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The Principles of Justice in the Application of National Health Insurance Program for the Poor People in Indonesia

Abu Huraerah[1], Ellya Susilowati[2], Aep Rusmana[3], Nina Kurniasih[4], Umi Hani[5]

Abstract

Health insurance is a form of social protection in improving the quality of health in Indonesia. The purpose of the study is to describe the principles of justice in the application of National Health Insurance Program for the poor people in Indonesia. The method used is qualitative, while the data collection techniques used are in-depth interview, observation and document study. Data analysis steps consist of data reduction, data display and conclusion drawing/verification. Poor people who receive the national health insurance program (beneficiaries) on the implementation of the national health insurance recognize and feel that the national health insurance program is beneficial. However, the quality of health services still does not meet their expectations, such as the length of treatment and there are differences in the service system between participants of the Social Security Administering Body for Health and general patients. Patients of the Social Security Administering Body for Health there are restrictions on the number of patients, while for general patients there are no restrictions on the number of outpatients in hospitals. Procedurally, there are still many poor people who have not been recorded, so they do not have access to health services. Socially, there is still a person bias, the poor do not get the right to health insurance, while the non-poor gets the right to health insurance. Politically, there is the provision of access for people who are close to the power elite at the grass root level to obtain health services. It is necessary to develop creative ideas and rapid actions to build a health service innovation system in hospitals and other health services. This should be done to improve the quality of health services.

Keywords: *principles of justice, health insurance program, poor people, social protection, health services.*

Introduction

Since January 2014, the National Health Insurance has been held with the aim of guaranteeing citizens to obtain health care benefits and protection in meeting their basic health needs. The implementation of the National Health Insurance is one part of the national social security system mandated by Law Number 40 of 2004 concerning the National Social Security System and Law Number 24 of 2011 concerning the Social Security Administering Body. The National Health Insurance is organized by the Social Security Administering Body for Health, which is a transformation of PT Askes (Persero). All residents, including foreigners who have worked for at least six months in Indonesia, are required to participate in this health insurance program. In 2019, it is targeted that the

[1] Social Welfare Department, Faculty of Social and Political Sciences, Pasundan University, Bandung, Indonesia
[2] Bandung Polythechnic of Social Welfare, Indonesia
[3] Bandung Polythechnic of Social Welfare, Indonesia
[4] Social Welfare Department, Faculty of Social and Political Sciences, Pasundan University, Bandung, Indonesia
[5] Social Welfare Department, Faculty of Social and Political Sciences, Pasundan University, Bandung, Indonesia

entire population of Indonesia has entered the health insurance system (universal health coverage).

In Indonesia itself, the pillars of the social security system were strengthened through the enactment of Law Number 40 of 2004 concerning concerning the National Social Security System. Through this law, Indonesia is mandated to have a social security system that can guarantee the fulfillment of basic needs for a decent life for every resident of the social security program. Law Number 40 of 2004 concerning concerning the National Social Security System was again strengthened by the issuance of Law Number 24 of 2011 concerning the Social Security Administering Body for Health. The law describes in more detail the implementation of the social security system in Indonesia, which consists of the social security program in the health sector and the social security program in the employment sector (Supriyanto, Ramdhani, & Rahmadan, 2014).

Health insurance provided by various implementing bodies prior to the social security system era had different coverage of benefit packages. There is a health insurance system that only covers curative services in primary health facilities, to a more comprehensive health insurance covering promotive, preventive, curative and rehabilitative health services. This condition has not met the equity principle as mandated by Law Number 40 of 2004 concerning the social security system. The different benefit packages need to be improved so that health insurance participants can have the same opportunity to obtain services according to their medical conditions.

The coverage of the benefits of the current health insurance system is illustrated by Law Number 40 of 2004 concerning the social security system. Health services that must be guaranteed are all services that according to medical personnel are necessary for health insurance participants. The benefits that participants can get include promotive, preventive, curative and rehabilitative services. Early detection checks for certain diseases can be given periodically to participants who meet the requirements and are adjusted to the Social Security Administering Body for Health benefit package. The health insurance benefit package must be adequate and in accordance with service standards, so that participant satisfaction is maintained and the payment of contributions by participants can also be fulfilled regularly. Differences in the amount of contributions also occur in the health insurance system that was previously organized by various organizing bodies. This can result in differences in the coverage and quality of health services that can be obtained by health insurance participants. Based on Law Number 40 of 2004 concerning the National Social Security System, health insurance contributions must be borne jointly by employers and job recipients. Contribution assistance is also provided by the government to the poor and underprivileged (Supriyanto, Ramdhani, & Rahmadan, 2014).

Theoretically, this research is useful for adding new perspectives on dimensions of justice in the implementation of Indonesia's national health insurance. Dimensions of justice touches political, legal, economic, social, and cultural. Politically, related to the political interests of the power elite. Legally, it is in contact with statutory regulations which are the reference/reference in regulating the implementation of national health insurance. Economically, it relates to the financing and sustainability of the national health insurance program. Socially, it touches the dimension of protection for the poor. Culturally, it is related to the bureaucratic culture of the apparatus or health workers. Meanwhile, practically, this research becomes a reference for policy makers to purposes of establishing social protection policies in the health sector for the poor in their assigned areas. It is also hoped that the Regional Government, especially the Regional Government of the city of Bandung, West Java Province, Indonesia can study social protection policies in the health sector for the poor.

Purpose of the Study

Purpose of the study is to describe the principles of justice in the application of National Health Insurance Program for the poor people in Indonesia.

Poverty in Indonesia

Indonesia's Statistics Central Agency has reported that poverty rate in the country declined to 9.54 percent in March 2022 and cited the economic recovery program as one of the main driving factors. According to Indonesia's Statistics Central Agency, the rate in March dropped by 0.17 percent and 0.60 percent compared to the figure in September and March 2021, respectively. Economic recovery in the first quarter of 2022 impacted the declining poverty rate. According to the Agency, the number of citizens who live in poverty in March this year was recorded at 26.16 million people, or decreasing by 340,000 compared to September 2021 and 1.3 million compared to May 2021 (Statistics Indonesia, 2022).

In September 2021, the poverty rate was at 9.71 percent with 26.5 million Indonesians lived in poverty. Indonesia's poverty rate has yet to return to pre-pandemic level which was at 9.41 percent in March 2019 and 9.22 percent in September 2019. Furthermore, Indonesia's Statistics Central Agency also reported that poverty reduction is happening faster in rural than in urban areas. In March 2022, poverty rate in urban areas declined from 7.60 percent to 7.50 percent while in rural areas the figure declined from 12.53 percent to 12.29 percent. However, the head of Indonesia's Statistics Central Agency also reminded that poverty in rural areas in Indonesia remains significantly higher than in urban areas (Statistics Indonesia, 2022).

Table 1 Number and Percentage of Poor People by Province, 2020 and 2021

Province	2020		2021	2020		2021
	September	March	September	September	March	September
(1)	(2)	(3)	(3)	(4)	(5)	(6)
Aceh	833,91	834,24	850,26	15,43	15,33	15,53
Sumatera Utara	1 356,72	1 343,86	1 273,07	9,14	9,01	8,49
Sumatera Barat	364,79	370,67	339,93	6,56	6,63	6,04
Riau	491,22	500,81	496,66	7,04	7,12	7,00
Jambi	288,10	293,86	279,86	7,97	8,09	7,67
Sumatera Selatan	1 119,65	1 113,76	1 116,61	12,98	12,84	12,79
Bengkulu	306,00	306,00	291,79	15,30	15,22	14,43
Lampung	1 091,14	1 083,93	1 007,02	12,76	12,62	11,67
Kepulauan Bangka Belitung	72,05	72,71	69,70	4,89	4,90	4,67
Kepulauan Riau	142,61	144,46	137,75	6,13	6,12	5,75
DKI Jakarta	496,84	501,92	498,29	4,69	4,72	4,67
Jawa Barat	4 188,52	4 195,34	4 004,86	8,43	8,40	7,97
Jawa Tengah	4 119,93	4 109,75	3 934,01	11,84	11,79	11,25
DI Yogyakarta	503,14	506,45	474,49	12,80	12,80	11,91
Jawa Timur	4 585,97	4 572,73	4 259,60	11,46	11,40	10,59

Banten	857,64	867,23	852,28	6,63	6,66	6,50
Bali	196,92	201,97	211,46	4,45	4,53	4,72
Nusa Tenggara Barat	746,04	746,66	735,30	14,23	14,14	13,83
Nusa Tenggara Timur	1 173,53	1 169,31	1 146,28	21,21	20,99	20,44
Kalimantan Barat	370,71	367,89	354,00	7,24	7,15	6,84
Kalimantan Tengah	141,78	140,04	141,03	5,26	5,16	5,16
Kalimantan Selatan	206,92	208,11	197,76	4,83	4,83	4,56
Kalimantan Timur	243,99	241,77	233,13	6,64	6,54	6,27
Kalimantan Utara	52,70	52,86	49,49	7,41	7,36	6,83
Sulawesi Utara	195,85	196,35	186,55	7,78	7,77	7,36
Sulawesi Tengah	403,74	404,44	381,21	13,06	13,00	12,18
Sulawesi Selatan	800,24	784,98	765,46	8,99	8,78	8,53
Sulawesi Tenggara	317,32	318,70	323,26	11,69	11,66	11,74
Gorontalo	185,31	186,29	184,60	15,59	15,61	15,41
Sulawesi Barat	159,05	157,19	165,99	11,50	11,29	11,85
Maluku	322,40	321,81	294,97	17,99	17,87	16,30
Maluku Utara	87,52	87,16	81,18	6,97	6,89	6,38
Papua Barat	215,22	219,07	221,29	21,70	21,84	21,82
Papua	912,23	920,44	944,49	26,80	26,86	27,38
Indonesia	27 549,69	27 542,77	26 503,65	10,19	10,14	9,71

Source: Statistics Indonesia, National Socioeconomic Survey (2022)

The Theory of Justice

Justice is the primary virtue in social institutions, as is truth in systems of thought. A theory, however elegant and economical, must be rejected or revised if it is not true. Likewise laws and institutions, no matter how efficient and orderly, must be reformed or abolished if they are unjust. Everyone has an honor that is based on justice, so that even the whole society cannot cancel it. On this basis, justice denies that the loss of freedom for some can be justified by a greater gain for others (Rawls, 1999).

Rawls (1999) said that two principles of justice. First: each person is to have an equal right to the most extensive scheme of equal basic liberties compatible with a similar scheme of liberties for others. Second: social and economic inequalities are to be arranged so that they are both (a) reasonably expected to be to everyone's advantage, and (b) attached to positions and offices open to all. There are two ambiguous phrases in the second principle, namely "everyone's advantage" and "open to all."

Meanwhile, according to Iatridis (1994), although the exact meaning is still controversial and against consensus, social justice implies the relationship between people (civil society organizations) and the distribution of community resources on the basis of valid claims (distributive justice). Furthermore, Iatridis (1994) says that the center of the debate on social justice and equality is the difference between "natural" and civil, social or institutional resources of human differences. Then, firmly Iatridis (1994) says that natural or physical differences are determined by nature - age, health, body strength, quality of mind and soul. Social and political distinctions, including wealth, power, status,

discrimination, knowledge, and services of the welfare state, are legalized by public consent and are thus appropriate elements of social justice and equality.

Marshall (1950) defines citizenship as "full membership of society". According to Marshall (1950), citizenship is based on three elements: civil, political, and social as shown in the following table 3.

Table 3 Citizenship Rights

Citizenship Eelements	Definition	Institutions more closely associated
Civil rights	Rights necessary for individual freedom-liberty of the person, freedom of speech, thought and faith, the right to own proverty and to conclude valid contracts, and the right to justice.	Courts of justice
Political rights	Right to participate in the exercise of political power, as a member of a body invested with political authority or as an elector of the members of such a body.	Parliament and councils of local government.
Social rights	The right to a modicum of economic welfare and security.	Educational system and social services.

Sumber: Marshall (2005)

According to Marshall (1960) that civil rights are rights that are necessary for everyone's freedom, freedom of speech, thought and belief, the right to free oneself from poverty and the right to justice, political right is the right to participate in political power, as a member of an agency invested with political authority or as an elector of the members of such bodies and social right is the right to achieve economic prosperity and security.

Health Insurance Program for the Poor People

Law Number 40 of 2004 concerning the National Social Security System was established with the main consideration to provide comprehensive social security for all people. The law stipulates five types of social security programs: health insurance, work accident insurance, old age insurance, pension insurance and death insurance for the entire population. The participation of the social security program only covers a small part of the community, while the majority of the community has not received adequate social security.

Law number 40 of 2004 concerning the National Social Security System determines that the social security program implemented by several implementing agencies can gradually reach a wider membership, and provide better benefits for each participant. Through the implementation of the wider social security program, it is hoped that the entire population will be able to meet the basic needs of a decent life, including those who are classified as poor and needy.

Article 14 paragraph (1) of Law Number 40 of 2004 concerning the National Social Security System stipulates that, "The government will gradually register the recipients of contribution assistance as participants with the Social Security Administering Body". Then in article 17 paragraph (4) it is determined that, "Social security program contributions for the poor and people who cannot afford to be paid by the Government". In paragraph (5) it is determined that, "In the first stage, the contribution as referred to in paragraph (4) is paid by the Government for the health insurance program". Furthermore, in paragraph (6) it is determined that, "The provisions as referred to in paragraph (4) and paragraph (5) shall be further regulated by a Government Regulation".

Concept of Social Protection

What is Social Protection

Social protection refers to the public actions taken in response to levels of vulnerability, risk and deprivation which are deemed socially unacceptable within a given polity or society. Social protection thus deals with both the absolute deprivation and vulnerabilities of the poorest, and also with the need of the currently non-poor for security in the face of shocks and life-cycle events. The 'public' character of this response may be governmental or non-governmental, or may involve a combination of institutions from both sectors (Norton, Conway, & Foster, 2001).

Within the field of social protection, two general kinds of action are conventionally distinguished (Norton, Conway, Foster (2001):

1. Social assistance, which encompasses public actions which are designed to transfer resources to groups deemed eligible due to deprivation. Deprivation may be defined by low income, or in terms of other dimensions of poverty (e.g. social or nutritional status).

2. Social insurance is social security that is financed by contributions and based on the insurance principle: that is, individuals or households protect themselves against risk by combining to pool resources with a larger number of similarly exposed individuals or households.

The components of Social Protection

The policies and projects included in social protection can be thought of as involving five major kinds of activities, summarized below (ADB, 2003). Table 2 shows the target clientele for social protection.

(i) labor market policies and programs designed to facilitate employment and promote the efficient operation of labor markets;

(ii) social insurance programs to cushion the risks associated with unemployment, health, disability, work injury, and old age;

(iii) social assistance and welfare service programs for the most vulnerable groups with no other means of adequate support;

(iv) micro and area-based schemes to address vulnerability at the community level; and

(v) child protection to ensure the healthy and productive development of the future Asian workforce.

Table 2 Components of Social Protection–Intended Clientele and Targeted Vulnerable Groups

Labor Market Programs	Population in working age, being either wage or nonwage employees (formal or informal), employed, unemployed, or underemployed.
Social Insurance	The sick, elderly, widowed, disabled people, pregnant women, unemployed, eligible for insurance schemes.
Social Assistance and Welfare Services	The mentally and physically disabled, ethnic minorities, substance abusers, or phans, single-parent households, refugees, victims of natural disasters or civil conflicts, sick, elderly, widowed, disabled, pregnant women, and unemployed ineligible for insurance schemes.
Micro and Area-	Rural and urban communities at risk.

Based Schemes	
Child Protection	Children and youth (0–18 years).

Source: Asian Development Bank, 2003

Method

The method used is qualitative, while the informant selection technique used is purposive sampling. Bryman (2008) says "most sampling in qualitative research entails purposive sampling of some kind". Informants in the study were patients from the poor community as members of the the Social Security Administering Body for Health from recipients of contribution assistance (beneficiaries) who had received health services at the hospital. The criteria for selecting the informants were patients aged 40-60 years and receiving health services at the hospital at least five times and four informants were selected.

The data collection techniques used are in-depth interview, observation and document study. Data analysis steps consist of data reduction, data display and conclusion drawing/verification (Miles & Huberman, 1994). In detail, data analysis using coding. Coding means categorizing segments of data with a short name that simultaneously summarizes and accounts for each piece of data. Your codes show how you select, separate, and sort data to begin an analytic accounting of them. Four types of coding: initial coding, focused coding, axial coding and theoretical coding (Charmaz, 2006).

Results and Discussion

Social protection organized by the state in guaranteeing its citizens to fulfill health insurance has basically been clearly regulated in article 25 paragraph (1) of the 1948 United Nations Declaration on Human Rights and Resolution of the World Health Assembly (WHA) 2005. The declaration states that every country needs to develop scheme of a Universal Health Coverage (UHC) through a social health insurance mechanism to ensure sustainable health financing. The implementation of this social security needs to be accommodated in article 28H paragraph (3) and Article 34 paragraph (2) of the 1945 Constitution of the Republic of Indonesia.

Article 28H paragraph (3) of the 1945 Constitution states that everyone has the right to social security that allows his or her full development as a dignified human being. For this reason, in order to provide social security to every citizen, the government considers it necessary to develop a social security system for all people in accordance with the mandate of Article 34 paragraph (2) of the 1945 Constitution. Article 34 paragraph (2) of the 1945 Constitution states that the state shall develop a system of social security for all people and empowering the weak and incapable in accordance with human dignity. This is done as an effort to achieve the highest degree of public health, as is the goal of health development.

The Indonesian government has gradually implemented the National Health Insurance in the national social security system for all its people. This National Health Insurance is a mandatory financing pattern. With the implementation of the National Health Insurance, it is hoped that there will be no more Indonesian people, especially the poor who do not go to health care facilities when they are sick because they have no money. Poor people who receive the national health insurance program (beneficiaries) on the implementation of the national health insurance recognize and feel that the national health insurance program is beneficial. That matter maching with the research result Siram & Khan (2020) that Enrolment in the public health insurance programs for the poor increased the utilization of inpatient health care. However, the quality of health services still does not meet their expectations, such as the length of treatment and there are differences in the

service system between participants of the Social Security Administering Body for Health and general patients. Patients of the the Social Security Administering Body for Health there are restrictions on the number of patients, while for general patients there are no restrictions on the number of outpatients in hospitals.

The results of this study indicate that the principles of justice in the application of Indonesia's national health insurance are as follows:

Procedural Injustice

Procedurally, there are poor people who have not been recorded accurately. Mapping of the poor is still not done well, as stated by informant S.

The fact is that there are still many people who cannot afford to pay contributions, the poor who are not recorded. Why are poor people not listed? There is no data in the Village (Kelurahan), not in the Subdistrict. What methodology is used to collect data. Is the methodology used right or not? Especially when talking about incompetence is relative. For example, a person who originally had a nice house, had wealth, suddenly got a disaster, for example, fell into poverty. It does not necessarily fall into the category of poor people. So, when the mapping is not done well, it is not updated they will be missed (Interview 08).

This poor people data mapping information system is one of the government's ways to map the poor. The existing data in the information system for mapping data on the poor include poverty levels, such as prosperous, medium, near poor, poor and very poor. Then, arrange the poor people based on clear and measurable criteria. In addition, this data collection of the poor can also provide input to stakeholders in terms of making policies on national health insurance and poverty alleviation in particular.

Social Injustice

Socially, there is still a person bias, the poor do not get the right to health insurance, while the non-poor gets the right to health insurance. Informant assessment (S) of the application of the principle of social justice in the national health insurance program is as follows.

One of the principles that must be met from a social security system is equality and social justice. So, social security is not called if there is a distribution of money, fulfillment of needs to citizens if the distribution and fulfillment of needs is not based on equality and social justice. What needs will be guaranteed by the State/Government, for example, for the fulfillment of nutrition and health services. Many people who appear to be really poor, are not even classified as poor (Interview 08).

Social justice in the health insurance program is mainly related to accurate and reliable data collection of the poor, including the criteria for the poor. Many poor people who should have entered as poor people and get health insurance programs, on the contrary they do not get health insurance. In addition, what needs to be done is to prioritize the needs of the poor, including the needs of the people in the health insurance program.

Political Injustice

Politically, there is the provision of access for people who are close to the power elite at the grass root level to obtain health services. It is necessary to develop creative ideas and rapid actions to build a health service innovation system in hospitals and other health services. This should be done to improve the quality of health services. Political injustice in the application of national health insurance as reflected in the statement of informant S below.

In fact, every citizen, including the poor, has the same rights in the eyes of the law. Only then when it comes to rights, which criteria are there, the data is not clear. Not validly

recorded. So, in the end it was discriminatory, especially then people ended up being nepotism. So collusion because the demand competition is so great (interview 08).

Discrimination occurs because poor people are not registered so that they do not have access to services including health services. The existing data collection of poor people is invalid, because it is not carried out every time. The data for the poor should be updated at any time. In addition, due to intense competition for access to services, they end up taking shortcuts with collusion or nepotism.

Figure 1 The Principles of Justice in the National Health Insurance Program for the Poor People in Indonesia

Importance of increasing equity and equity in utilizing quality health care confirmed by Kurniati et al (2021) that is the findings highlight distributive justice challenges in implementing the NHI (National Health Insurance) system in hospitals, as voiced by nurses. Despite more people enjoying the benefits of NHI, the hospital service system has allowed a discriminatory approach in caring for patients, with nurses bearing the burden of impacts and being obliged to make continuous adjustments. Understanding and addressing these issues will improve fairness and equity in utilizing quality health care.

Meanwhile, Forman, et al (2022) explain that "we believe that this social protection program is important not just for poverty reduction, but also for pushing towards poverty prevention by reducing the incidence of CHE. However, there is more work to be done and considerations to be made regarding what is covered, who gets these services and how they can access them under a government-sponsored scheme like this. It is likely that more health gains are possible if additional funding is invested into preventive measures and outpatient care, if the program is actively monitored and adjusted based on impact evaluation results, and if there is particular concern paid to equity issues to ensure that no one is left behind".

In addition, the health information system is an important aspect to promote health and prevent the possibility of contracting disease experienced by the community. Therefore, Handayani, et al (2022) explain that further research could also design an information system that can support promotional and preventive programs in Indonesia, particularly those aimed at men. Kaongaa, Masiyeb, & Kirigiac (2022) said that the evidence presented in this paper suggests that the revenue potential of social health insurance would not be sufficient to fund major improvements in quality of care for insured members, let alone cross- subsidize benefits to non-members. Tuan, Nam, & Loan (2022) emphasize that the results suggest that health insurance improves households'financial well-being. The implication of the findings is that when developing social security policies aimed at achieving universal health insurance, the influence of health insurance on household finances should not be underestimated.

Funds for the national health insurance program for the poor are still limited. Therefore,

the budget for this program is carried out in stages to achieve universal health coverage (UHC) in 2019. Funds for the membership of the Social Security Administering Body for Health from category of beneficiary contribution are allocated in each fiscal year. Due to limited funds in each fiscal year, the scope of participation that can be borne by the costs of the Central Government and Regional Government is also limited. Meanwhile, the poor who need urgent health services take shortcuts, by approaching the power elite, so that they can immediately be served by the health insurance program (Huraerah, 2019).

Social protection is an important dimension in the reduction of poverty and multidimensional deprivation. It is an approach towards thinking about the processes, policies and interventions which respond to the economic, social, political and security risks and constraints poor and vulnerable people face, and which will make them less insecure and less poor, and more able to participate in economic growth. More narrowly, it describes a set of policies that governments can pursue in order to provide protection both to the ‘active poor’, enabling them to participate more productively in economic activity, and to the less active poor, with considerable benefits for society as a whole. Such policies can help to fulfil states’ obligations to ensure basic rights for all individuals. Social protection policies are always part of a broader set of policies – on macroeconomic stability, enterprise and employment development, health, and education – aimed at reducing risk and vulnerability and encouraging pro-poor growth (Shepherd, Marcus, & Barrientos, 2004).

The primary purpose of social protection has three parts: to prevent, mitigate and enhance the ability to cope with and recover from the major hazards faced by all poor people; to contribute to chronically poor people’s ability to emerge from poverty, deprivation and insecurity, and to challenge the oppressive socio-economic relationships which could be keeping them poor, by increasing livelihood security and linking such increases to the promotion of enhanced livelihoods; and to enable the less active poor to live a dignified life with an adequate standard of living, such that poverty is not passed from one generation to the next (Shepherd, Marcus, & Barrientos, 2004).

Investment in social protection and social assistance can be extremely effective in reducing current poverty and vulnerability, as well as poverty persistence across time and generations. Countries with stronger social protection and assistance institutions show lower rates of poverty and vulnerability, and are more resilient in the face of economic and social transformation (Barrientos, 2010). In line with this, Siebera, et al (2022) said that higher social protection expenditure reduced socioeconomic health inequalities in both men and women for grip strength, and in women but not men for self- rated health (SRH).

Conclusion

Poor people who receive the national health insurance program (beneficiaries) on the implementation of the national health insurance recognize and feel that the national health insurance program is beneficial. However, the quality of health services still does not meet their expectations, such as the length of treatment and there are differences in the service system between participants of the Social Security Administering Body for Health and general patients. Patients of the Social Security Administering Body for Health there are restrictions on the number of patients, while for general patients there are no restrictions on the number of outpatients in hospitals. Procedurally, there are still many poor people who have not been recorded, so they do not have access to health services. Socially, there is still a person bias, the poor do not get the right to health insurance, while the non-poor gets the right to health insurance. Politically, there is the provision of access for people who are close to the power elite at the grass root level to obtain health services. It is necessary to develop creative ideas and rapid actions to build a health service

innovation system in hospitals and other health services. This should be done to improve the quality of health services.

This research has advantages related to procedural, social and political justice in the implementation of national health insurance in Indonesia. On the other hand, research on quality control of health services has not been carried out by many researchers and academics. In general, the research that has been carried out is the control of health care costs. Therefore, the limitations of this study are not specifically related to research on the quality of health services. Quality control of health services is an important part to study, because health services are one of the UHC (universal health coverage) indicators, in addition to financing and membership. Quality control is carried out to improve technical competence, access to health services, effectiveness, human relations, continuity of health services and convenience.

Therefore, the authors suggest that further research be carried out related to strategic steps to improve the quality of health services in Indonesia, by involving stakeholders, such as hospitals, polyclinics, Community Health Centers located in each sub-district, as well as Social Security Administering Body for Health, Ministry of Health of the Republic of Indonesia, public health office in both provincial and district/city areas, Non-Governmental Organizations and the community itself, including the poor as beneficiaries of health services.

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