REVISTA RELAÇÕES INTERNACIONAIS DO MUNDO ATUAL

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THE CONSTRUCTION MODEL OF THE NATIONAL HEALTH INSURANCE POLICY FOR THE POOR PEOPLE IN INDONESIA

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ABSTRACT
The purpose of this study is to explain the construction of the Indonesian national health insurance policy model for the poor and its theoretical and practical implications for the implementation of the Indonesian national health insurance policy for the poor. This study used qualitative research methods. Meanwhile, data collection used in-depth interviews, observation, and document studies. Data analysis consists of data reduction, data display, conclusions drawing, and verification. The construction model of the Indonesian national health insurance policy produces several important aspects that interact with each other, namely the apparatus performance patterns, apparatus capabilities, bureaucratic culture, political interests, principles of universality, and financing of health coverage. Theoretically, the Indonesian national health insurance policy has implications for a broader dimension, such as political, legal, economic, social, and cultural. In addition, it touches on a philosophical dimension, concerning the rights of citizens, such as civil rights, political rights, and social rights. Meanwhile, practically, it is related to the development of health resources, improvement of the population administration system, financing, and quality and cost control.

Keywords: *Construction Model, Policy, Health Insurance, the Poor People*

1 INTRODUCTION

We are living in a century known today as the age of growth. The concept of liberating the problem of poverty and underdevelopment for people in the Third World concerns the period when an idea was able to dominate and influence the thinking of nations globally (Fakih, 1999). Indonesia is a nation where the problem of poverty is still faced by most of the population. Poverty is still there in Indonesia. The poverty problem is very closely linked to social policy. The history of social policy's emergence cannot be separated from the presence in society of the problem of poverty. In essence, social policy is a response to social problems conducted through the provision of various social service programs. Social policy is one of the public policies governing matters of social welfare. Social policy is a government regulation designed to respond to issues of a public nature,

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to overcome social problems or to meet the needs of many individuals. In order to reduce poverty and to reduce multidimensional disparities, social protection is an important element in social policy strategies. Social protection is, in a broad sense, a set of policies and programs designed to reduce poverty and vulnerability. Thus, social protection programs can prevent people from falling into poverty, providing opportunities when, through investment in human capital and health, changes in the community and society occur. Social insurance, social assistance, social services and labor market policies are included in this (ESCAP, 2011).

Since January 1, 2014, Indonesia has recorded a new history within the National Social Insurance System, namely the operation of the Health Social Insurance Administration Organization. The implementation of Law No 40 of 2004 relating to the National Social Insurance System, following the decision of the Constitutional Court on case Number 007/PUU-III/2005, in order to provide legal certainty for the establishment of the Social Insurance Administration Organization for implementing Social Insurance programs throughout Indonesia. Article 1 paragraph 1 of Law Number 24/2011 concerning the Social Insurance Administration Organization states that the Social Insurance Administration Organization is a legal entity established to conduct social insurance programs. It must be understood, according to Thabrany, that the Law on the National Social Insurance System was drafted as far as possible, approaching the ideal as a direction for the development of social welfare in Indonesia. Health insurance is one element of social welfare. A reform of the social security system, including social health insurance, is the law of the National Social Insurance System. Furthermore, each region in Indonesia has the right to develop a social insurance system as part of its development. In accordance with the decision of the Constitutional Court of Indonesia concerning the judicial review of Article 5 of Law No 40/2004 on the National Social Insurance System, that authority is a form of implementation of the Regional Government Law, in particular Article 22h, requiring regions to develop social security systems, including health insurance (Mukti, 2007). For the implementation of the National Social Insurance System, Bandung City is a trial area. Since July 2013, the Bandung City Health Office has prepared for the implementation of the Indonesian National Health Insurance by drawing up a roadmap for the preparation of the Indonesian National Health Insurance in Bandung for

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this purpose. Aspects of the membership database, regulations, mapping of health facilities and funding are mainly related to the preparation for the implementation of Indonesian National Health Insurance. The results of the study to clarify many problems faced by Indonesia's public bureaucracy, including uncertainty of time, cost, method of service, discrimination in service. Indonesia's public bureaucracy has not been able to become a service provider that treats all citizens of the country equally, regardless of the characteristics of subjectivity. In addition, research results obtained by revealing a long hierarchy of service, complicated public service procedures, and very high uncertainty of service that has increased intermediary service sellers in the practice of public service delivery (Dwiyanto, 2012). There are still problems with the implementation of health insurance for the poor towards universal health coverage, namely uncertainty at the time of health checks by doctors and nurses, slow health services, discrimination in health care services between general patients and patients of the Health Social Insurance Administration Organization. Furthermore, the availability and quality of health facilities and infrastructure is insufficient and the number, type, quality and distribution of health workers have not been met, particularly at the district level of primary health services (*Community Health Center-Pusat Kesehatan Masyarakat).* The low quality of health services demonstrates this. Moreover, the access of the poor to the fulfillment of health service rights is still limited. This happens because it is not valid for the membership data of the poor. There are, therefore, still many poor individuals who are not well documented. Data on the poor is dynamic, changing often. It is possible for people who were nearly poor to fall into poor people or who were poor to not be poor. This is, if their mapping is not done well, then they are not clearly and validly recorded. The objective of this research, in accordance with the above description, is to explain the model for the construction of the Indonesian national health insurance policy for the poor and the theoretical and practical implications for the implementation of the Indonesian national health insurance policy for the poor.

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2 NATIONAL HEALTH INSURANCE FOR THE POOR PEOPLE

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

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In developing countries such as Indonesia, issues of health insurance when it comes to access to health services remains a big challenge because there are new advances in the implementation of various health insurance in many low and middle income countries. The use of health insurance is considered as an important means of achieving universal health agreement. However, encouraging health insurance in most developing countries remains low as a result of several challenges. In their study of health insurance for poor people in Ghana, Alesane and Anang (2018) found empirical evidence of factors that inhibit registration in many developing countries, including Ghana, which is rare. The findings of their study showed that insurance activation was higher among younger individuals, but lower among women. More elderly women, compared to older men, prefer health insurance. Furthermore, this research shows how to boost insurance by increasing education, but by increasing the size of the household. Possibly small, socio-demographic characteristics such as age, gender, literacy rate and household size influence the results of registration to learn more about premium payments in Ghana. Some of the steps needed to improve insurance safety in Ghana and other developing countries include sufficient community awareness of pension benefits and age reduction for exemption from premium payments, mostly in rural areas. Increasing community-based health insurance is therefore a growing alternative as a tool for financing health care in developing countries. Health insurance is an important mechanism that, in general, helps people, states and nations. Many variables affect the attitude of an individual towards a health insurance policy and variables that affect the decision to renew their health insurance policy when it expires. The study conducted by the World Bank (2004) in Ghana also showed that 61.1% of respondents were currently registered with NHIS, 23.9% had not renewed their insurance after registration and 15% had never registered. Poor service quality (58%), lack of cash (49%) and taste from other care sources were reasons cited for not renewing insurance (23%). Therefore, all stakeholders, including the community, must make efforts to educate people about the benefits of health insurance to ensure that everyone has optimal access. For example, in rural Senegal, Johannes (2002) says that the poor have better access to health care than non-members by becoming members of reciprocal health insurance coverage, and that members have a higher rate of use of inpatient services compared to non-members, and they need

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treatment to buy more of their compilations. This research has consequences that require the community to have the potential to enhance the management of the home. Reinsurance policies, subsidies for the poorest and the development of links to the private sector through the promotion of group insurance policies must be appropriate tools for further publication. All tools provide better health needs for populations than public health problems.

In Jamaica's context, Bourne (2009) states that health insurance is identified as an indicator of health care seeking behavior. Despite this fact, there is no study in Jamaica examining the variables that determine the coverage of private health insurance. This study bridges the literature gap because it seeks to determine the correlation between the coverage of private health insurance. The aim of this research is to understand those in Jamaica who have health insurance coverage so that it can help to formulate public health policy. Socio-demographic variables (such as area of residence, education, marital status, social support, social class, gender, age) and economic factors can predict health insurance coverage (consumption and income). Interestingly, poor health status was not correlated with insurance coverage for private health. Urban areas are responsible for more health insurance coverage than other urban or rural residents. Socio-demographic variables (such as area of residence, education, marital status, social support, social class, gender, age) and economic factors can predict health insurance coverage (consumption and income). Interestingly, poor health status was not correlated with insurance coverage for private health. Urban areas are responsible for more health insurance coverage than other urban or rural residents. The alarming development of the aging trend in China has attracted a great deal of attention at home and abroad. The New Cooperative Medical Scheme (NCMS) was launched in 2003 by the Chinese central government to solve uneven health problems in areas with inadequate infrastructure and relative poverty. The main beneficiaries of this policy are rural seniors; exploration is required to improve their health through a health insurance policy. During a subsidized 3-year scheme based on Public Health Insurance (CHI) in rural China, Zhang & Wang (2008) examined adverse selection changes from time to time. People with a history of chronic conditions, fair health, and poor health are more likely than those without chronic conditions and with good health status to be registered in the system. Furthermore, we

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found that the health status variable and the CHI wave variable were not significant in almost all interaction terms, indicating that the adverse selection effect did not change significantly over time. Furthermore, middle-income and high-income individuals are more likely than low-income individuals to enroll in the scheme. This shows that in the subsequent registration of the CHI scheme, even with government subsidies for premiums, adverse selection remains.

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

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information imbalances, microfinance groups are the most reliable and convenient way to deliver micro health insurance products to poor communities in rural regions.

3 SOCIAL WELFARE POLICY IN INDONESIA

The achievements of social welfare in Indonesia can't be separated from the existence and performance of state-developed social policies. According to Midgley (2009), social policy is a policy instrument that has been specifically designed and implemented to improve citizens' welfare. It adds that four main objectives will be served by social policy in general, namely: (1) reducing poverty; (2) improving living standards; (3) reducing social vulnerability; and (4) creating job opportunities. The main tool for achieving the objective of reducing social vulnerability is the social protection policy. It illustrates the limited role of the state in optimizing Indonesia's social policy, including a public health system that is not adequately funded and unable to provide all citizens with qualified services (Lindenthal, 2004). Social welfare policy, which concerns the field of social welfare, can be interpreted as a policy that concerns social aspects in a narrow sense. The social dimension here relates to the social welfare sector as an area or part of social development or to the welfare of individuals aimed at improving the quality of human life, particularly those classified as disadvantaged groups and vulnerable groups. Social policy is therefore a strategy, action or plan to address social problems and to meet social needs (Siporin, 1975). Social policy is a government regulation designed to respond to problems of a public nature, to overcome social problems or to meet the needs of the general public. Social welfare policy therefore refers to what governments do when they try to improve the quality of the lives of people by providing a variety of income support, community services and support programs (Bessant, Dalton, Smith & Watts, 2006). Meanwhile, "the study of social services and the welfare state" was defined as social policy in general. This field of research has expanded and expanded, but social services remain at the core of the study. Social security, housing, health, social work and education are included in these social services (the top five). The work service also sometimes includes the sixth element, adding other services that resemble social services, namely

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employment services, as indicated, which resemble the sixth element, correctional institutions, legal services, and even drains (Spicker, 2000). Social policies are expressed broadly in three categories, namely legislation, social service programs, and taxation. Based on this category, it can be stated that any social and life-related legislation, law or local regulation is a form of social policy. Not all social policies take the form of legislation, however. Social policies often involve support programs that are difficult to touch or intangible aids are seen. Public policy, therefore, is broader than that of social policy. Some examples of public policies are transport, roads, clean water, defense and security policies. Examples of social policy, meanwhile, are social security policies, such as social assistance and social insurance, which are generally given to poor or vulnerable groups. In the meantime, say that social policy includes processes and products. Social policy, as a process, is a series of phases followed by problem solving. (Gilbert, Specht and Terrell, 1993). As a product, social policy is a legal, program or court decision. In the meantime, according to the policies, there are two aspects: (1) the actual policies and programs of government, policies that affect people's welfare, and (2) the academic field of inquiry which deals with the description, explanation and evaluation of these policies. The social policy study therefore basically covers the two fields of study mentioned above.

4 CITIZENS' RIGHTS

Cole and Marshall (2005) define citizenship as "full membership of society". According to Cole and Marshall (2005), citizenship is based on three elements: civil, political, and social, as seen in the following table below.

Table 1. Citizens' 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

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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.

Source: Cole and Marshall (2005)

Civil rights are the rights required for everyone's freedom, freedom of speech, thought and belief, the right to free oneself from poverty and the right to justice; Political rights are the right to participate in political power, as members of an entity invested with political authority or as voters of the members of these bodies, and social rights are the right to achieve economic prosperity and security. (Cole & Marshall 2005), also say that welfare efforts by the state are a culmination of the evolution of citizenship rights. And, explains that western democratic society develops slowly from situations where only small minorities enjoy civil, political, and social rights. In the early days, the king and the nobility held political and economic power, and rights were limited to a few people. However, as society develops, rights are expanded. In the 18th century, when civil rights were applied to a larger group of people, the idea of citizenship was broadened. In the 19th century, political rights were also extended to enable men and women to participate in political affairs. This development further enhances the notion of citizenship. However, the move towards full citizenship requires that people also have social rights. In the perspective of social work, social services have various forms in accordance with their functions (Siporin, 1975) such as;

1. Access services, including information, referral, advocacy, and participation services. The goal is to help people to be able to achieve or use the services available.
2. Therapist, rescue and rehabilitation services, including protection and replacement care, such as services provided by agencies that provide counseling, child welfare services, medical and school social work services, correctional programs, care for elderly people, and so on.

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3. Socialization and development services, such as babysitting/childcare, family planning, family education, recreation services for youth, community activities center, and so on.

5 SOCIAL PROTECTION

Social protection is mainly understood as a policy framework that explains "public actions taken in response to the level of vulnerability, risk and deficiency that are deemed socially unacceptable in government or society". Define social protection as “public actions taken in response to levels of vulnerability, risk and deprivation, which are deemed socially unacceptable within a given polity and society”. Furthermore, explain that “social protection has three main components: social insurance, social assistance, and labor market regulation. Social insurance refers to programs providing protection against life courses and employment hazards, financed out of contributions from employers, workers and governments. Social assistance includes programs supporting those in poverty, and is largely financed from government revenues. Labor market regulation includes protection against unfair dismissal and the right to voice and representation of workers”. Indonesia continues to develop social protection programs, including social protection programs in the health sector. Social protection programs in the health sector, such as regional health insurance in the form of social assistance, have now evolved into the Indonesian national health insurance. In this regard, state that social protection evolves, from assistance, insurance to potential development, as shown in the following figure.(Garcia & Gruat, 2003)

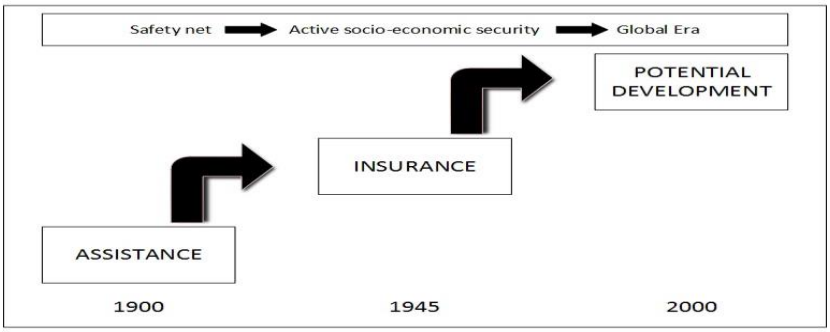

Figure 2. Social protection evolution (Source: Garcia dan Gruat, 2003)

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6 THE ELEMENTS OF DYNAMIC GOVERNANCE

The foundation of dynamic governance is a country's institutional culture, shown at the base of Figure 1. The three dynamic capabilities of thinking ahead, thinking again, and thinking across that lead to adaptive policies are shown in the middle section. There are two main levers for developing dynamic governance capabilities, able people and agile processes and these are shown on the left of Figure 1. The external environment affects the governance system through future uncertainties and external practices that are shown as rectangles on the left. Dynamic governance achieves current and future relevance and effectiveness through policies that continually adapt to changes in the environment. Policy adaptation is not merely a passive reaction to external pressure but a proactive approach to innovation, contextualization, and execution (Neo & Chen, 2007)

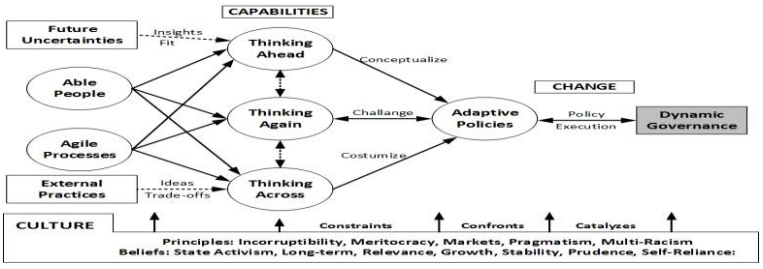

Figure 1. Framework for dynamic governance system
Source: Neo and Chen (2007)

Conceptualize and discuss three critical governance capabilities: i) thinking ahead — the ability to perceive early signals of future developments that may affect a nation in order to remain relevant to the world; ii) thinking again — the ability and willingness to rethink and remake currently functioning policies so that they perform better; and iii) thinking across — the ability and openness to cross boundaries to learn from the experience of others so that new ideas and concepts may be introduced into an institution. Associated with change as the basic essence of dynamic governance, explain that the two elements of culture, namely (1) principles: incorruptibility, meritocracy, markets, pragmatism, multi-racialism and (2) beliefs: state activism, long-term, relevance, growth,

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stability, prudence, and self-reliance. Furthermore, Mathis and Jakson (2006) state that organizational culture is a pattern of mutually agreed upon values and beliefs that give meaning to members of the organization and rules of behaviour. Meanwhile the definition of organizational culture according common set, taken to provide an implicit assumption that groups hold and determine how they view, think and react to various environments. In other word, organizational culture is a form of assumption that is owned and implicitly received by the group that determines how the group feels, thinks and reacts to its diverse environment. In addition, according to Robbins (2008), the functions of organizational culture (Arifin, et al., 2019).

7 METHODOLOGY

This study used a qualitative research design. says that “qualitative research in a natural setting where the researcher is an instrument of data collection”(Creswell, 1998). Sampling method used in this study is purposive sampling. As said, that purposive sampling is a non-probability form of sampling. Determination of the subjects in this study is the use of non-probability sampling with purposive manner. That said “most sampling in qualitative research entails purposive sampling of some kind”(Bryman, 2008). The results of this research are then analyzed; using data analysis workflow model of Miles and Huberman was consisting of three concurrent flows of activity: data reduction, data display, and conclusion drawing and verification. This data was collect used in-depth interview, observation, document study. In detail, related to the analysis of the data, especially the interview, involves four types of coding, namely: the initial coding, focused coding, axial coding and coding theoretical. Initial phase coding, the researchers do the coding manually, by looking at the transcript of the interview word for word, line-by-line, sentence-per-line, per-incident or incidents to define what is happening and what it means. So, at this stage, researchers attempt to capture a variety of codes, abstract ideas, or concepts that are emerging (Charmaz, 2006). Then, the next phase is focused coding, according to Glaser, the coding is done more focused, selective, and conceptual. Furthermore, in the stage axial coding, researchers link between categories and sub-

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categories, detailing the dimensions or attributes of a theme or category, and synthesizing various narrative or excerpt of the data to be fit or coherence with a framework of analysis that appears. Finally, theoretical phase coding, aims to make a more specific range of possible relationships between categories are created on a dedicated stage coding. Or by using the term Glaser, this stage seeks to knit back story crumbled into a conceptual or theoretical building intact.

8 RESULTS AND DISCUSSION

8.1 THE CONSTRUCTION MODEL OF THE HEALTH INSURANCE POLICY FOR THE POOR PEOPLES

The Indonesian national health insurance is a system implemented by the government in order to meet the basic needs of proper health for all Indonesian people. One of the targets of the Indonesian national health insurance program is the poor people. Contributions for this community group are paid by the Government. In the health insurance membership, this group is called the recipient of contribution assistance (*beneficiaries*). The model of the Indonesian national health insurance policy construction for the poor people can be described as follows:

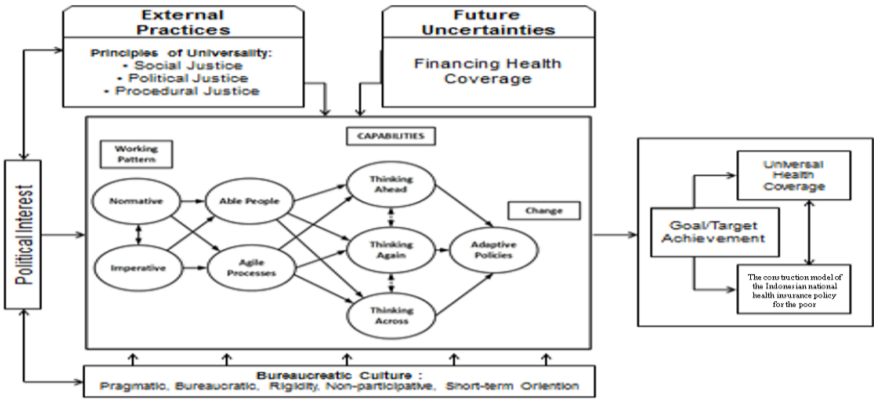

Figure 3. *The model of the Indonesian national health insurance policy construction for the poor people*

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Figure 3. the model of the Indonesian national health insurance policy construction for the poor people shows the inter-component linkages that can be explained as follows;

First, the performance of the apparatus in the application of the Indonesian national health insurance is shown by the bureaucracy culture: (1) pragmatic relating to the interests of the government, (2) bureaucratic in the mechanism for submitting Health Social Insurance Administration Organization - membership of recipient of contribution assistance (beneficiaries), (3) rigidity in the interaction of tasks or occupation, (4) non-participatory data collection on participation of membership of recipient of contribution assistance (beneficiaries), and (5) short term orientation in achieving the target of participation in the Indonesian national health insurance program. This apparatus performance culture influences the apparatus performance patterns (normative and imperative attitude), able people and agile processes, apparatus capabilities (thinking ahead, thinking again, and thinking across), and adaptive policies). These concepts are interrelated with one another. In the perspective of the theory of dynamic governance systems from that bureaucratic culture is very important and therefore becomes the initial part in discussing the dynamic governance system. Able people and agile processes are the key drivers for the development of the three dynamic governance capacities of thinking ahead, thinking again and thinking across, which then are embedded in the paths of chosen strategies, policies and programs. Their approaches to the paths differ according to which dominant dynamic capability is being utilized (Neo & Chen, 2007).

Second, the normative performance pattern of the apparatus can influence able people. The normative performance pattern of the apparatus is not in conflict with the laws and regulations. In fact, on the other hand the authorities can make the regulations as a reference in transforming the the Indonesian national health insurance program. Principally, aspects of the Indonesian national health insurance policy have been known by the authorities in implementing the Indonesian national health insurance program. With the existence of laws and regulations that specifically handle the Indonesian national health insurance, the public can know and realize the importance of the Indonesian national health insurance program. However, there are still obstacles in the socialization of the Indonesian national health insurance. The socialization of the Indonesian national

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health insurance still needs to be intensified intensively, so that the community, especially the poor, can understand the Indonesian national health insurance program. The normative performance pattern of this apparatus can also affect agile processes. Normative attitudes can realize agile processes; it requires the development of human resources, especially the development of innovation and creativity in describing the Indonesian national health insurance policies and especially in relation to the growing awareness of the apparatus of the importance of health for the poor people. The imperative apparatus performance pattern can also affect able people. Social policy not only has the nature of directing and developing initiatives in the implementation of the Indonesian national health insurance program. Finally, making a commitment to the institution and the institutional consequences itself can lead to institutional consistency in the legislation and reduce the turmoil that may arise, especially regarding membership, budget, and services. Imperative apparatus performance patterns can also affect agile processes. The imperative attitude can make a positive thing for the performance of current and future officials. The imperative attitude can lead to quick work, both individually and organizationally. An organization both in type and form cannot be separated from the imperative element as a consequence of the end of the position, because in it there is authority inherent in the position. This imperative attitude also depends on the leadership style that involves the authorities, so that it can lead to new ideas and fresh perceptions in implementing the Indonesian national health insurance program.

Third, able people can influence thinking ahead, thinking again, and thinking across. The implementations of the Indonesian national health insurance, able people are manifested in the commitment of the apparatus to the service of the poor. Able people in the apparatus' commitment to the service of the poor can influence thinking ahead. Thinking ahead is realized in the roadmap for preparation of implementation of the Indonesian national health insurance, officials' perceptions of the Indonesian national health insurance success, and planning for the quality of health services. Officials who are committed to serving the poor, make officials able to think ahead in preparing for the implementation of health insurance, such as preparing a roadmap for implementation of the Indonesian national health insurance, having a perception of the Indonesian national health insurance success and planning to improve health services. The commitment of

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the apparatus can also make the apparatus able to think again, namely in understanding problems and problem-solving methods, setting up a referral system, and forming a team and carrying out monitoring and evaluation of the Indonesian national health insurance implementation. In addition, the commitment of the authorities can also make them have the ability to think across, namely in implementing institutional and program transformation, coordinating poverty reduction, and innovating health services. Agile processes are demonstrated by transparency and accountability, both internal and external to the organization. Health human resources and health facilities are needed in order to serve patients with excellent service. Health human resources must have the mentality of wanting to compete. The authorities should be able to review that health facilities are not related to the structuring of the referral system, they must also meet the challenges of future needs. Health human resources must have a vision for the future and have innovations and be able to implement these innovations to facilitate and accelerate health services and can make patient comfort.

Fourth, thinking ahead, thinking again, and thinking across can affect adaptive policies. The apparatus that has the ability to think ahead, think again, and think across cause's policy makers to adopt adaptive policies, such as readiness of participatory data collection, bureaucratic readiness, budget, human resource, and health facility.

Fifth, in addition to the culture of apparatus performance, political interest factors, external practices, such as social justice, political justice, and procedural justice, and future uncertainties, namely financing health coverage also affects the dynamic governance system. This shows how a dynamic governance system is a very broad system, because there are many factors associated with the dynamic governance system.

Sixth, all components are to produce a goal achievement, namely the Universal Health Coverage (UHC) and the Indonesian national health insurance policy model for the poor. UHC indicators are related to membership, services, and financing. These three UHC indicators are targets to be achieved in the implementation of the Indonesian national health insurance program. The three UHC indicators must be of central and regional government attention and need support from various stakeholders so that the UHC target can be achieved. Without serious attention from the government and strong support from stakeholders, it is difficult to achieve the UHC target. National health insurance is one

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component of social protection that has been developed in Indonesia as a way to achieve UHC. This includes protection for the poor in Indonesia, whose numbers are still very high. However, the poor must get adequate social protection, not least the social protection in the health sector. This is in line as stated by Conway, Haan and Norton (Barrientos & Santibáez, 2009), social protection as "public actions taken in response to levels of vulnerability, risk and deprivation, which are deemed socially unacceptable within a given polity and society". In Indonesia, health insurance which was originally in the form of social assistance has evolved into insurance. Therefore, social protection programs in Indonesia have evolved as stated by the state that social protection evolves, from assistance, insurance to potential development (Garcia & Gruat, 2003)

9. THEORETICAL AND PRACTICAL IMPLICATIONS FOR THE IMPLEMENTATION OF THE INDONESIAN NATIONAL HEALTH INSURANCE POLICY

9.1 THEORETICAL IMPLICATIONS

Theoretically, this study has the following implications:

1. The Indonesian national health insurance policy for the poor is understood in a broader and multidimensional context: political, legal, economic, social and cultural. Politically, it is related to the political interests of the power elite. By law, it is in contact with the laws and regulations that serve as a reference in regulating the implementation of The Indonesian national health insurance. Economically, it is related to the financing and sustainability of the Indonesian national health insurance program. Socially, it touches on the protection dimension for the poor. And culturally, related to bureaucratic culture or culture of apparatus performance.

2. The reality of this research touches on the philosophical dimension, which is basic to humanity, namely civil rights, political rights, and social rights of citizens. The Indonesian national health insurance policy for poor must be able to free them from poverty and get justice, participate in political power, and achieve social welfare. The civil rights are rights needed for the freedom of everyone, freedom of speech, thought and

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belief, the right to free oneself from poverty and the right to justice; political rights are the right to participate in political power, as members of an entity invested with political authority or as voters of the members of these bodies, and social rights are the right to achieve economic prosperity and security.

3.Accessibility in the perspective of social work is one of the functions of social services, an important part to be discussed. In fact, it not only concerns the accessibility of the poor in health services, but also services of the poor in other social services, such as education, employment, housing, social security, transportation, advocacy, etc.

9.2 PRACTICAL IMPLICATIONS

Practically, this research has the following implications:

1. This research further confirms to policy makers to invest in human resources and health facilities, by providing and developing human resources and providing, improving, and developing health facilities to realize quality and professional health services.
2. The results of this study require improvements to the population administration system, specifically the data collection of the poor to make it easier for the poor to have access to health services. The government must have an accurate and accountable data system that can be accessed easily and quickly. Based on this, the government through the statistics Indonesia needs to build a complete and accurate data base. At the grass root level, it needs to be involved in data collection activities. With a accurate and accountable database, it is easier for the poor to have access to health services.
3. The government must provide sufficient funding for the continuation of the Indonesian national health insurance success program, especially for the poor. In general, illustrates the limited role of the state in optimizing social policy in Indonesia, including a public health system that is not adequately funded and unable to provide qualified services to all citizens.

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4. The implementation of Indonesian national health insurance policy needs to carry out quality and cost control in each level of health services. Quality control is carried out to improve technical competence, access to health services, effectiveness, human relations, sustainability of health services, and comfort. Meanwhile, cost control is needed for efficiency and to prevent wasteful health budgets.

10 CONCLUSION

In this study, the performance of the apparatus in the application of the Indonesian national health insurance is shown by the bureaucracy culture: pragmatic, bureaucratic, rigidity, non-participatory and short term orientation. This apparatus performance culture influences the apparatus performance patterns (normative and imperative attitude), able people and agile processes, apparatus capabilities (thinking ahead, thinking again, and thinking across), and adaptive policies). The normative performance pattern of the apparatus can influence able people. The normative performance pattern of the apparatus is not in conflict with the laws and regulations. In fact, on the other hand the authorities can make the regulations as a reference in transforming the Indonesian national health insurance program. And then, the imperative apparatus performance pattern can also affect able people. Finally, making a commitment to the institution and the institutional consequences itself can lead to institutional consistency in the legislation and reduce the turmoil that may arise, especially regarding membership, budget, and services. Imperative apparatus performance patterns can also affect agile processes. The imperative attitude can make a positive thing for the performance of current and future officials. The imperative attitude can lead to quick work, both individually and organizationally. Able people can influence thinking ahead, thinking again, and thinking across. Meanwhile, thinking ahead, thinking again, and thinking across can affect adaptive policies. The apparatus that has the ability to think ahead, think again, and think across cause's policy makers to adopt adaptive policies, such as readiness of participatory data collection, bureaucratic readiness, budget, human resource, and health facility. In addition to the culture of apparatus performance, political interest factors, external practices, such as

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