institutional analysis of Indonesia's proposed road map to universal health coverage'. Melbourne; 2013.
10. BPJS-Kesehatan H. Peserta Program JKN [Internet]. BPJS-Kesehatan. 2023 [cited 2023 Jan 21]. Available from: https://www.bpjs-kesehatan.go.id/bpjs/home
11. BPS. Persentase Penduduk Miskin Maret 2022 turun menjadi 9,54 persen [Internet]. Badan Pusat Statistik. 2022 [cited 2023 Jan 18]. Available from: https://www.bps.go.id/pressrelease/2022/07/15/1930/persentase-penduduk-miskin-maret-2022-turun-menjadi-9-54-persen.html
12. Windi YK. An Emerging Health Protection System and Its Coverage of a Vulnerable and Marginalised Population: The Waste Pickers of Surabaya, Indonesia. Monash University; 2018.
13. Adhi Wicaksono. 10,8 Juta Orang Miskin Ekstrem Belum Dapat Akses ke BPJS. CNN Indonesia [Internet]. 2021; Available from: https://www.cnnindonesia.com/ekonomi/20211021204845-532-710710/108-juta-orang-miskin-ekstrem-belum-dapat-akses-ke-bpjs
14. Laksono AD, Rukmini R, Tumaji T, Ipa M, Wulandari RD. National Health Insurance Membership among Urban Poor Societies in Indonesia in 2019: Are They Protected? Economies. 2022;10(8):1–9.
15. Kotoh AM, Van Der Geest S. Why are the poor less covered in Ghana's national health insurance? A critical analysis of policy and practice. Int J Equity Health [Internet]. 2016;15(1):1–11. Available from: http://dx.doi.org/10.1186/s12939-016-0320-1
16. Tolbert J, Drake P, Damico A. Key Facts about the Uninsured Population [Internet]. KFF. 2022 [cited 2023 Jan 21]. Available from: https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/
17. BPS Sumba Timur. Jumlah Penduduk (Jiwa), 2015-2017 [Internet]. BPS Sumba Timur. 2023 [cited 2023 Feb 2]. Available from: https://sumbatimurkab.bps.go.id/indicator/12/32/1/jumlah-penduduk.html
18. Hauteas J. Wow, Pemkab Sumba Timur Daftarkan 44.429 Warga jadi Peserta JKN-KIS. Victory News Sumba Timur [Internet]. 2022 Jul; Available from:

https://sumbatimur.victorynews.id/sumba-timur/pr-3433874663/wow-pemkab-sumba-timur-daftarkan-44429-warga-jadi-peserta-jkn-kis
19. Persyaratan Dan Tata Cara Perubahan Data Penerima Bantuan Iuran Jaminan Kesehatan. KEMENSOS [Internet]. Indonesia: KEMENSOS; 2019 p. 24. Available from: https://peraturan.bpk.go.id/Home/Details/129448/permensos-no-21-tahun-2019
20. Noer KU, Madewanti NLG. Too many Stages, Too Little Time: Bureaucratization and Potential Impasse in the Social Safety Net Program in Indonesia. J Stud Pemerintah. 2020;11(3):270–300.
21. Bambang Shergi Laksmono, Hartini Retnaningsih H. Operational Improvement On Data Validation And Verification Of Health Insurance Assistance Beneficiaries In Indonesia: An Overview Of Accountability/Governance Perspective. Psychol Educ J. 2021;58(1):2236–47.
22. Kurniawati W, Rachmayanti RD. Identifikasi Penyebab Rendahnya Kepesertaan JKN pada Pekerja Sektor Informal di Kawasan Pedesaan. J Adm Kesehat Indones. 2018;6(1):33.
23. Apriani L, Rumana NA. Karakteristik dan Pengetahuan Pasien tentang BPJS Kesehatan di Puskesmas Kecamatan Kebon Jeruk. J Penelit dan Pengemb Pelayanan Kesehat. 2019;2(3):191–7.
24. Basaza R, Criel B, Van Der Stuyft P. Low enrolment in Ugandan Community Health Insurance Schemes: Underlying causes and policy implications. BMC Health Serv Res. 2007;7.
25. Alesane A, Anang BT. Uptake of health insurance by the rural poor in Ghana: Determinants and implications for policy. Pan Afr Med J. 2018;31:1–10.
26. Dewi R. Studi Kasus Penolakan Publik Atas Kebijakan Publik [Case Study of Public Rejection of Public Policy]. Publikauma J Adm Publik Univ Medan Area. 2017;5(1):6.
27. Windi YK. An Emerging Health Protection System and Its Coverage of a Vulnerable and Marginalised Population: The Waste Pickers of Surabaya, Indonesia. Monash University; 2018.
28. Roesalya P. HUBUNGAN TERPAAN SOSIALISASI BPJS KESEHATAN DAN SIKAP MASYARAKAT PADA PROGRAM DENGAN KEPUTUSAN MASYARAKAT SEBAGAI PESERTA BPJS KESEHATAN. Diponegoro University; 2014.
29. Laili N. Hubungan Sosialisasi Program BPJS Terhadap Pemahaman Tentang Hak Peserta BPJS Kesehatan Di RSUD Syarifah Ambami Rato Ebu Bangkalan. DIA, J Adm Publik. 2014;12(1):27–38.
30. Sinamo M. The effect of socialization and business entity's understanding towards compliance and its impact on bpjs premium payment (at BPJS Kesehatan South Jakarta branch). Int J Soc Sci Humanit Res. 2018;6(2):329–36.
31. Fitriana EN, Probandari AN, Pamungkasari EP, Ardyanto TD, Puspitaningrum RA. The importance of socialization in achieving universal health coverage: case study of Jaminan Kesehatan Nasional (JKN) implementation in two different region in Central Java province. J Kedokt dan Kesehat Indones. 2019;10(2):110–

20.
32. Nuryani, Ghalib S, Jamaluddin. Implementation of the national health assurance program in North Barito District. Int J Polit Law, Soc Sci [Internet]. 2022;2(3):1–8. Available from: https://ijpls.org/index.php/IJPLS/article/view/1/19
33. Suhadi ., Maidin A, Palutturi S, Astuti E. The Effectiveness of National Health Insurance Membership Services at Social Security Agency Office in South-East Sulawesi Province. In: 4th Annual Meeting of the Indonesian Health Economics Association. 2017. p. 303–9.
34. Sembodo TH, Azzahra SN, Ramadhania SA. Dampak Pandemi COVID-19 terhadap Implementasi Jaminan Kesehatan Nasional di Indonesia. Researchgate. 2021;(December):1–11.
35. OXFAM. UNIVERSAL HEALTH COVERAGE: Why health insurance schemes are leaving the poor behind [Internet]. 2013. Available from: https://oxfamilibrary.openrepository.com/bitstream/handle/10546/302973/bp176-universal-health-coverage-091013-en .pdf;jsessionid=3438081AB7F6136E3C36A8EE255CD834?sequence=4