

Poverty, Entitlement Approach, and the Program of Health Insurance for the Poor in Indonesia

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ABSTRACT

This study analyzes the implementation of the Health Insurance for the Poor (HIP) program in Indonesia, focusing at the advantages and constraints faced by the beneficiaries in accessing healthcare. A case study is conducted in Purbalingga District, Central Java Province. A total of 648 households were randomly selected to be the respondents, and data are collected through questionnaires, interviews and observations. Both qualitative and quantitative technique of data analysis are employed in this study. By applying the approach of entitlement within the framework of healthcare access, it is found that the program brings positive impacts in increasing financial abilities of the beneficiaries and creating good treatment from the medical workers. However, problems on the distribution inaccuracy and low supply side readiness of health infrastructure and service system dilute the overall benefits of the program in poverty alleviation. The government of Indonesia is recommended to involve communities and local officers in the enumeration of the beneficiaries, to increase the participation of private healthcare providers in the program, and to establish clear reward and punishment system for the health workers. Keywords: Entitlement Approach; Social Protection Program; Access to Healthcare; Poverty Alleviation.

ABSTRAK

Studi ini menganalisis pelaksanaan Program Jaminan Kesehatan bagi Masyarakat Miskin di Indonesia, dengan fokus pada keuntungan dan kendala yang dihadapi oleh penerima manfaat, melalui studi kasus di Kabupaten Purbalingga. Dengan menerapkan pendekatan hak dalam kerangka akses layanan kesehatan, ditemukan bahwa program tersebut membawa dampak positif dalam meningkatkan kemampuan finansial para penerima manfaat, dan menciptakan perawatan yang baik dari para pekerja medis. Namun, kesiapan sisi pasokan yang rendah dari infrastruktur kesehatan dan sistem layanan men-

gurangi manfaat program dalam pengentasan kemiskinan. Pemerintah Indonesia direkomendasikan untuk melibatkan masyarakat dan petugas lokal dalam penghitungan penerima manfaat, untuk meningkatkan partisipasi penyedia layanan kesehatan swasta dalam program, dan untuk menetapkan imbalan yang jelas dan sistem hukuman bagi para pekerja kesehatan.

Kata Kunci: Pendekatan Kepemilikan; Program Perlindungan Sosial; Akses ke kesehatan; Pengentasan Kemiskinan.

INTRODUCTION

Poverty is generally understood as the inability to obtain proper living standard. It is a multidimensional concept encompassing both economic dimension like income and non-economic dimension like health, education, and access to public services ([Henry, Sharma, Lapenu, & Zeller, 2001](#)). [Sen \(1981\)](#), in her works to analyze the causes of poverty in several countries, found that famine might happen even when the country experienced surplus in food production. Famine occurred not due to the problems of food supply, but because the poor did not have access to the foods, or that they were not entitled to access the foods. Causes and processes of famine could therefore be understood through an approach of "Entitlement." Entitlement is "a set of alternative commodity bundles that a person can command in a society using the totality of rights and opportunities that he or she faces ([Sen, 1984, p. 497](#))." A set of entitlement may consist of goods and services that can be acquired if a person converts his endowment, asset and resources. Entitlement comes from self-production, trading, own-labour, inheritance or transfer ([Devereux, 2001](#); [Nussbaum, 2003](#); [Sen, 1984](#)). While the approach of entitlement was initially used to analyze famines, it is now extensively used to analyze the other dimensions of poverty.

Based on the entitlement approach, it can be understood that poverty alleviation will not be successful only through the increase in production of goods and services. There must be effort to ensure that the poor had access to the goods and services to maintain their standard of living, which was effort to transfer a set of entitlement to the poor. In this regard, social

protection programs are implemented as a way to transfer the entitlement to the poor. Social protection is generally defined as transfer of cash and kinds to the poor in order to maintain sufficient standard of living. The programs become very popular in the last decade, and are implemented by many countries to reach the poor and the vulnerable groups not benefitted from conventional development programs ([Brooks, 2015](#); [Haan, 2014](#)). The roles of the programs have been expanded to include protective, preventive, promotive and transformative measures by providing aid, preventing poverty, empowering the poor and creating equal opportunities to transform the society ([Sabates-Wheeler & Stephen, 2007](#)). From the perspective of social justice, the programs aim to guarantee the rights of the citizen to a minimum standard of living through free or subsidized distribution of basic goods and services.

In Indonesia, social protection programs reached their momentum just after the 1998 Asian monetary crisis. To help the poor cope with adverse impact of the crisis, the government of Indonesia implemented social safety nets. Although the crisis had been resolved and the economy was recovered thereafter, social safety nets were continued and modified into social protection programs. The programs become one of the main strategies to reduce poverty and vulnerability in the country ([Poverty Reduction Committee of Indonesia, 2003](#)). The Health Insurance for the Poor (HIP) Program is one of the largest social protection programs, which aims to entitle the poor a free medication in designated healthcare providers. The program is seen very important in national development agenda. High political commitment of the government makes the HIP be the main priority despite frequent changes in ministerial cabinet. By 2013, the program was claimed to cover nearly 86 million people categorized as 40% of the population with lowest income ([Aspinall, 2014](#); [Mboi, 2015](#)). The coverage was a high achievement, as it was nearly zero in 1990s, and only 14% in 2006 ([Rokx, Schieber, Harimurti, Tandon, & Somanathan, 2009](#)).

Despite high investment and various efforts to succeed the HIP, some targets present that the program is not completely successful. Rates of malnutrition remains high, in which 35.6% of children under age five are underweight, while rates of infant and child mortality within the poor are double than the rich ([Harimurti, Pambudi, Pigazzini, & Tandon, 2013](#)). Maternal mortality rates are decreased in the recent years, but remaining far below the target of Milenium Development Goal ([Ministry of Health of Republic Indonesia, 2013](#)). In the broader context, national povertyrate decreased byaveragely 0.58% per year after 2001, relatively lower than the decrease in the previous decades, 1.4% per year on average ([Sutiyo & Maharjan, 2017](#)). Numbers of studies find that the main causes were problems of distribution, in which substantial numbers of the poor were not listed in the program ([Christiani, Byles, Tavener, & Dugdale, 2017](#); [Sutiyo & Maharjan, 2011](#)). The other problems include disparities of health care facilities throughout the country ([Vidyattama, Miranti, & Resosudarmo, 2014](#)), organizational problems from the implementing agency ([Mboi, 2015](#)), weak coordination among the implementing institutions ([Hardini, 2015](#)), and high potentiality of fund misuse in the HIP ([Aspinall, 2014](#)).

It can be assumed that the entitlement given by the government through the HIP does not always function well. A deeper understanding of the advantages and constraints faced by the poor in utilizing the HIP is needed to formulate recommendation to improve the program. This paper aims to analyze the process in which the poor utilize the HIP to access healthcare in order to understand functionalities of entitlement approach in Indonesian health sector. The remainder of this paper is organized as follows: Section 2 reviews program description and research framework; Section 3 elaborates the used method; Section 4 presents results, which include socio-economic condition of study sites and respondents, the distribution of the HIP, access to healthcare, and the utilization of the HIP; Section 5 develops discussion; Section 6 draws conclusion.

LITERATURE REVIEWS

Program Description

The HIP is a program to help the poor to access health services. It distributes a card for free health service in designated institutions, which include all government facilities and some selected private providers. The HIP began in 1998, with the name of Sosial Safety Net of Health Sector (*Jaring Pengaman Sosial Bidang Kesehatan*). In 2001, the program was renamed into *Askeskin*, which was financed from the reallocation of the fund from withdrawal of fuel subsidy. In 2008, *Askeskin* was changed into *Jamkesmas*, which was equipped with better institution and funding scheme. In 2013, *Jamkesmas* and multiple health insurance scheme managed by the government, like those for civil servants and industrial workers, were integrated. An agency named Social Security Management Agency (*Badan Penyelenggara Jaminan Sosial*) was established in 2014 to manage the program. The integration aimed at promoting cross-subsidization and reducing administrative costs as well as inequalities to health care ([Lagomarsino, Garabrant, Adyas, Muga, & Otoo, 2012](#)). Two main regulations were issued to be the legal basis of the program, namely Law 40/2004 on National Social Security System and Law 24/2011 on the Social Security Management Agency.

The beneficiaries of the HIP consist of the households that meet several criteria of dwelling condition, access to electricity, access to clean water and type of cooking fuel. Periodical enumeration was conducted in 2005, 2008, 2011 and 2015, respectively. The package of insurance includes inpatient, outpatient, preventive and maternal cares. It excludes cosmetic surgery, annual physical check-ups, alternative medicine, dental prosthesis and fertility treatment ([Minister of Health of Republic Indonesia, 2014](#)).

Conceptual Framework

The basic idea of entitlement approach is that poverty occurs not due to unavailability of goods and services in the

society, but due to inability of a person to access them. [Sen \(1984\)](#) concluded that to alleviate poverty, the government could not rely only on market mechanism. The government should transfer legal and economic rights for the poor to access the basic goods and services they needed. In this regards, social protection programs philosophically aim at entitling the poor an access to the goods and services for proper living. The programs play roles as a legal transfer of entitlement from the state. Entitlement approach has an implicit assumption that once the poor are given the program, they will be able to access those goods and services.

While poverty and social protection programs are conceptually connected by entitlement approach, many studies present that the implementation of the programs are influenced very much by local social and political environments. [Devereux \(2001\)](#) argued that it was wrong to consider entitlement approach as only an individual process. Various socio-political determinants will influence the utilization of the programs. This is why, as founded by [Brooks \(2015\)](#) and [Haan \(2014\)](#), poverty remained difficult to be alleviated despite the extensive implementation of social protection programs in developing countries. Psychological factors also matter, especially in health related programs. Study by [Ergler, Sakdapolrak, Bohle, and Kearns \(2011\)](#) in India found that many poor people preferred to use private healthcare providers due to good treatment, despite the costs involved and that free government facilities existed. Their study highlighted that social protection program in health sector needed to consider not only effective access to healthcare, but also affective treatment.

[Peters et al. \(2008\)](#) identified four dimensions of access that might either enable or constrain entitlement in healthcare, as follows:

1. Geographic accessibility, means the physical distance or travel time between healthcare providers and households;
2. Availability, means having the right type of care as demand-

ed, such as hours of operation, waiting times, equipment and materials; ccessibility, means the relationship between cost of services and thewillingness as well as ability of users to pay the services; Acceptability, means the match between the quality of services and the expectations of users.

These dimensions are very useful to use in analyzing the linkage between health insurance programs and access to health services in developing countries ([Domapielle, 2014](#)). [omapielle \(2014\)](#) argued that irrespective of the model of insurance applied by a country, these four dimensions will govern the decision of the beneficiaries to access healthcare. It is argued here that each of dimensions has supply and demand elements that will influence the HIP beneficiaries in utilizing their entitlement (Fig 1)

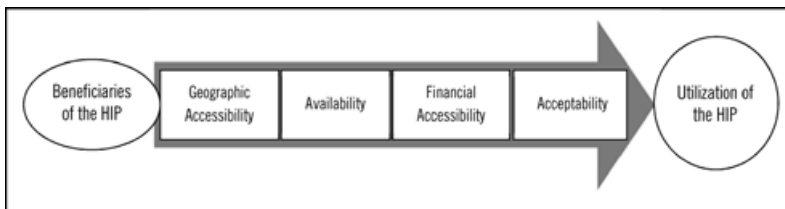


FIGURE. 1 RESEARCH FRAMEWORK

RESEARCH METHODS

The study was conducted in Purbalingga District of Central Java Province, which is astronomically located at longitude of 7010' - 7029' South and latitude of 101011' - 109035' East. It is about 360 Km east of Jakarta, the capital city of Indonesia. The district was purposively selected due to its high poverty rates, which ranked second in the province. Within the district, eighteen villages were purposively selected based on geographical condition (Fig. 2).

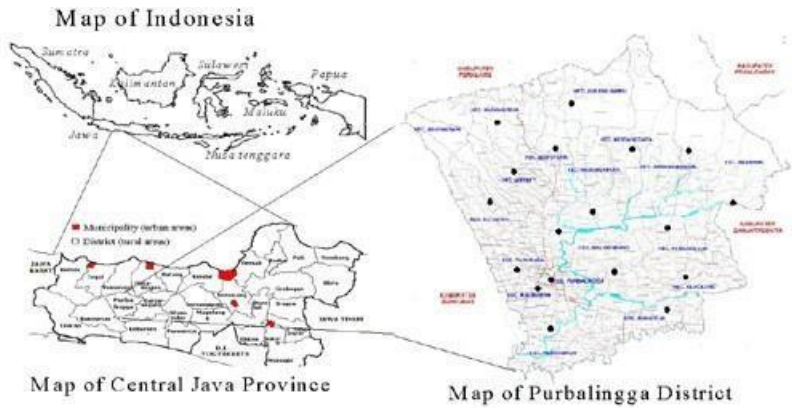


FIGURE. 2 MAP OF PURBALINGGA DISTRICT PRESENTING STUDY VILLAGES (WITHOUT SCALE)

The population of this study consisted of 100,281 poor households registered in the Unified Targeting System of 2011 Social Protection Program (*Basis Data Terpadu*) in Local Planning Agency. A total of 648 households in the district, or 36 households per village, were randomly selected to be the respondents. Fieldworks were conducted in July to August 2015 by the authors and eighteen trained enumerators. The other key informants of this study included village officers, local health officers and prominent community members. Questionnaires, interviews, focused group discussions and observations were applied as per need. This study employed mixed methods of qualitative and quantitative data analysis techniques. The quantitative analysis was applied mainly through statistic descriptive method.

RESULTS

Socioeconomic Condition of Study Sites and Respondents

Purbalingga district has an area of 777 Km², and is divided into 18 sub-districts and 230 villages. The area was inhabited by 950,000 people ([BPS Purbalingga, 2015](#)). The study sites were predominantly hilly areas located just in the foot of *Slamet* Mountain. The settlements (*Dusun*) of the study sites typically

consisted of about 100 to 300 households grouped in the flat areas. Each settlement was separated by cropland areas, hills, rice fields and other natural boundaries. About 5 to 10 settlements were grouped into a village, and about 10 to 15 villages were grouped into one sub-district. On average, each village has area of 2 to 5 Km². The villages were connected by asphalted road passable for cars. Public transportation was available only to connect the sub-district and district capital. People from village mainly used foot, bike and motorcycle to go to the other villages and sub-district capital.

The district was still dealing with problems of low level of health condition of the population. In 2013, it was reported 187 cases of malaria, 389 cases of pneumonia, 13 cases of leprosy, 572 cases of dengue, and 37,301 cases of diarrhea. Child mortality rate was 11 per 1,000 births ([District Health Agency of Purbalingga, 2014](#)). The high incidence of diseases indicated the need of the government to improve healthcare system for the population.

Statistically, most of the households were headed by male (89%) with elementary level of education (52%) and working in agriculture (30%). The average member per households was four people. About 5% of the households had members with physical defect. About 16% of the households had members suffering from chronic illness, which mainly included diabetes and problems related to heart and respiratory organs. There were 3% of the households having pregnant members, and 25% of the households have child under age five. These present the need to access health services, which implies additional health spending. Ownership of the HIP is essential to reduce the health spending (Table 1).

TABLE1 SOCIO-ECONOMIC CONDITION OF THE RESPONDENTS

Socio Economic Condition	Number	Percentage
Gender of HH Heads		
Male	577	89%
Female	71	11%
Education of HHHeads		
Having no formal education	274	42%
Elementary School	335	52%
Junior High School	35	5%
Senior High School	4	1%
Occupation of HH Heads		
Agriculture	250	39%
Labour	203	31%
Business	52	8%
Service	24	4%
Other	95	15%
Number of HHs with chronic illnesses	102	16%
Number of HHs with pregnant members	18	3%
Number of HHs with child under five	164	25%
Number of HHs with physical disabilities	31	5%

Note: HH: Household
Source: Field Survey, 2015

Distribution Accuracy of the HIP

On the paper, all of the respondents deserved the HIP program because they were listed as the poor and vulnerable in the government database. However, only 605 respondents (93%) actually became the beneficiaries of the HIP, which was proven by their ownership of the HIP card. Another 43 respondents (7%) were excluded from the HIP.

The inaccuracy of distribution was the consequences of various troubles in enumeration process. Village officers said that they were not involved or given tasks to enumerate the people. Hired enumerators were directly coordinated by the statistical agency to perform the tasks. It was reported that many enumerators did not visit the households to observe and interview. The questionnaires were simply fulfilled on the desk just based on estimation with limited references. Most of the enumerators were not the residents of the study villages, thus having low understanding about the real condition of the poor. Consequently, when the list of beneficiaries was issued by the

statistical agency, many poor households were not listed. The government could not issue additional cards for the unlisted households. These became the main cause of inaccuracies in the program distribution.

Access to Public Healthcare Facilities

Geographic Accessibility

The healthcare providers available in the settlements are entailed in the Health Post (*Posyandu*), which is opened once a month to monitor the health status of the pregnant and child under age five. A village clinic (*Polindes*), with only one midwife, was available in most villages, with the task to install contraception and to provide primary healthcare for the pregnant and child under age five. In the sub-district, there is a Community Health Center (*Puskesmas*, herewith abbreviated as the CHCs), completed with nurse and medical doctor. More advanced hospitals were available in the district capital, which had specialist doctors, laboratory installation and inpatient units. The government of Purbalingga district had 1 hospital, 22 CHCs, 199 Village Clinics, and 1,194 Health Posts. On average, each CHC had one doctor, seven nurses and four midwives. In addition, there are four hospitals and 25 private clinics in the district, but only less than one third of them accepted the utilization of the HIP ([District Health Agency of Purbalingga, 2014](#)). The other primary cares are privately provided by the doctors in their houses before and after the working hours in the CHCs.

The CHC is still the main provider of primary healthcare in rural areas. Its working area ranges from 8 Km² in the district capital to 62 Km² in the remotes sub-districts. Based on the number of residents, one CHC should serve 18,221 to 58,769 people ([District Health Agency of Purbalingga, 2014](#)). If secondary treatment is needed, the respondents should go to the district hospital by using referral from the CHC. The distance from the most remote village to the hospital is 45 Km, which could be reached within about two hours of travel with motor

cycle or car. The main roads to connect most settlements with the CHCs and district hospital are asphalted and passable by car. Yet, the dispersed characteristic of rural settlements and the nature of hilly areas of the study villages presented challenges to access the CHCs and the district hospital.

About 59 respondents (10%) complained about the geographical distance of the public healthcare facilities from their houses. This became the reason why they did not always utilize the HIP when sick. On the other hand, the interviewed district officers told that the government was aware about the problems of limited number of public healthcare facilities. However, problems of limited budget to build and operate new facilities as well as limited number of doctors to be sent hindered the creation of new health facilities. The government efforts were limited only to increase the number of the CHCs capable for inpatient treatment. By 2015, about half of the CHCs were able to provide inpatient cares.

Availability

In terms of the HIP utilization, many respondents asserted that the geographical distance of public healthcare facilities was not the main issue, rather its operating hours. The working hours of the CHCs and other public facilities in the study sites were officially from 08:00 AM to 12:00 AM, every Mondays to Saturdays. This operating hour is similar with working hours of most residents as well as the schooling hours. Some respondents, especially industrial workers and students, could not visit the public health facilities during working hours and when visits are made beyond the working hours, the HIP could not be used.

The low number of public health facilities implies that longer time will be spent when getting treatments. As an illustration, in 2013, it was reported that 763,655 visits to the CHCs throughout the district ([District Health Agency of Purbalingga, 2014](#)) or an average of 116 visits per day per CHC. With only one

doctor available in the CHC, patients had to wait a long time to have the treatment. In addition, many respondents shared that the operating hours were often delayed because the doctors prioritized their private service in the houses before the CHC operating hours. Their private operating hours were mostly conducted from 06.00 AM to 07.00 AM and 05.00 PM to 07.00 PM. Most respondents suggested that it would be better if the operating hours of the CHCs were extended to 05.00 PM, and that the CHCs were also open in Sunday. Limited number of doctors as well as limited budget from the government to extend the operating hours of the CHCs are the major concerns. The interviewed district officers told that supervision had been conducted to ensure that the CHCs are obedient to the stated schedule and that the doctors came on time to give the services. Yet, the results of the supervision were still not optimal due to limited implementation of reward and punishment system.

Financial Accessibility

The HIP covered the insurance for inpatient, outpatient, preventive and maternal cares. These benefit packages were quite generous as most of the costs of medication were guaranteed by the HIP. These meant that in the supply side, the government had performed well in increasing financial accessibility of the poor. There were no reports of troubles in the reimbursements of the service costs by the healthcare providers, which meant that the government could well manage the funding of the HIP.

Yet, despite the costs of medication, the households also need to set aside extra money for travel (transportation) costs as they visit public healthcare facilities. Among the respondents, 12% had no travel (transportation) fund as they visit the nearest CHCs or district hospital, which meant they could go there on foot or by bicycle. Most respondents spent IDR 10,000 for travel cost to the facilities. The highest travel cost spent by the respondents to visit the CHCs was IDR 40,000 (Table 2).

TABLE 2 TRAVEL COST TO THE NEAREST CHC

Travel cost from houses to the nearest CHC	Number	Percentage
Without costs	80	12%
IDR 1 to 10,000	369	57%
IDR 10,001-20,000	169	26%
IDR 20,001-30,000	28	4%
IDR 30,000-40,000	2	0%
Total	648	100%

Source: Field Survey, 2015

To imagine the meaning of those amounts of money, it could be illustrated that IDR 30,000 was comparable to the wage of one-day agriculture labor or the price of 3 Kg of rice. Generally, the respondent's willingness to pay travel costs was high. Most respondents said that when they were sick, they were willing to spend the travel costs to visit the CHCs in order to have free treatment. These means that the travel costs did not become a constraint for the beneficiaries to utilize the HIP.

Many respondents stated that the highest cost they should spend is for the person and family accompanying a family member when inpatient treatment is needed. The cost was necessary to buy the food and other necessities during the treatment. Some of the poorest respondents told that when they were sick and needed inpatient treatment in the hospital, they pretended to choose routine outpatient treatments in the CHCs due to financial difficulties.

Acceptability

The HIP was financially designed so that the doctors and nurses would be paid appropriately. This may become the encouraging factor for the quality of service given to the poor in utilizing the HIP. In general, the respondents perceived that the quality of treatment in public health facilities was good enough. There were statistically no significant differences of quality of health service given to the patients with the HIP and those without the HIP (Fig. 3).

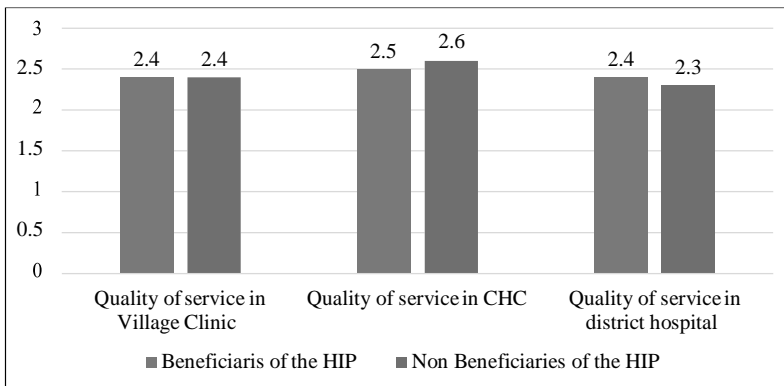


FIGURE 3. RESPONDENT'S PERCEPTION TOWARD THE QUALITY OF PUBLIC HEALTH SERVICES

Note: 1-1.66: bad; 1.67-2.3: Medium; 2.3-3: Good

The respondents expressed various narratives, especially their expectation toward better quality of services of the public healthcare facilities. Mostly, they expected that the services were conducted faster, with shorter waiting time, better facilities and more convenient room in the CHCs. The government will have a difficulty in meeting this expectation due to various challenges in the management. Regulation of Standard of Minimum Services (SMS) and Standard of Operating Procedures (SOP) have been issued to serve as the guidelines in delivering public service. However, periodic survey of the consumer's satisfaction towards public service is not conducted. The government does not have a mechanism yet to monitor whether the SMS and SOP are delivered well.

Utilization of the HIP

Most of the beneficiaries of the HIP preferred to visit public healthcare facilities for medication, which mostly included the CHCs (71%) and the village clinics (26%). There is a substantial portion of the respondents who preferred the private services of doctors (26%), which meant that they did not use the HIP. The visitation to private doctors was substantially higher by the non-beneficiaries of the HIP (Fig.4)

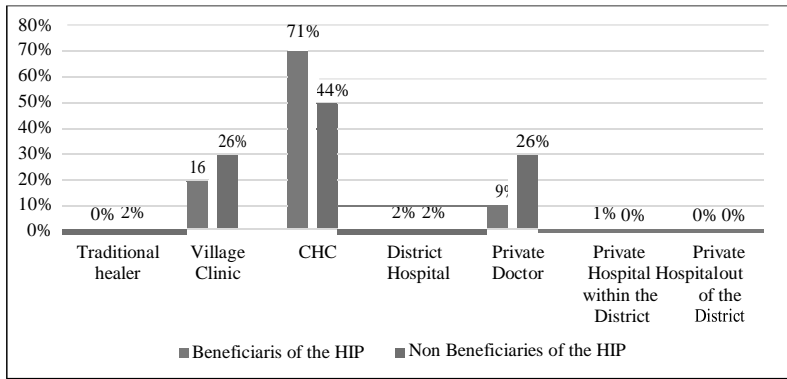


FIGURE. 4 THE PRIORITY OF MEDICATION PROVIDERS VISITED BY THE RESPONDENT

The figures indicated that the beneficiaries of the HIP did not always utilize the insurance when accessing medical treatment. In a year, each household sought for health services at least six times, but they used the HIP for four times only. This explains why the beneficiaries of the HIP still spends substantial amount for health services. As a result, although the health spending of the beneficiaries is 9% which is lower than the non-beneficiaries, there is statistically no significant differences between them (Table 3).

TABLE 3. HEALTH SPENDING OF THE RESPONDENTS

Status in the HIP	TheAverage of AnnualHealthSpending	P value
Beneficiaries	IDR 295,920	0.816
Non Beneficiaries	IDR 324,948	

Source: Field Survey, 2015

Note: Chi Square Technique was applied, and the P value indicated no significant differences

On an average, the beneficiaries of the HIP spent IDR 295,920 a year for health-related costs. This amount is spent for travel costs, and treatment costs because HIP is not always used to access healthcare, and part of the expenditure is for the family members accompanying the patient during the inpatient cares. The amount of money is also related to the decision of

the beneficiaries for not always using the HIP to access healthcare. As previously presented in Fig. 4, there are 9% of the HIP beneficiaries who prefers to go to private doctors to get medical treatments. Various reasons were identified, which mostly included long distance to the CHCs, having no time to go to the CHCs during working days, and having been convenient with the drug prescription and treatment of the selected private doctor.

DISCUSSION AND IMPLICATION

A closer examination of socio economic profile of the poor respondents show that their households have substantial number of members with physical disabilities, chronic illnesses, pregnant mothers as well as child under age five. They highly need healthcare treatments, on an average of six times per household in a year. Considering these facts, the HIP is needed as a way to transfer entitlement of healthcare from the government to the poor. By design, the HIP aims at transferring the poor with legal, economic, and social rights to access the healthcare. Over time, the HIP is expected to help the poor maintain their health status, decrease their health spending, and improve the overall poverty alleviation programs in the country.

In this study, the utilization of the HIP is explained within the framework of healthcare access underlining the dimensions of geographical accessibility, availability, financial accessibility and acceptability of the services ([Peters et al., 2008](#)). It is found here that both advantages and barriers influence the utilization of the HIP. The advantages of the HIP mainly come from high political commitment of the central government to finance the program. This makes HIP a non-contributory program covering almost all inpatient and outpatient medication costs with well-managed reimbursement system. These lead to the increasing financial accessibility of the beneficiaries to healthcare. More importantly, these become the encouraging factor for the medical workers in delivering better treatment to the beneficiaries

and creating acceptability of the services. The financial design of the HIP is seen supportive to the unique nature of healthcare service. As [Ergler et al. \(2011\)](#) found, healthcare services involve the affective dimension of treatment. If the treatment given by the medical workers in one HIP provider is perceived bad, then the patients tend to move to the other providers.

However, the high political commitment of the government to finance the HIP faces significant technical and managerial problems. *Firstly*, the capacity of street level bureaucracy to manage the enumeration of program beneficiaries is low. There is inaccuracy of program distribution, in which 7% of the deserved households were not listed as the beneficiaries of the HIP. Findings of this study about the distribution inaccuracy of the HIP confirms the findings of [Christiani et al. \(2017\)](#) and [Sutiyo and Maharjan \(2011\)](#), which also present the problem of mistargeting in the distribution of the program. The causes of distribution inaccuracy identified here is the centralized system of enumeration and low involvement of village officers and community in the issuance of the beneficiaries list. *Secondly*, there is a challenge of on the side of supply readiness. There is an inadequate number of public health facilities based on geographical areas, and their operating hours are still limited. Consequently, the HIP is under-utilized because the beneficiaries do not always utilize the HIP in accessing the healthcare.

The long-term objectives of the HIP to reduce the health spending of the poor and to accelerate poverty alleviation are undermined by the problem of mistargeting and weak supply of infrastructure and service system. As implication, there is statistically no significant differences of health spending between the beneficiaries and non-beneficiaries. In other words, it can be said that entitlement approach through the social protection program in health sector do not optimally works in Indonesia. Similar cases also happen in India, as presented by the findings of [Ergler et al. \(2011\)](#) and [Akerkar, Joshi, and Fordham \(2016\)](#) that social protection programs do not always successful due to

the low readiness of the government to provide the infrastructures needed. In case of the HIP, it is argued here that the transfer of entitlement is inadequate without the readiness of health infrastructure and service provision. To improve the overall effectiveness of the HIP, there are number of factors should be prioritized by the government. With regard to the problem of distribution inaccuracy, there is no other option but to improve the mechanism of enumeration through effective monitoring, data updating, and in involving local officers and communities in the issuance of the beneficiary list. Number of studies have presented that participatory enumeration system and transparency in enlistment of social protection programs will substantially decrease the inaccuracies and leakages of the program ([Fritzen & Brassard, 2007](#); [Jha, Shankar, & Gaiha, 2011](#)). It is also important to reconsider the findings of [Hardini \(2015\)](#) about the organizational problems of the Social Security Management Agency as the implementing agency of the HIP. Institutional reform within the agency, and establishing clear coordination mechanism between central and local government, are needed to improve the accuracy of program distribution.

With regard to the problem of limited public healthcare facilities and their operating hours, there are several options to consider. If financially applicable, the government needs to increase the number of healthcare facilities, especially the CHCs, together with lengthening their operating hours. However, with the constraints of government budget, it is seen that the government will face difficulties to build new facilities as well as to finance their operational costs. The most possible option is to increase the number of private healthcare facilities linked with the HIP. The involvement of private healthcare providers in the HIP is expected to overcome the problems of geographical distance and limited service hours of public healthcare facilities. Hand in hand with these efforts, the government needs to establish a clear system of rewards and punishments for the health workers so that they will observe and implement the Standard

of Minimum Service and Standard of Operating Procedures in order to optimize the existing service systems.

This study still cannot deeply explain the reasons why many doctors prioritize their private practice, despite the fact that the HIP pay them properly in public healthcare facilities. Another research should be conducted from perspective of moral economy and local political economy to understand this phenomenon.

CONCLUSION

Entitlement approach in poverty alleviation through the implementation of the HIP does not function well due to the problems of distribution inaccuracy and low supply-side readiness. About 7% of deserved households are excluded from the HIP due to weak capacity of the central government to enumerate the poor people. In addition, there are substantial problems of geographical accessibility and service availability of public healthcare facilities. The number of public healthcare providers are not enough to serve the population, and there is limited number of doctors, limited working hours and long waiting time to get treatment. As an implication, the poor do not always utilize the HIP to access healthcare, and substantial portion of them prefer to go to the private healthcare providers to get the treatment, making their health spending not significantly decreasing. In order for the HIP program to create stronger impact on poverty alleviation, the government of Indonesia is recommended to improve the targeting effectiveness through validation and re-enrolment based on participatory enumeration system. Additionally, the government needs to solve the problem of limited public health providers by developing a cooperation with private healthcare facilities to be linked to the HIP. It is also important for the government to establish clear system of rewards and punishments for the health workers in delivering the services.

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