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# Mapping socioeconomic disincentives to public health insurance usage among informal sector workers

A case study on Lombok, Indonesia

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## Abstract

Indonesia faces large epidemiological and demographical challenges that make a functioning health system and social protection accessibility increasingly important. In line with UN Agenda 2030, inequality in health and healthcare access is a top priority among the country's policy-makers. However, social protection coverage among low-middle income households is inadequate. Management of public programmes is hampered by decentralisation effects such as extensive bureaucracy and regulations. This study analyses underlying socioeconomic drivers of low registration and non-usage of Indonesia's public health insurance scheme among informal sector workers. It builds on data collected through in-depth interviews conducted during eight consecutive weeks on the Indonesian island of Lombok. The informal sector employs some 70 per cent of Indonesians, yet social protection of this group is lacking which may, in turn, have broad socioeconomic consequences on both individual and national level in a potential crisis. This study shows that discriminatory treatment and lack of certain resources together with effects of decentralisation comprise the primary reasons among interviewees to remain unregistered or refrain from using public insurance. Amartya Sen's capability approach combined with the concepts of social exclusion and unintended consequences are applied to explain the findings. User-evaluation of the public health insurance is limited, especially in regards to individuals in the informal sector as the characteristics of this sector make recordkeeping difficult. The combined contribution of applied concepts and presented findings therefore complement existing research because it emphasises subjective accounts of former public insurance users employed in the informal sector.

*Keywords: Informal sector, Indonesia, health insurance, social exclusion, capabilities, ethical individualism*

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## List of abbreviations

ADB	Asian Development Bank
AFC	Asian Financial Crisis
BPJS-K	Badan Penyelenggara Jaminan Sosial Kesehatan
BPS-I	Badan Pusat Statistik Indonesia
CA	Capabilities Approach
GDP	Gross Domestic Product
GERMAS	Gerakan Masyarakat Hidup Sehat
GNHE	Global Network for Health Equity
GRiSP	Global Rice Science Partnership
HDI	Human Development Index
HRBA	Human Rights-Based Approach
ISW	Informal Sector Worker
JKN	Jaminan Kesehatan Nasional
NHI	National Health Insurance
OOP	Out-of-pocket
SDGs	Sustainable Development Goals
SMERU	Social Monitoring and Early Response Unit
UN	United Nations
UNDESA	United Nations Department of Economic and Social Affairs
WHO	World Health Organization

## 1. Introduction

Inequality in health is a global problem that has been prioritised in the United Nations' (UN) agenda to improve equal access to fair healthcare (WHO, 2015). According to the World Bank (2017), health challenges are some of the most urgent developmental issues in Indonesia,<sup>1</sup> which together with effects of decentralised governance put large pressure on the national health system. Hence, functioning social protection is of outmost importance to improve the health of Indonesians. This study analyses qualitative user feedback regarding Indonesia's public health insurance and suggests that discriminatory treatment is the most prevalent reason for non-usage in the studied community. Thus, it contributes to existing research by accounting for personal experiences and obstacles relating to public health insurance usage and emphasises the role of local participation for its future development.

Due to the many factors that affect a person's health and access to healthcare, interventions to improve health operates in a peculiar context. Unfortunately, the majority of leading causes of death in low- and middle-income countries are communicable diseases that could easily be prevented or cured (WHO, 2018a).<sup>2</sup> Hence, ensuring equal and efficient healthcare is particularly important in such settings. Health inequalities are also becoming more prevalent within countries (WHO, 2018b). Internationally, the dichotomy between formal and informal sectors is the foundation to many inequalities and Indonesia is no exception since access to social protection benefits is coupled with government employment (WHO, 2017). Some 70 per cent are employed in the informal sector (ADB and BPS-Statistics Indonesia, 2010) without work-related healthcare benefits (Dartanto et al., 2016). Evidence from Indonesia Bureau of Statistics (2015) shows that every third Indonesian considers him or herself to be in poor health, and there are evident cumulative differences between regions as well as income groups (Kristiansen and Santoso, 2006; World Bank, 2014). Unequal access to healthcare may have several life-impeding effects since ill health may hinder income generation, ability to fully assimilate education and could, in unfortunate cases, be directly life threatening (WHO, 2018c).

To improve healthcare access and decrease inequalities in health, the Indonesian government introduced a universal healthcare policy in 2014. While many are already registered in the insurance scheme, registration rates are low among informal sector workers (ISW), particularly among those residing on outer islands (WHO, 2017). According to the

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<sup>1</sup> Indonesia is facing a triple burden of disease where communicable diseases and neglected tropical diseases have been joined by lifestyle-related non-communicable diseases such as diabetes and lower respiratory illnesses, particularly worsened due to general habits of heavy smoking.

<sup>2</sup> I.e. respiratory infections or diarrhoea.

Global Network for Health Equity (GHNE), government spending on health constitutes only a third of the global average (Trisnantoro, Marthias, and Harbianto, 2014). Out-of-pocket (OOP) payment remains the most common payment method for medical services despite 2014's healthcare policy (WHO, 2017:65). Evaluation of Indonesian healthcare services is scarce (p. 221) and there is a lack of research covering user perspective of public health insurance, especially in studies conducted after the policy was implemented in 2014 (World Bank, 2014).

### **1.1 Specific aim and research questions**

This research analyses non-usage of public health insurance on individual level. Grounded in Amartya Sen's capabilities approach, it argues that taking the perspective of vulnerable groups into account could enlighten problem diagnosis as it may bring to the surface mechanisms in need of further exploration. The study hopes to broaden the understanding of low registration and non-usage of Indonesia's public health insurance by analysing depositions from *former* users collected through in-depth interviews on Lombok, Indonesia. Lombok, an outer island, belongs to the Nusa Tenggara province. The province suffers shortages in medical staff and its Human Development Index (HDI) is low compared to other provinces (Indonesia Bureau of Statistics, 2015). This indicates a need to increase attention to socioeconomic development in the province. Moreover, during the field study, it became clear how parts of Lombok flourish as a result of tourism, while many villages are rural and difficult to access. This nourishes inequality and poverty remains a prevalent issue on the island. A combination of two questions frames the issues brought up in the study. The questions attended to are

- 1. Which are some of the major socio-economic factors impacting perception of public health insurance among interview participants?*
- 2. To which extent could the observed phenomena of low registration and under-utilisation be explained by the capabilities approach and social exclusion?*

### **1.2 Background**

#### *1.2.1 The Indonesian context*

For decades after the independence in 1945, authoritarian leaders held power in Indonesia and development was mainly an economic concern (Suryahadi, Febryani and Yumna, 2017). The Indonesian economy bloomed as a result of top-down strategies focusing on financial growth, and lack of democracy facilitated the continuation of authoritarian leadership (Bresnan, 1993). As a result, the country experienced three decades of constant economic growth. During this time, however, social protection only addressed the formally employed while the majority of



Indonesians were practically excluded from any welfare support.<sup>3</sup> Instead, informal sector workers depended on community and family for social protection (Suryahadi, Febryani and Yumna, 2017).

At the end of the 1990s, the Asian Financial Crisis (AFC) hit Indonesia, leaving the previously strong and rapidly growing economy in shambles. Additionally, the country was struck by crops failure as a result of heavy drought which had severe effects on production and price of rice.<sup>4</sup> The combined effects were devastating and generated public protests as the former regime was unable to resolve the situation. However, it was the extensive effects of AFC that eventually lead the regime to resign in the end (Suryahadi, Febryani and Yumna, 2017). Subsequently, Indonesia's government revisited its priorities, and socioeconomic interventions since lead development in the country (Croissant, 2004).<sup>5</sup> Top-down ruling has gradually been replaced by democratically grounded institutions and aspirations to provide efficient public services such as social protection (Buehler, 2011; WHO, 2017). Construction of Puskesmas facilities has improved proximity of healthcare services in many parts of the country,<sup>6</sup> bettering geographical healthcare accessibility. Implemented social protection programmes also cushioned socioeconomic consequences among the Indonesian population when the global financial crisis hit in 2008 (Suryahadi, Febryani and Yumna, 2017).

However, the road has been long and paved with corruption and lack of administrative transparency (Aspinall, 2014; Mietzner, 2015). As democracy grew, more political parties battled for public support, which has created a tendency among politicians to promise and implement extensive programmes without sufficient knowledge of the kind of interventions necessary. On top of this, decentralisation of governance has impaired communication between the various levels of government (WHO, 2017).<sup>7</sup> Consequently, local voice is neglected or, at best, lost along the way due to complex bureaucracy. Thus, democracy has according to some become a tool to uphold power structures as parties carry out populist policies to remain in power. In the process, policy-makers' attentiveness to local experience diminishes as interest in public opinion is dubious and primarily a campaign strategy (Aspinall, 2014).

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<sup>3</sup> 'Formally employed' refers civil servants or private sector employees.

<sup>4</sup> Rice is the most important food crop in Indonesia (GRiSP, 2013:117).

<sup>5</sup> The current president, Joko Widodo, has put education and health as the top two priorities in Indonesian development. His administration emphasises democracy and participatory development (Mietzner, 2015; Moeloek, 2017).

<sup>6</sup> Puskesmas are Indonesian public healthcare centres.

<sup>7</sup> GNHE states there are currently 500 different authorities on central, provincial and community level (Trisnantoro, Marthias, and Harbianto, 2014).

### 1.2.2 *Goals, utilisation and shortcomings of the public insurance*

In 2014, a new national health insurance (NHI) policy was introduced, putting previously scattered health insurances under one policy scheme: Jaminan Kesehatan Nasional (JKN) (Dartanto et al., 2016).<sup>8</sup> While JKN was designed at central level in Jakarta, a 2001 decentralisation reform authorises each district to manage it autonomously. The government requires mandatory enrolment in JKN for all citizens in order to reach the goal of universal health insurance by 2019 (WHO, 2017). BPJS-K has made online registration available and runs a 24-hour hotline to which users can turn for support regarding insurance- and registration matters (BPJS-K, 2017).

The insurance scheme divides beneficiaries into three groups: (1) persons who, due to low income, are eligible for free healthcare as subsidised by the state, (2) persons employed by the government, or in the private sector, and their families, and (3) informal sector workers (ISW), not waged by the state, and their families. The latter also includes retired persons and veterans or their widows. Registration of eligible households is quota-based and conducted on village level by the Kepala Desa (head of village) in relation to general population registration.<sup>9</sup> Premium fees are commonly paid by monthly salary or pension contributions, whereas ISWs pay a separate monthly fee. There are three steps of premium fees, ranging from 30 000 IDR – 80 000 IDR per month.<sup>10</sup> On paper, all premiums include the same services and the sole difference is ward comfort (WHO, 2017:78-82).<sup>11</sup> The arguably low fees have been criticised for being insufficient and weakening the overall quality of healthcare (Aspinall, 2014). A slight rise in prices in 2016 made little difference since some 70 per cent of users are eligible for subsidies by the state and, hence, do not contribute financially (WHO, 2017:82). While previous insurance schemes have charged households as one unit, i.e. one fee for all members of the family, the new scheme builds on individual payments (Suryahadi, Febryani and Yumna, 2017).

Communication and transparency within government bodies have been affected by decentralisation and the health system is not an exception. Already in 2006, Kristiansen and Santoso documented frustration among various stakeholders as a result of decentralisation effects. Over a decade later, World Health Organization (WHO) and researchers at SMERU

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<sup>8</sup> JKN is administered by Badan Penyelenggara Jaminan Sosial Kesehatan (BPJS-K), the Social Security Administrator for Health, which is one of two pillars constituting administration for social security programmes in Indonesia (Dartanto et al., 2016).

<sup>9</sup> Information obtained during a key informant interview with Mrs. Athia Yumna, researcher at SMERU Research Institute (Interview 1, 19.01.2018, Jakarta).

<sup>10</sup> This equals approximately 18.41-36.83 SEK. Most interviewees in this study have volatile monthly income which make set fees like this difficult to afford or prioritise.

<sup>11</sup> I.e. comfort of beds or the number of people sharing room.

Research Institute in Jakarta maintain communication and promotion difficulties as the main challenges within the Indonesian health system, and the ambitious insurance scheme seems to suffer from the same disease (Suryahadi, Febryani, and Yumna, 2017; WHO, 2017).<sup>12</sup>

### 1.2.3 *Vulnerability of informal sector workers*

Informality is pervasive in development contexts, where approximately 73 per cent of the world's workers lack social security (ILO, 2014:V). The definition of informal sector employment applied in this thesis is ‘.../ employment in unincorporated small or unregistered enterprises /.../ and employment that is not covered by legal and social protection...’ (UN, 2010:88). In a report by Asian Development bank (ADB) and the Indonesian Central Bureau of Statistics (BPS-I), it is clearly stated that general measurements of the country's informal sector are scarce. It is a difficult task to audit informal employment in general and a total population of approximately 250 million Indonesians (OECD, 2018) does not make it any less complicated (ADB and BPS-Statistics Indonesia, 2010).

Some 70 per cent of Indonesia's workers are active within the informal sector. Hence, the sector makes large contributions to Indonesia's gross domestic product (GDP) and offers more employment opportunities than any other sector. Nevertheless, ISWs suffer from low wages and income is often irregular as many jobs are shaped by seasonal demand (ADB and BPS-Statistics Indonesia, 2010), and few ISWs have access to employment benefits or employment-related social protection (UN, 2010). Other negative factors within the informal sector are long working hours and poor conditions (ILO, 2018). Employees are generally excluded from government support as businesses within the informal sector are unregistered and do not generate taxes (Tambunan and Purwoko, 2002). Therefore, Indonesian ISWs are obligated to pay a monthly insurance premium (WHO, 2017). Bearing in mind the low wages related to informal sector employment (ADB and BPS-Statistics Indonesia, 2010), additional premiums may have constraining effects on household economy since it might constitute a large share of a person's income. While the poor are supposedly subsidised by state funds,<sup>13</sup> many non-poor ISWs are trapped in what literature refers to as the ‘Missing Middle’ (Dartanto et al., 2016).<sup>14</sup> An additional factor marginalising ISWs is lack of agency or voice in public policy

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<sup>12</sup> Social Monitoring and Early Response Unit.

<sup>13</sup> The definition of ‘poor’ or ‘poverty’ in this context is based on income in relation to the national poverty line. Households with an income below the national poverty line, i.e. below 1.90 dollars a day (World Bank, 2018), are defined as poor and are, thus, eligible for free healthcare subsidised by the state.

<sup>14</sup> The ‘Missing Middle’ imply the part of the population who are not poor enough to receive financial support yet not wealthy enough to afford social protection expenditures.

and politics. Firstly, inadequate knowledge and regulation of informal sectors overall hampers communication between government institutions and individuals. Secondly, ISWs generally do not contribute directly to funding of public programmes because they are rarely subject to income tax. Consequently, ability to impact decisions related to such programmes becomes limited due to non-contribution (Joshi, Prichard and Heady, 2014). Noticeably, inclusion of the ‘Missing Middle’ is a current issue and has been given priority in recent research on development issues in Indonesia (Sparrow et al., 2017; WHO, 2017).

With the above described factors in mind, it is clear that ISWs are vulnerable because of manifold marginalisation. Correspondingly, WHO (2018c) states that segments of a population that suffer from social, political and economic power also commonly are subject to health inequalities. Extending social security coverage among ISWs therefore becomes important. However, it is a difficult task considering decentralisation effects as well as lack of user-evaluations regarding healthcare delivery and public insurance. To simply assure inclusion of all citizens is unlikely to be the panacea to inequality and management issues in Indonesia’s health system, nor will it have any large implications on overall health standards unless healthcare delivery is equal and accessible. Lastly, the UN’s definition of democracy includes following statement: “Democratic governance, as supported by the United Nations emphasizes the role of individuals and peoples — all of them, without any exclusion — in shaping their human growth and the human development of societies” (UN, 2018).<sup>15</sup> This points to the importance of including segments such as the ‘Missing Middle’ in policy evaluation and development. Failure to do so would arguably further marginalise individuals in the informal sector, in contrast to international recommendations (UNDESA, 2016).

### **1.3 Existing literature**

#### *1.3.1 Social protection and health in Indonesia*

The Indonesian constitution protects social security of its population by stating that all citizens have the right to live a dignified life (Suryahadi, Febryani and Yumna, 2017). However, many factors complicate efficient and fair delivery. Firstly, Indonesian policy-making operates under peculiar circumstances already from the outset due to practical conditions such as population size, geographical setting and multiculturalism (WHO, 2017).<sup>16</sup> Secondly, democratisation and

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<sup>15</sup> United Nations (2018). Available at <http://www.un.org/en/sections/issues-depth/democracy/>. Accessed 08.04.2018.

<sup>16</sup> Indonesia consists of over 17 500 islands with more than 700 local cultures and around 300 local languages (WHO, 2017).

decentralisation are joined by challenges of demographical and epidemiological shifts (Suryahadi et al., 2011; Aspinall, 2014; Suryahadi, Febryani and Yumna, 2017). Together, these aspects create a web of challenges that impacts the production and delivery of social protection in Indonesia.

Suryahadi, Febryani and Yumna (2017) explain how the existing social protection system emerged and the challenges that paved its development. The combination of various suppliers is discussed since responsibility of provision does not lay solely on the state.<sup>17</sup> The study explains how shortcomings in staff, healthcare facilities and equipment put additional pressure on the country's health system. It concludes by presenting various challenges facing social protection in Indonesia, particularly in health.<sup>18</sup>

WHO presents a health system review regarding Indonesia, providing comprehensive information from an informative standpoint. The report focuses on health aspects of social protection and goes into detail on how the NHI functions. It is stated that, out of around 250 million people, only 172 million were covered by the insurance in 2016, three years after its implementation (WHO, 2017). It examines shortcomings and underlying factors that are similar to the ones presented in Suryahadi, Febryani and Yumna (2017) regarding general social protection. WHO's report explains the additional pressure that demographical and epidemiological shifts put on provision of healthcare support in Indonesia. Moeloek (2017), the Indonesian Minister of Health, builds on these challenges as she discusses the triple burden of disease that recently have become a worry to Indonesian healthcare provision. Her article discusses and promotes Gerakan Masyarakat Hidup Sehat (GERMAS). GERMAS is a government initiative to promote health and wellbeing among the Indonesian population and aims to make all stakeholders actively involved in health promotion efforts to improve national health standards. By doing so, it aspires to aid delivery of healthcare and enhance general health of the population (Moeloek, 2017).

In 2006, Kristiansen and Santoso published a study reporting limitations of Indonesian healthcare delivery from a qualitative perspective. Their study draws on the impacts of decentralisation and red tape in relation to the 2001 health reform that gave districts decision-power over healthcare funds.<sup>19</sup> The authors explain how medical staff feel hindered by limited

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<sup>17</sup> Many communities rely on informal social protection structures, and employers are also to an extent responsible to provide assistance to employees.

<sup>18</sup> E.g. ambiguity in local government responsibilities, slow implementation, insufficient promotion and inclusion of ISWs.

<sup>19</sup> Red tape is defined by Merriam-Webster as official bureaucratic processes, attributed by unnecessary complexity, resulting in deferral or inaction (Merriam-Webster, 2018).

funds and bureaucracy, and how some patients feel mistreated due to these circumstances. A household survey was conducted in relation to the study which makes it one of few studies to bring in user-perspective.

Few studies investigate Indonesia's public health insurance after 2014. Dartanto et al. (2016), however, look at participation rates among ISWs, collecting quantitative data related to willingness to pay. The study finds that many ISWs think the monthly fee is too expensive. Lack of knowledge on how to register and utilise the insurance are other factors documented in the study. Since it is primarily a quantitative study, there are no in-depth explanations as to *why* prices are considered expensive, which is what the present study aims to contribute with.

### 1.3.2 *Decentralised management of health systems*

The process of democratisation is commonly coupled with decentralisation of institutions as governments aim to bring decision-making closer to local communities in order to increase efficiency, and Indonesia is no exception (Aspinall, 2014). However, decentralisation is often blamed to be a prominent factor of delays and mismanagement, mainly because transparency is difficult to uphold in devolved systems (Kristiansen and Santoso, 2006; Lewis, 2006; González-Pier et al., 2006; Aspinall, 2014; WHO, 2017). In other words, good governance and democratic practice do not ensure well-functioning institutions (Banerjee and Duflo, 2011:246-248). Lewis (2006) discusses this issue in relation to healthcare in development contexts and explores the negative effect of various kinds of mismanagement within healthcare, focusing on corruption.<sup>20</sup>

González-Pier et al. (2006) discuss social security management in relation to universal health insurance in Mexico. Indonesia is undergoing epidemiological and demographic transitions resembling those Mexico underwent about 20 years ago which inspired the implementation of Mexico's universal health insurance. According to this study, correct management and transparency are crucial for fair and accessible healthcare. Similarities in circumstances, aims and functions between the two countries' national health insurances make González-Pier et al.'s (2006) findings necessary to consider also in the present study. Essentially, the study concludes that genuine incentives and right funding have little impact if institutions do not function correctly.

Aspinall (2014) together with Kristiansen and Santoso (2006) discuss decentralisation in the Indonesian healthcare system. The former depicts issues in healthcare provision from a

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<sup>20</sup> One major aspect acknowledged in the article relevant to the present study entails how complex bureaucracy and mismanagement causes restrictions on public healthcare resources.

governance perspective, arguing that problems stem from democratisation and decentralisation. It describes a trend among local authorities to expand social benefit expenditure as a result of decentralisation but says marginalisation of certain vulnerable groups and their interests continues due to elite capture. Kristiansen and Santoso (2006) more directly discuss the impact of decentralisation on Indonesia's healthcare delivery. According to them, healthcare has become a mode of profit accumulation due to deficient or non-existent transparency and liability. The authors argue that this issue overshadows health improvements efforts for the poor population and suggest increased government spending to ensure the latter.

### 1.3.3 *Inclusion of vulnerable groups*

Inclusion of vulnerable communities is emphasised in Agenda 2030 and the Sustainable Development Goals (SDGs) as an important element of development (UN, 2015). A report by United Nations Department of Economic and Social Affairs (UNDESA) from 2016 explains that, despite great progress in socioeconomic matters during recent decades, the world becomes increasingly uneven in many aspects, not least concerning health. Mapping of social exclusion needs to include subjective accounts of disadvantaged persons to battle inequality. The report states that ISWs are an exposed group due to exclusion and limited socioeconomic opportunities. It explains how social exclusion and ill health together with lack of political voice often go hand in hand. Social exclusion may be based on prejudices regarding a person's socioeconomic identity. This might produce humiliation or shame and lead to diminished sense of agency. Conclusively, the report states that increased inclusion of vulnerable or marginalised groups has positive impacts on sustainable development (UNDESA, 2016).

Informal sector employment is described by many to make workers particularly vulnerable (Brata, 2010; UN, 2010; UNDESA, 2016). As previously noted, the 'Missing Middle' is neglected in many development efforts since much focus lay on the Indonesian poor (Suryahadi, Febryani and Yumna, 2017). Moreover, significant studies point to the importance of extending inclusion of vulnerable and marginalised people in development efforts (WHO, n.d.; UNDESA, 2016). Peters et al. (2008) particularly discuss this topic in relation to healthcare and suggest interventions should to a larger extent incorporate disadvantaged groups of local communities in order to be successful.

Social inclusion is important current development work since a large share of international interventions follows a Human Rights-Based Approach (HRBA) (UNFPA, 2014;

WHO, n.d.).<sup>21</sup> In line with UNDESA, the HRBA believes that, by including marginalised groups, elimination of inequality will make marked progress in sustainable development. Banerjee and Duflo (2011:247-251) discuss this development trend. For example, the authors describe a development project in Indonesia which initially failed due to lack of participation among beneficiaries. When local elites steered meetings according to project guidelines, beneficiaries remained unintentionally excluded. However, participation rose when individual invitations were sent out to beneficiaries. The point is that, even though this particular project operated in a small community close to its beneficiaries, positive outcomes were reached only after directly approaching beneficiaries.

## **2. Theoretical concepts**

### **2.1 The capabilities approach**

Stating social change as the driver of development, in contrast to economic growth (Sen, 1999), Amartya Sen's capabilities approach (CA) has had large implications for the development discourse and social research in several ways (Sen, 2002).<sup>22</sup> Similar to the present study, CA prioritises ethical individualism.<sup>23</sup> The baseline of CA acknowledges that other factors than income impact poverty and quality of life. This is clear and highlighted in the core of the approach, stating that each and every person is entitled to capabilities which let them lead the life they revere.

CA discusses relations between four concepts: (1) well-being achievement, (2) agency achievement, (3) well-being freedom and (4) agency freedom. These four concepts are utilised to assess to what extent an individual is able to live a life that he or she desire. The discourse also includes the relation between capabilities and functionings. Functionings imply what actions an individual realises, whereas capabilities entail opportunities made available by combinations of those functionings. The two latter concepts regarding freedom correspondingly refer to an individual's rights and capabilities, whereas achievement refers to functionings. The core message of CA and ethical individualism suggests capabilities should be further emphasised in development efforts, since functionings may largely depend on contextual factors (Sen, 1985; Sen, 1993). Hence, advocates argue that there is a risk of basing

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<sup>21</sup> This approach accentuates individual agency and holds duty bearers, such as the state or private sector, responsible to facilitate individual capability to claim one's rights (UNFPA, 2014, WHO, n.d.).

<sup>22</sup> E.g. sustainable development, socioeconomic inequality and reduction of poverty (Sen, 2002; Fukuda-Parr, 2003; Giullari and Lewis, 2005).

<sup>23</sup> Ethical individualism entails high value of subjective perspectives, primarily in relation to evaluations of public programmes (Sen, 2000; Giullari and Lewis, 2005).



development interventions on research that focuses on functionings since functionings are subject to materialistic resources and physical ability (Anand, 2005).

CA takes into account the various reasons why differences in capabilities arise. One such reason is allocation of non-personal resources within a society. Hence, the structure of a national healthcare system might, for example, be an underlying cause of unequal capability among members in a population. Generally, CA aims to increase freedom of choice and ensure equality of capabilities. This is done by influencing development research from the perspective vulnerable individuals or groups that are commonly not consulted about interventions that are in fact specifically put in place to improve the lives of those groups (Sen, 1999). Some, however, claim that CA neglects interrelations between individuals by treating each individual's reflections as separate from others. According to sceptics, this generates highly specific findings that are not generalisable (Giullari and Lewis, 2005). Having acknowledged this, the present paper does not argue that data deriving from capability-focused research neither should nor could be the sole source of data for development of Indonesia's public health insurance. It does, however, argue that increasing evaluation from the point of individual perception of one's capabilities may bring new insights. It is based on this reasoning the present study will attempt to explain why the view of the individual user could deepen the understanding of low registration rates and non-usage of the Indonesian public health insurance.

### 2.1.1 *Capabilities and health*

To anchor CA in a more tangible perspective, section 2.1.1 presents and discusses connections between the approach and health found in existing research. The aim is to show connections that purposefully tie the concept of capability to the study.

Ruger (2004) presents a comprehensive discussion on the many connections between CA and contemporary problems in health and healthcare, revisiting moral and philosophical grounds on which health interventions are shaped. Firstly, one of the most relevant aspects in the capabilities-health connection in this is the previously described emphasis on capabilities over functionings. Much resources in health are allocated on financial ability to pay instead of medical need. To allocate resources and design interventions based on the latter would plausibly decrease health inequality (Ruger, 2004). Correspondingly, this study argues that flaws in the management of Indonesia's health insurance scheme need to be addressed to ensure income do not affect access to fair healthcare.

Principally, CA proposes that human development is achieved by empowering the individual and eliminating barriers such as democratic constraints or ill health (Fukuda-Parr,

2003). The difference between ‘access to health’ and ‘access to healthcare’ needs clarification, as they are many times mistaken to be equivalents. In other words, access to healthcare does not automatically suggest access to health. Factors such as financial resources, proximity to medical centres or number of doctors are all important but do not guarantee health as such. The individual’s political and societal position also play in and Ruger (2004) argues that such factors are not sufficiently considered in current health interventions. Similarly, the present study focuses on interviewees’ perception of healthcare management and delivery, attempting to show how sector of employment may affect equality of healthcare access in Indonesia.

## **2.2 Social exclusion**

Social exclusion may emerge on a variety of grounds and have large implications on whether or not a person can access rights and freedoms. Thus, its effects may be multidimensional (UNDESA, 2016). Sen (2000) describes the relational aspects of social exclusion, explaining how deprivation in one area, may it be economic, social or other, might lead to further deprivation in other areas as well. For examples, exclusion from services such as healthcare or education may negatively affect income or create feelings of low self-worth. Sen (2000) states that social exclusion limits individual capabilities and should be prioritised in societal development since ignoring it hampers socioeconomic progress. Thus, to address issues of social exclusion is important in global development work and has, fortunately, gained more attention in recent decades (UNDESA, 2016).

Social exclusion takes on a variety of forms. It may be connected to discrimination and marginalisation of particular groups in society or be an individual concern. Moreover, one may be actively or passively excluded. The former relates, for example, to policies directed at limiting certain people from access to particular benefits or opportunities. It may also imply that policies consciously exclude individuals from benefits that are available to others. Passive exclusion entails to oversee some peoples’ needs and rights without consciously taking actions to exclude them. In addition to active and passive forms of social exclusion, there is a third element: unfavourable inclusion. That is, inclusion on unequal basis which may hamper an individual’s well-being in ways similar to exclusion (Sen, 2000). Informal sector workers are indeed included in Indonesia’s NHI. Nevertheless, both existing literature and the present study point to factors of unfavourable inclusion and limited targeting of this particular group. Hence, unfavourable inclusion, passive exclusion and limited individual capabilities have arguably created disincentives among ISWs to utilise the NHI, which have in turn resulted in increased

OOP expenditures and reinforced inequalities in the national health system (Dartanto et al., 2016; Suryahadi, Febryani and Yumna, 2017; WHO, 2017).

### 2.2.1 *Unintended consequences*

Passive exclusion relates to the concept of unintended consequences of interventions. This concept, coined by Merton (1936), is discussed by Portes (2000) in relation to sensitivity regarding unexpected outcomes of public programmes. Portes (2000) emphasises the importance of contemplating the unexpected in order to understand the complex nature of social contexts and its impact on the outcome of public programmes. An *unintended* consequence does not necessarily mean an *undesirable* consequence. However, according to the authors, an unintended consequence commonly has negative effects on the overall outcome of a programme since it was not considered in formulation of the goal (Merton, 1936; Portes, 2000).

Merton (1936) describes how, when choices are limited, an otherwise irrational act becomes rational due to lack of available options, possibly extending any unintended consequences. Connecting unintended consequences to capabilities in health, one may argue for increased attention to capability in health-related interventions compared to functionings.<sup>24</sup> Capabilities could aid in mapping factors less tangible but which, nevertheless, have impacts on health and health equity. Negative effects of unexpected consequences may thus decrease if more attention is given to capability. Similarly, Portes (2000) highlights the importance of analysing social processes and peoples' individual experiences. By doing so, the aim is to uncover hidden factors that plausibly impact public policy and programmes.

Portes (2000) brings up five situations which may spur unintended consequences. Out of those five, the one most applicable here reads “/.../ the goal is what it seems – but the intervention of outside forces produces unexpected consequences different and sometimes contrary to those intended /.../” (Portes, 2000:8). Universal coverage of the public health insurance is the Indonesian government's genuine goal but social exclusion together with other unconsidered factors have had impacts on this goal. Emotional and habitual factors among interviewees may alter incentives as well as priorities. Hence, building programmes based on too generalised plans may enhance the risk of negative unintended consequences. An additional situation which may introduce unintended consequences is individuals' sense of being manipulated by authorities (Portes, 2000). It is with regards to these situations that the present study applies the concept of unintended consequences to its findings.

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<sup>24</sup> I.e. tangible and measurable indicators of health such as number of professionally attended births or density of doctors.

## **3. Methodology**

### **3.1 Research design**

The present research follows a qualitative case study design. In qualitative research, methodological tools are chosen based on how the questions are formulated and what they aim to answer. Qualitative, in-depth studies bring valuable insights, complements quantifiable research (Auerbach and Silverstein, 2003) and aim to provide results that give a profound understanding of a topic. It implies interactive data collection and allows for flexibility throughout the research (Bryman, 2012:399). This study is case-driven, meaning it is interested in one particular case and applies relevant theoretical concepts to the findings (George and Bennett, 2005). Such a design is appropriate in this case as it is a small-scale project which aims to explore subjective experiences of each interviewee (Auerbach and Silverstein, 2003). As it accounts for what the interview participants think and have experienced, the study takes on a descriptive approach (de Vaus, 2013).

### **3.2 Sampling and data collection**

Sampling of interview participants was conducted through purposive sampling. This method was chosen as it is a common method for small-scale studies such as the present one, and because it identifies information-rich cases which is essential to in-depth studies (Patton, 1990). Hence, interviewees have not been chosen on a random basis but have been asked to join as it is believed they could provide useful and in-depth knowledge (Bryman, 2012:418). Patton (1990:169) specifically point to the appropriateness of purposive sampling in cases that aspire to evaluate and improve interventions by inclusion of lower socioeconomic groups. The individuals partaking in this study were sampled with three main aspects in mind: (1) active in informal sector employment, (2) not eligible for free healthcare as subsidised by the state and (3) experienced in utilising public health insurance to pay for medical services but not currently utilising it. The last factor is of particular importance to the relevance of the study's findings because it strengthens the focus on disincentives and improving inclusion for all in the scheme.

Further, the main purposive sampling method was snowball sampling. Snowball sampling means consulting interviewees for contacts to additional possible participants (Auerbach and Silverstein, 2003). Snowballing guided the sampling process to relatives, friends, neighbours or acquaintances of interviewees. It was found helpful and generated the kind of in-depth information wished for. Opportunistic sampling was applied occasionally to

not miss out on information due to lack of flexibility as unanticipated opportunities arose in the field (Patton, 1990).

Data collection commenced by a key informant interview with a researcher at SMERU Research Institute in Jakarta. The interview contributed with a deeper perception regarding the topic and situation from a local perspective, complementing general information gained beforehand. It helped in directing further sampling and data collection, especially since the consulted key informant has vast knowledge about the insurance scheme as well as general social protection and health in Indonesia (Bryman, 2012:439-440). Based on the topics discussed during this interview, the initial interview guide developed prior to the field was purposefully altered and expanded.

A total of 14 persons were formally interviewed, ten men and four women. The interviewees range between 25-53 years of age. While half of them are registered in public health insurance, none of the 14 are using it. Thus, the most common way to pay for medical expenses among the group is OOP cash payments, similar to the general public in Indonesia (WHO, 2017:65). Among those registered, two persons use the first class premium whereas the other five pay the lowest premium. One person is employed by the state in a family planning promotion programme and thus has his membership paid via monthly salary contribution. However, named person also owns a local, unregistered business and is therefore involved in the informal sector. None of the interviewees are officially eligible for state subsidies, however one of them had previously (until the end of last year) received it due to close connections with Kepala Desa, i.e. the person in charge of village population registration and who reports eligible persons to the government.<sup>25</sup> All of the non-registered interviewees except one have previously been registered and have experience in utilising public insurance to pay, but have decided to deregister for reasons discussed below.

Qualitative in-depth interviews comprise the main source of data. In-depth interviews are strongly connected to qualitative research and, likewise, aim to acquire a deep understanding of the research topic (Bryman, 2012:213, 399). The majority of interviews were conducted in pairs as most interviewees felt more comfortable being accompanied by an acquaintance.<sup>26</sup> Moreover, the majority of interviews were semi-structured and, hence, followed the interview guide to an extent. Using an interview guide helps in maintaining a certain focus during interviews (Bryman, 2012:471). However, topics not mentioned in the

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<sup>25</sup> This is elaborated on in section 4.4, Analysis: Effects of decentralisation

<sup>26</sup> The implications of conducting interviews in pairs will be further problematised in the limitations. See section 5.

guide were occasionally touched upon, e.g. tourism and environmental questions, because such flexibility may help identifying previously unconsidered issues. All interviews were held either at interviewees' place of work or, in one case, at a quiet social area nearby the interviewees' current place of residence. These interview features all aim to make interviewees' feel comfortable and were particularly important to the study as it centres around personal feelings and experiences (Auerbach and Silverstein, 2003). In addition, meetings with people inspired spontaneous conversations on the research topic and resulted in a number of unplanned, unstructured interviews. While the semi-structured interviews were digitally recorded on permission of interviewees, the unstructured interviews were documented in writing soon after completion.

Lastly, participant observation took place while in the field. One such occasion included an invitation to join a health promotion meeting in a nearby village.<sup>27</sup> While the meeting per se was not directly related to public insurance (during this meeting, all members of the village were allowed and encouraged to take part, irrespective of medical insurance), it was a valuable experience as this method of conducting research provides insights not available through interviewing (Bryman, 2012:494-495). In this case, a practical insight in health promotion and the Indonesian health system was gained, purposefully complementing the overall understanding of decentralisation issues and challenges hindering outreach of public programmes. Moreover, general observation on number of healthcare facilities in the local community was conducted and documented in field notes. It was also noted how many of those are connected to BPJS-K and, hence, allow its visitors to pay by public insurance.<sup>28</sup>

### **3.3 Data analysis**

Generally, in qualitative research, findings are analysed repetitively and continuously throughout the research process (Bryman, 2012:386). Accordingly, transcription of interview recordings and some first cycle coding began while still in the field. Moreover, the data analysis consists of two main coding methods: (1) descriptive coding (Saldaña, 2009) and (2) thematic coding (Boyatzis, 1998). A certain extent of *In Vivo* coding (Saldaña, 2009) has also been employed.

Descriptive coding is an elemental technique that attends to conversation topics, i.e. what is talked about in the interview by dividing the information into categories. It is a common

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<sup>27</sup> The researcher was invited by one of the interviewees to join a bi-monthly health promotion meeting in a nearby village.

<sup>28</sup> All public healthcare centres should be connected to BPJS-K whereas collaboration is voluntary for private clinics.

method to apply to interview transcripts and field notes which makes it suitable for analysis of data in this study. To bring more detail into the coding, sub-categories may be applied. Further, it is an essential tool in first cycle coding that grounds second cycle coding. Hence, descriptive coding helped identifying general topics and sub-categories in interviewees' responses (Saldaña, 2009:70-73). It was combined with thematic analysis, a coding method regularly used in sociology and that allows for conceptual analysis. It helps to structure phenomenological data into information that is easier for the researcher to grasp and can be used in both first and second cycles. Labelling recurrent mechanisms, this method works with both verbal and visual data and finds relations between labels and applied concepts (Boyatzis, 1998:4-7). In this study, thematic coding has underlined how interviewees' told experiences relate to social exclusion, capabilities and effects of decentralisation. Lastly, *In Vivo* coding makes appropriate contributions as the study highlights interviewees' voice. *In Vivo* coding entails the use of phrases and terms as expressed by interviewees. To cite interviewees' responses helps create a more direct insight to feelings and experiences that is useful in the present study as it focuses on subjective opinions (Saldaña, 2009:74-77). For a synoptic coding scheme, see Appendix 2.

## **4. Analysis**

### **4.1 Introduction**

Findings in this study show that public insurance is not the first choice for any of the interviewees. Further, by focusing on individual experiences, the study finds that feelings of discrimination and disrespect are common when paying for medical services by public insurance. This factor is overshadowed in existing research as mechanisms of failing promotion and financial restraints possess the limelight in most studies regarding Indonesia's public health insurance. It is highlighted here since the study draws on values of the capability approach. The analysis identifies three main themes affecting the interviewees' choice to stop utilising public insurance: (1) social exclusion, (2) resources and (3) decentralisation effects. In interview transcripts as well as field notes of unstructured conversations and observations.

### **4.2 Social exclusion**

If we show the doctor our card: very, very low status! Not easy to find recommendation or agreement from the doctor. /.../ No respect! /.../ Better we don't have any card like that, if we can't have any good respect from the doctor.

(Interviewee 10, 31.01.2018)

This quote quite effectively summarises general feelings documented among interviewees. Feelings of being discriminated against when using public health insurance to pay for medical services is a recurrent topic in conversation regarding NHI. Such feelings seem to be common for persons in various premium groups, but are more distinct and stronger among the third-level premium users in this study. The third tier is the cheapest and most utilised one among interviewees.<sup>29</sup> Generally, medical staff are claimed to treat public insurance-users differently than those paying by cash or through private insurance. Corresponding to UNDESA (2016), it makes interviewees feel less worthy because they believe doctors care less about their health compared to patients with more money or resources. Discriminatory treatment often permeates entire visits, starting with excessively long waiting times, disrespectful behaviour towards patients as well as a lack of engagement to learn about the individual's condition, which in turn leads to prescription of generic drugs. During waiting times, interviewees also experience that people paying by private insurance or cash receive faster help. This is one reason why the majority of interviewees chose to pay in cash. One interviewee specifically explains how he is treated as a 'king' when paying for medical services in cash, compared to when he used public insurance to pay (Interviewee 5, 24.01.2018). Healthcare inequalities of this kind challenge international goals as presented by several global institutions (UNDESA, 2016; WHO, 2015; UN, 2018). It also shows how well-being and agency freedom of health become limited, as described by Sen (1999), because scarcity of personal as well as non-personal resources restrict individual opportunities to tap into health. By doing so, it also limits a person's capabilities to lead the life he or she values.

Feelings of disrespect may lead to feelings of low self-worth and comparison with formally employed persons enhances such feelings. For example, one interviewee explains that, had he been a teacher with a lot of money, he feels he would receive much more respect (Interviewee 11, 30.01.2018). Further, this creates hopelessness and feelings of being neglected by the government, primarily because of factors related to sector of employment and income. In turn, this generates general disbelief of public programmes among interviewees.<sup>30</sup> Tying into Portes (2000), this is an evident example of how social processes between authorities and the individual may affect willingness to conform to guidelines as implemented by authorities, which creates unintended consequences. The fact that public insurance registration becomes

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<sup>29</sup> The higher number of third level premium users compared to first or second level users should be taken into consideration as it may create alterations in findings as opposed to if the sample contained equal numbers of users from the various premiums.

<sup>30</sup> Distrust towards governmental policies is elaborated on in relation to decentralisation, see section 4.1.3, Analysis: Effects of Decentralisation.



mandatory by the end of this year could also be analysed and explained in relation to Portes' (2000) reflections regarding situations that create unintended consequences. In this case, such consequences result in marginalisation of the intended beneficiaries as they are passively excluded (Sen, 1999; Sen, 2000).

If possible, some interviewees wish to register in a private insurance scheme but state it is too expensive. Due to low income and fluctuations in monthly salaries related to informal sector employment, this option is commonly unavailable for ISWs. Consequently, discriminatory and inferior care provided to public health insurance users passively excludes ISWs from social protection. This often results in unjust and unequal access to health services. Thus, it becomes a main driver de-incentivising interviewees to utilise public insurance. Such a factor corresponds to unintended consequences stemming from social processes and the impact of emotional as well as habitual behaviour of individuals (Portes, 2000; Merton, 1936).

Moreover, there are indications that issues of discrimination and inferior care expand outside informal sector employment. This points to additional hindrances to equal and just healthcare access. During an unplanned conversation, a young woman explains how she has accompanied her mother to the local public clinic several times during the last year. According to her, the medical staff have given the mother the same diagnosis each time: masuk anging, which is equal to having a cold. However, the young woman continues to explain that she feels the doctors provide this diagnosis without much investigation and that the drugs prescribed are generic and often does not help much. She also witnesses about several times when she, herself, has been prescribed cough syrup even though she does not have a cough. This, in turn, causes her to experience hallucinations and dizziness, which affect her alertness and efficiency at work. Generally, the woman feels disbelief towards public medical services and states that she, if she had enough money, would prefer to use private services. The young woman's father used to be employed by the government until he passed away a few years ago. Therefore, the family receives state support through his pension premium, which pays for third level premium. In other words, despite public servant benefits this family experiences inferior healthcare because of third tier membership in the public insurance. It indicates that discriminatory care could be a problem also outside informal sector and suggests that ISWs are doubly marginalised considering their sector of employment. Interviewees in this study are therefore subject to discrimination resembling those of other vulnerable groups globally (ADB and BPS-Statistics Indonesia, 2010; UN, 2010; UNDESA, 2016; ILO, 2018; UN, 2018c).

There are solid indications that inferior treatment of public insurance users creates disincentives to remain registered and utilise public insurance. The quote opening this section

demonstrates this clearly: since the interviewee constantly feels disrespected, looked down at, and receives substandard care, the alternative of being uninsured becomes preferable. Passive social exclusion of this kind is the largest disincentive to utilise public insurance among interviewees in the present study. It strictly contradicts Indonesia's constitution concerning individual rights to a dignified life.<sup>31</sup> The government's aim to reach universal coverage shows that ISWs are included in official plans. However, the characteristics of informal sector employment make it difficult for most interviewees to pay a monthly premium. Therefore, they are adversely included due to various socioeconomic factors and this has lead interviewees to refrain from utilising public insurance. Sen's (2000) unfavourable inclusion may thus effectively be applied to explain disincentives among interviewees. Additionally, it means that ISWs participating in this study may eventually suffer from deprivations in other areas as well due to this unfavourable inclusion in the public health insurance (Sen, 2000).

It is important, however, to note that few interviewees consider the government directly responsible for flaws in Indonesia's healthcare system even though both healthcare service and the public insurance are managed by the state. Nevertheless, they do state that the government carries responsibility for promotion efforts and inclusion of vulnerable individuals. One interviewee specifically expresses how she expects the government to help her financially but that she hitherto has not received the help she wishes (Interviewee 9, 30.01.2018). Similarly, section 1.4.3 on inclusion of vulnerable groups mentions the importance of state efforts to enhance inclusion of marginalised individuals and emphasises the overall benefits of decreasing exclusion. It is also recognised to positively impact sustainable development (UNDESA, 2016).

Considering the increased attention to 'Missing Middle' inclusion in Indonesia and informal sector inclusion globally, the width of social exclusion and its implications for interviewees in the present study are relevant in current debates. However, other factors impacting treatment of patients, for example hospital resources, government regulations etc., are likely to affect patient experiences indirectly. It may, for example hinder medical staff to provide good quality care (Kristiansen and Santoso, 2006; Suryahadi, Febryani and Yumna, 2017). Yet, this study focuses on the experiences of participating individuals and aims to highlight their subjective thoughts. Thus, the combination of social and passive exclusion as a result of discrimination and disrespect is concluded to be one of the main drivers creating unequal access to public healthcare in the studied context.

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<sup>31</sup> See section 1.3.1., Existing literature: Social protection in Indonesia.

#### 4.2.1 *Lack of voice*

I have no power going to the government, I don't work for the government. /.../ Only people who work for the government can be listened [to] by the government.

(Interviewee 5, 24.01.2018)

Several interviewees mention low sense of agency in relation to authorities. The above statement exemplifies how ISWs lack voice and capability to influence public policy. Generally, ISWs are not contributing directly to funding of public programmes as they rarely are subject to income tax. Because of this, ability to impact decisions related such programmes, and overall politics, indirectly becomes limited.<sup>32</sup> The findings also relate to previously documented behaviour of government authorities regarding implementation of programmes that are not perhaps suitable to the local context as authorities not adequately consider individuals' opinion (e.g. Aspinall, 2014). Hence, public programmes are put in place that fail to mirror the needs of the people because implementers lack knowledge about the context. Similar to these findings, Portes (2000) argument regarding standardised programmes also considers the necessity to bring contextual factors in to public programme planning. Here, Sen's (2000) CA may help in guiding implementation based on more individual evaluations. In other words, lack knowledge among authorities could benefit from increased strengthened attention to user-evaluation.

Both medical staff and government employees are considered authorities in this study. Lack of agency in relation to the latter is visualised in the quote above. Interviewees feel public opinion is to a greater extent listened to by the local government compared to higher levels of government. In relation to medical staff, inferior care is impacting interviewees sense of self-worth and thus diminished capabilities to stand their ground against dissatisfactory treatment when seeking care. Apart from effects of overall discouragement created by unequal treatment, the findings document fear of being denied care if claiming the quality of care one is entitled to when paying the monthly premium. One interviewee specifically stated that, as a third tier member particularly, he has to show gratitude and respect towards medical staff even if he is treated disrespectfully or else he worries he would be 'kicked out' of the hospital. Thus, this study enhances Ruger (2004) point that access to healthcare does not automatically entail access to health since interviewees arguably hesitate to utilise the care they indeed have access to, due to social relations.

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<sup>32</sup> See section 1.2.3, Background: Vulnerability of informal sector workers.

Few interviewees are aware of customer support services regarding the insurance scheme, and those who are expressed disbelief in complaints response. One person says he has filed continuous complaints without result, and that this discourages him to continue. Others express positive feelings regarding complaints to BPJS-K as an institution but says that bringing up issues directly with medical staff might cause arguments.<sup>33</sup>

According to Sen (1993), agency-achievement is one of four core aspects influencing individual capability.<sup>34</sup> Experiences shared by interviewees in this study show how lack of power or voice in relation to the government make individuals feel insignificant in the eyes of the government. In relation to agency's impact on capability, interviewees' experiences have impacted their individual agency and created disincentives to register or utilise public insurance. This also ties in to social exclusion since interviewees feel excluded from political decisions on both local and central levels. Hence, lack of voice seems to expand social exclusion of ISW and, by doing so, it indirectly contributes to the overall negative perception of Indonesia's public health insurance found in this study. Thus, limited agency-achievement and freedom influence interviewees to refrain from utilising or register in the scheme. This is an issue which also relates to international standards of democracy, such as the UN's definition of democracy which entails the right for each individual to influence both personal and societal development freely and without exclusion (UN, 2018). Further, a report by UNDESA (2016) observes general relations between ill-health, social exclusion and lack of voice. This points to how findings from the studied context are mirrored internationally, and emphasises the importance of addressing issues of this kind thoroughly.

### 4.3 Resources

If you pay that amount every month, for ten years... You can count, it is very much money and then maybe you never use [the insurance]!

(Interviewee 15, 25.02.2018)

Resources are included in Sen's (1993) explanation of functionings. While the main argument of this study is the value-added of to a higher extent consider individual capabilities in the formulation of public programmes, solely basing interventions on capabilities is not advised nor doable since the two are interrelated. Sen's definition of the two concepts helps

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<sup>33</sup> Culture of not losing one's face is strong in Indonesia and, for this reason, arguing is avoided not to embarrass oneself or others.

<sup>34</sup> See section 2.1, Theoretical concepts: Capabilities approach.

exemplifying how capabilities are dependent on functionings and how the connections they form impact interviewees' access to equal healthcare.

The quote in the beginning of this section shows how some reflect on the fact that, by paying for medical care in advance, there is a risk of spending a lot of money on something that is never needed. Tying in to Merton's (1936) sociological reflections on the rational choice theory, interviewees' socioeconomic situation and limited financial freedom may make generally irrational choices become rational. Protecting oneself from high medical payments by paying a generally cheap fee in advance might seem like a good choice if payments otherwise become more expensive. However, because of the unstable and low wages characterising informal sector employment, what is generally rational might become irrational and vice versa, making in-advance payments irrational.

Similar to existing literature regarding ISWs participation in public insurance,<sup>35</sup> lack of ability or willingness to pay monthly fees are common among interview participants also in this study. In-depth interviews add indications regarding *why* interviewees think public health insurance fees are too expensive. The reasons are many, though the majority relate to how dissatisfactory care makes fees unattractively high. A general perception among interviewees is that one has to register all household members, i.e. that it is impossible or not allowed to register only one or two people. There is no official information supporting this, though one could consider the possible relation between such perceptions and the fact that premiums in previous health schemes were based on households rather than individuals. Nevertheless, it makes interviewees of large families unwilling to register because the collective sum of all individual fees becomes too expensive. Moreover, preference to prioritise other expenses, primarily cigarettes or rice, contributes to some interviewees' choice to remain unregistered.

Another resource affecting the ability to utilise the insurance is time. Again, this relates to Merton's (1936) reflections on rational choices, as well as functionings' impact on capabilities. Working in the informal sector, interviewees often work long hours for at least six days a week. Therefore, the thought of having to travel to the city to pay the fee makes some interviewees unwilling to register. Two interviewees are unaware of the fact that payments can be made in most Alfamarts and agreed that more people would likely utilise public insurance if convenience of payments were bettered.<sup>36</sup> This, however, is a stronger indicator of how lack of information impacts individuals' choice to remain unregistered. In addition, most interviewees

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<sup>35</sup> See section 1.3.1., Existing literature: Social protection in Indonesia.

<sup>36</sup> Alfamart is one of the most common minimart stores in Indonesia. There are three Alfamarts in the studied community, out of which two have BPJS-K payment services.

say BPJS-K covers all medical expenses. This is not entirely true, though the insurance indeed is comprehensive. However, not receiving sufficient and accurate information may create misunderstandings that contribute to misuse, higher costs due to misuse or even non-use as individuals refrain to register. Most interviewees mention television commercial as the means through which they first heard about BPJS-K. This is arguably an efficient way to reach most people, given the access to a TV. Many interviewees also suggest that door-to-door methods would improve outreach efforts and defeat information shortage. Some have experienced similar practices in family planning information (Interviewees 11 and 12, 31.02.2018) as well as in anti-stunting programmes (Interviewee 13, 17.02.2018) and state that personal contact is successful in including local people. This resembles the successful strategy documented in an Indonesian village-level development project where targeting on individual level made local people feel included and more eager to join (Banerjee and Duflo, 2011).

Resources have clear influences on interviewees' willingness to utilise public health insurance. Available resources, i.e. functionings, impact individual capability to access healthcare both directly as in the case of financial assets, or indirectly through lack of information and misconceptions. Therefore, lack of appropriate or sufficient resources is another underlying factor of low registration rates and unequal healthcare access among ISWs in the studied community. Sen's (1993) CA thus adequately mirrors findings in this study both regarding functionings and capabilities.

#### **4.4 Effects of decentralisation**

That is problem I think, there is TOO many step! When the programme come from the government, the government send [money] to the province, and the province send to the regency, regency send to... The money is always less /.../. Because too many levels it have to pass.”

(Interviewee 13, 17.02.2018)

Speaking to interviewees about BPJS-K and how it operates, complicated bureaucratic processes and 'too much regulation' are brought up frequently. Some mention it as a reason to not register whereas others speak of it in more general terms discussing how it impacts public social protection and healthcare services. Corruption is also commonly mentioned, specifically in relation to funding of public programmes as in the quote above. Corroborating Sen (1999), effects of decentralisation thus appears to decrease individual capability to tap into health and extend health inequality. Decentralisation also aimed to improve and streamline management of public programmes such as the public health insurance (Aspinall, 2014). However,

unintended consequences may introduce adverse effects leading to failure of initial aims (Portes, 2000).<sup>37</sup>

In terms of impacts on healthcare services, one interviewee tells a story about his co-worker who got in a traffic accident a while back (Interviewee 12, 31.02.2018). The co-worker was taken to the closest public hospital by friends, but did not receive immediate care despite serious injuries. The medical staff asked for proof of insurance registration, and refused to care for the injured man until proof was provided. Luckily, he was eventually treated after calling his manager who confirmed employment-related insurance, and the man survived. The interviewee telling this story says this is a clear example of how regulations and bureaucracy may directly impact healthcare access, but does also state that this fortunately is an extreme example that does not apply to all healthcare delivery. Other more common examples of how decentralisation effects impact utilisation of public insurance and healthcare are slow registration and excessive paper work that, according to interviewees, create disincentives to join. Similar to the quote above, some interviewees explain how registrations have to pass several levels of government, from village level to central government, and then back again. Others, however, have positive experiences regarding registration and say it is not complicated if you are able to go to BPJS-K's office in the city approximately 1,5 hours away. Then, it is explained, registration applications are handled directly in the office and sent to the central government for approval and recordkeeping.

The decentralisation reform in 2001 partly aimed to bring decision-making and management closer to the people, wishing to enhance democracy and inclusion of local communities (Aspinall, 2014). Corroborating findings put forth by Gonzalez-Piers et al. (2006), lack of accountability and extensive regulations appear to have contributed to under-utilisation of public healthcare insurance. Interviewees feel frustrated and discouraged to register because they think regulations surrounding the insurance make it too complicated since they, as ISWs, have to organise their own registration and payments. Formal sector workers, on the other hand, pay their premium by salary contributions. Many interviewees wish the insurance was administered in similar ways for them too, claiming it seems much easier. It would facilitate registration and increase willingness to join, many interviewees explain. Thus, Merton (1936) and Portes (2000) reflections regarding unintended consequences apply to effects of decentralisation, directly affecting efficiency of public administration and indirectly impacting individual usage of public health insurance.

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<sup>37</sup> In this case, unintended consequences primarily refer to extensive regulations and impaired communication.

Corruption in public programme administration is another aspect which many interviewees discuss, primarily in relation to financial assets provided to local governments by the central government. It is described several times how money disappears along the way to local communities, and that it creates a general disbelief in public programmes. A few interviewees, however, acknowledge that it is complicated for a country the size of Indonesia to remain free of corruption (Interviewees 7 and 8, 26.01.2018). Nevertheless, corruption is a well-known factor of decentralisation in many development contexts (Fan, Lin and Treisman, 2008) and it does not solely concern monetary issues. During this study, relational corruption was brought up a couple of times in connection to population regulation and subsidised healthcare.<sup>38</sup> While it officially depends on income, some interviewees explain that having close relations with Kepala Desa is beneficial and might mean a person receives subsidies despite not being legitimately eligible. Since the subsidies are quota-based, this allegedly infers that subsidy defaults occur, i.e. someone who is legitimately eligible is deprived of their subsidy in favour of someone who should not receive it according to regulations. It is an example of how decentralisation makes corruption of this kind increasingly difficult to monitor as communication between government instances becomes more distant.<sup>39</sup>

Hence, decentralisation of Indonesia's health system has negatively affected equality of healthcare access. Unintended consequences of decentralisation itself, such as elongated administrative processes and communication difficulties, have generated further unanticipated effects as users chose to deregister. Lack of transparency and accountability between different levels of government is also present in Indonesia's health system, which produces disbelief among interviewees in regards to public programmes like the NHI. Portes (2000) discusses this in relation to social processes and interactions between authorities and the public. He concludes that individuals may feel authorities have excessive influence over them and that they thus refrain to participate in a public programme. Hence, disbelief in authorities and overall administration of Indonesia's public health insurance have partially contributed to low registration rates and utilisation of the programme. Despite good intentions like increased participation of local communities, unintended consequences of decentralisation have weakened interviewees' willingness to utilise public insurance.

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<sup>38</sup> Distribution of subsidised healthcare insurance to the poor is administered on village level, then sent to the central government for registration. It is Kepala Desa who registers eligible persons in each village. See section 1.2.2, Background: Goals, utilisation and shortcomings of the public insurance.

<sup>39</sup> Other accounts witness about how some Kepala Desas occasionally register fewer poor households than de facto exist in order to make the village seem more successful. This relates to existing literature regarding effects of decentralisation, (e.g. Aspinnall, 2014) stating that elite capture remains a prevalent issue in Indonesia despite introduction of democratic functions.



## **5. Limitations**

The limitations of this study are primarily methodological. Its in-depth approach facilitates deeper understanding of interviewees' views but limits generalisability of the results. In other words, the study builds on a small number of personal accounts that cannot be considered representative for any population outside the studied sample. Moreover, the study was conducted in a limited geographical area during a short period of time which weaken its generalisability further. It could, however, complement future research by bringing up previously overlooked factors concerning *what* issues lay the ground to ISWs perception of public health insurance and *why* that is the case.

Considering concepts of social exclusion, discrimination and government critique, the study treats topics that may be sensitive to some interviewees. It could affect interviewees' responses, perhaps both consciously and subconsciously. The comfort of interview participants has therefore been prioritised and everyone was informed of the right to refrain from answering any questions they do not feel comfortable to answer. All interviewees were also guaranteed complete anonymity. Interviews have been held in pairs if interviewees so wished. To carry out interviews in pairs could have impacts on responses due to aspects such as social or peer pressure. It might also be that the interviewees' responses influence each other. Additionally, there are limits to applied sampling methods. To employ purposive sampling entails to strategically chose interview participants. This decreases generalisability of findings but enhances in-depth understanding of the studied topic. Purposive snowball sampling may limit variances of perspectives as interviewees may refer the researcher to persons of similar values and experiences. The present study seeks to account for the subjective view of each interviewee and this limit is therefore part of the purpose.

Lastly, the study specifically addresses non-users of the insurance (registered or non-registered), which creates biased results as it disregards the view of users who might have positive experiences of public insurance usage. However, it is the delimitation to investigate non-usage that makes an important complement to existing literature.

## **6. Concluding discussion**

The purpose of this research is to investigate why informal sector workers are reluctant to utilise public insurance to pay medical expenses. By accounting for personal experiences and opinions regarding the insurance, user-perspective is at the core of the research. The findings indicate three main reasons creating disincentives among interviewees: (1) social exclusion as an effect

of inferior, disrespectful treatment when paying with public insurance, (2) lack of resources such as money, time and information impact knowledge of and ability to join the scheme and (3) unintended effects of decentralisation create a general distrust regarding public programmes due to extensive regulations and bureaucracy. Similar to existing literature, both resources and decentralisation affect access to healthcare in the studied context (Kristiansen and Santoso, 2006; WHO, 2017). The primary argument, however, derives from ethical individualism. All interviewees provide accounts of discriminatory and inferior treatment in utilisation of public insurance, hence passive social exclusion is a primary disincentive among interviewees in this study. Since few existing studies consider this issue, especially in more current research, such findings indicate benefits of user-evaluations to future research in order to expand knowledge regarding Indonesia's public health insurance.

Connecting to Sen's capability approach, the concepts of functionings and capabilities structure findings in this study. Functionings cannot themselves provide comprehensive understanding of necessities for public programmes. This become clear in this study as the issue of social exclusion has not been adequately considered in existing literature on Indonesia's health system. It is evident in examples that describe the lack of knowledge regarding local needs acquired by Indonesian authorities prior to implementing existing programmes (Aspinall, 2014). This research finds that, by asking for individual feedback, it is to a greater extent possible to map less tangible or measurable disincentives. Hence, the benefits of applying capability-related values and concepts complement already existing data and provide a deeper understanding of underlying issues.

It is evident in this study that interviewees' reluctance towards public insurance usage is based on a mixture of underlying reasons combining practical assets with social and political circumstances. Consequently, circumstances of informal sector employment impact individual capability to access just healthcare, which indirectly may affect their quality of life. Basing interventions on materialistic factors like income (as in the case of subsidies) or measuring healthcare delivery efficiency through, for example, number of healthcare facilities risks create situations like the one presented here, where a segment of the population remains excluded or is not included on fair terms. Unfavourable inclusion of informal sector workers in social protection, together with the overall vulnerability of this sector, thus create multiple-factor marginalisation.

Inclusion of informal workers and other vulnerable groups has high priority in international efforts battling inequality. The findings of this study thus connect to several of the SDGs and are relevant to current development debates (UN, 2015). Moreover, without

successfully including all informal sector workers in social protection, inequality in health and healthcare will likely continue. In the case of another financial crisis, implications of such inequalities may not only push a large amount of households into poverty but could also potentially have deteriorating consequences on the economy as a whole considering informal sector workers' vast contributions to the national economy.

Nevertheless, inclusion of this kind cannot be the panacea to health inequality in Indonesia. This is clear considering the fact that the Indonesian government have made previous efforts to bring development interventions and decision-making closer to the people by democratisation processes, yet inequalities in health and healthcare access remain evident. Effects of decentralisation documented in this thesis show that interviewees to feel constrained by regulations and bureaucracy. Informal sector workers do not pay for the insurance via salary contributions, and interviewees in this study explain the manifold struggles of paying a separate monthly fee and express particular frustration regarding bureaucracy.

While decentralisation itself perhaps does not directly influence health access, unintended consequences of decentralisation effects, i.e. elongated bureaucratic processes, do sustain health inequality. Informal sector workers are particularly subject to these effects because of their exclusion from formal employment. Moreover, decentralised administration of the public health insurance is perceived by interviewees of this study to contain uncontrollable corruption in both monetary and relational terms. On the other hand, local authorities enjoy increased autonomy and the ability to introduce programmes more suitable for the specific area. This is, however, conditioned by genuine interest on behalf of local authorities and the extent to which individual voice is considered when formulating development interventions.

The arguments in this study highly relate to Amartya Sen's concept of ethical individualism and it is necessary to note here the critique pointed towards this concept. Individual accounts cannot solely, or mainly, lay the foundation for development efforts as results rely on the local context. Consequently, disincentives among informal sector workers interviewed in this study are likely to differ compared to individuals residing elsewhere. Moreover, it might be too time-consuming to collect data of this type, particularly in a country the size of Indonesia. Difficulties in sampling and deciding whom to ask is another aspect which criticises ethical individualism in terms of evaluations. However, this study aims to show some of the contributions of ethical individualism and similar concepts and methods. Since existing literature shows how local authorities fail to consider public opinion and because interviewees in this study as well as other studies in Indonesia (e.g. Kristiansen and Santoso, 2006) indicate

larger success if actively approaching individuals, the benefits of ethical individualism become significant.

Lastly, the findings in this study points to the complexity of solving issues of health inequalities. Contributing factors are manifold and comprise an interrelated web of challenges for both local, national and international actors to address. The study complements existing research in two main ways. Firstly, it makes a contribution to existing body of work by focusing on former users' disincentives to utilise public health insurance. By doing so, other previously disregarded or overlooked drivers of low registration and non-usage of Indonesia's public health insurance are brought to the surface. Secondly, the research enhances the value of qualitative user-evaluations, which to date have remained limited in the Indonesian context, and indicates the benefits of broadening research's focus to more adequately incorporate capabilities and social exclusion. Hence, this research presents important findings that could bring valuable insights to existing literature. Future research could build on a combination of results presented here and in existing literature. It could hopefully bring about a more holistic and in-depth understanding of the policy implications of Indonesia's health insurance important to enhance health equality.

## 7. References

- Anand, P., (2005). Resource Allocation: Capabilities and Health. *Journal of Medical Ethics*, 31, pp. 299-303.
- Asian Development Bank and BPS Statistics Indonesia, (2010). The informal sector and informal employment in Indonesia: Country Report 2010. Asian Development Bank, Mandaluyong City, Philippines.
- Aspinall, E., (2014). Health care and democratization in Indonesia. *Democratization*, 21(5), pp. 803-823.
- Auerbach, A. and Silverstein, B., (2003). *Qualitative Data: An introduction to coding and analysis*. New York, NYU Press.
- Badan Penyelenggara Jaminan Sosial Kesehatan, (2017). Available at <https://bpjs-kesehatan.go.id/bpjs/>. Accessed 06.05.2018.
- Banerjee, A.V. and Duflo, E., (2011). *Poor Economics: A Radical Rethinking of the Way to Fight Global Poverty*, Public Affairs, New York.
- Boyatzis, R.E., (1998). *Transforming Qualitative Information: Thematic Analysis and Code Development*. Thousand Oaks, California.
- Brata, A. G., (2010). Vulnerability of urban informal sector: street vendors in Yogyakarta, Indonesia. *Theoretical and empirical researches in urban management*, 5(5 (14), 47-58.
- Bresnan, J., (1993). *Managing Indonesia. The Modern Political Economy*. New York, Columbia University Press.
- Bryman, A., (2012). *Social Research Methods*, 4<sup>th</sup> Edition. New York, Oxford University Press.
- Buehler, M., (2011). Indonesia's Law on Public Services: changing state-society relations or continuing politics as usual?. *Bulletin of Indonesian Economic Studies*, Vol. 47, Issue 1, pp.65-86.
- Croissant, A., (2004). Changing welfare regimes in East and Southeast Asia: Crisis, change and challenge. *Social Policy & Administration*, 38(5), 504-524.
- Dartanto, T., Rezki, J. F., Pramono, W., Siregar, C. H., and Bintara, H., (2016). Participation of Informal Sector Workers in Indonesia's National Health Insurance System. *Journal of Southeast Asian Economies (JSEAE)*, 33(3), 317-342.
- Fan, C., Lin, C., Triesman, D., (2008). Political decentralization and corruption: Evidence from around the world. *Journal of Public Economics*, Vol.93, Issues 1-2, p.14-34.
- Giullari, S. and Lewis, J., (2005). The Adult Worker Model Family, Gender Equality and Care: The Search for New Policy Principles, and the Possibilities and Problems of a Capabilities Approach. *Social Policy and Development Programme Paper 19*.
- George, A. L. & Bennett, A., (2005). *Case Studies and Theory Development in Social Sciences*. Cambridge: MIT Press.
- Global Rice Science Partnership, (2013). *Rice Almanac 4<sup>th</sup> Edition*. Los Baños, Philippines. International Rice Institute.
- González-Pier, E., Gutiérrez-Delgado, C., Stevens, G., Barraza-Lloréns, M., Porrás-Condey, R., Carvalho, N., Lonchich, K., Dias, R. H., Kulkarni, S., Casey, A., Muramaki, Y., Ezzati, M., and Salomon, J. A., (2006). Priority setting for health interventions in Mexico's System of Social Protection in Health. *The Lancet*, 368 (9547), pp. 1608-1618.

- Indonesia Bureau of Statistics, (2015). Health Indicators 1995-2015. Available at <https://www.bps.go.id/linkTabelStatis/view/id/1559>. Accessed 2017.09.06.
- International Labour Organisation, ILO, (2014). *World Social Protection Report 2014/15: Building economic recovery, inclusive development and social justice*. International Labour Office – Geneva.
- International Labour Organisation, (2018). Informal Economy. Available at <http://www.ilo.org/global/topics/dw4sd/themes/informal-economy/lang--en/index.htm>. Accessed 06.05.2018.
- Joshi, A., Prichard, W., and Heady, C., (2014). Taxing the Informal Economy: The Current State of Knowledge and Agendas for Future Research, *The Journal of Development Studies*, 50(10), 1325-1347.
- Kristiansen, S. and Santoso, P., (2006). Surviving decentralization? Impacts of regional autonomy on health service provision in Indonesia. *Health Policy* 77 (2006) pp. 247–259.
- Lewis, M., (2006). Governance and Corruption in Public Health Care Systems. *SSRN Electronic Journal*. pp. 1-57.
- Merriam-Webster, (2018). *Red tape*, definition of. Available at <https://www.merriam-webster.com/dictionary/red%20tape>. Accessed 09.05.2018.
- Merton, R.K., (1936). *The Unanticipated Consequences of Purposive Social Action*. *American Sociological Review*, 1(6), pp. 894-904. Published by American Sociological Association.
- Mietzner, M., (2015). Reinventing Asian population: Jokowi’s rise, democracy and political contestation in Indonesia. *Policy Studies*, (72).
- Moeloek, N. F., (2017). Indonesia national health policy in the transition of disease burden and health insurance coverage. *Medical Journal of Indonesia*, 26(1), 3-6.
- Organisation for Economic Co-operation and Development, (2018). Available at <https://data.oecd.org/indonesia.htm>. Accessed 10.04.2018.
- Patton, M., (1990). *Qualitative evaluation and research methods*. pp. 169-186. SAGE Publications, Beverly Hills, California.
- Peters, D., Garg, A., Bloom, G., Walker, D., Brieger, W. and Hafizur Rahman, M. (2008). Poverty and Access to Health Care in Developing Countries. *Annals of the New York Academy of Sciences*, 1136 (1), pp. 161-171.
- Ruger, J., (2004). Health and social justice. *The Lancet*, 364(9439), pp. 1075-1080.
- Saldaña, J., (2009). *The Coding Manual for Qualitative Researchers*. SAGE Publications, Great Britain, TJ International Ltd, Padstow, Cornwall.
- Sen, A.K., (1985). Well-being, agency and freedom. *The Dewey Lectures* (82) 4, pp. 169-224.
- Sen, A.K., (1993). Capability and Well-being. In: Nussbaum, M., and Sen, A.K., eds. (1993). *The Quality of Life*. Oxford, Clarendon Press.
- Sen, A.K., (1999). *Development as Freedom*. Oxford, Oxford University Press.
- Sen, A.K., (2000). SOCIAL EXCLUSION: Concept, application and scrutiny. *Social Development Papers* (1), published by Asia Development Bank.
- Sen, A.K., (2002). Why Health Equity? *Health Econ* (11), pp. 659-566.

- Sparrow, R., Budiyati, S., Yumna, A., Warda, N., Suryahadi, A. and Bedi, A. S., (2017). Sub-national health care financing reforms in Indonesia. *Health policy and planning*, 32(1) pp. 91-101.
- Suryahadi, A., Febriany, V. and Yumna, A., (2017). Expanding Social Security in Indonesia: The Current Processes and Challenges. In: I. Yi, ed., *Towards Universal Health Care in Emerging Economies: Opportunities and Challenges*. United Kingdom: Palgrave Macmillan, pp. 373-403.
- Suryahadi, A., Widyanti, W., Suryadarma, D. and Sumarto, S., (2011). Targeting social protection programmes: The experience of Indonesia. In: S. Cook and N. Kabeer, ed., *Social Protection as Development Policy: Asian perspectives*. New Delhi: Routledge Taylor & Francis Group, pp.278-318.
- Tambunan, T. T., Purwoko, B., (2002). Social protection in Indonesia. *Social Protection in Southeast and East Asia – Towards a Comprehensive Picture*, 1(1.66), pp. 1-35.
- Trisnantoro, L., Marthias, T., and Harbianto, D. (2014). *Universal Health Coverage Assessment: Indonesia*. Global Network for Health Equity.
- United Nations, (n.d.) Sustainable Development Knowledge Platform. Available at <https://sustainabledevelopment.un.org/?menu=1300>. Accessed 06.05.2018.
- United Nations, (2010). *The World's Women 2010: Trends and Statistics*. United Nations Publication, Sales No.E.10XVII.11. pp. 88-89.
- United Nations (2015). *A/RES/70/1 Transforming our world: The 2030 Agenda for Sustainable Development*. United Nations General Assembly.
- United Nations, (2018). Available at <http://www.un.org/en/sections/issues-depth/democracy/>. Accessed 08.04.2018.
- United Nations Department of Economic and Social Affairs (2016). *Leaving no one behind: The imperative of inclusive development*. United Nations, New York.
- United Nations Population Fund (2014). Available at <https://www.unfpa.org/human-rights-based-approach>. Accessed 11.04.2018.
- de Vaus, D., (2013). *The Context of Design*. In: *Research Design in Social Research*. London, SAGE Publications Ltd, pp. 1-16.
- World Bank, (2014) *Health in Indonesia*. Available at <http://www.worldbank.org/en/country/indonesia/brief/world-bank-and-health-in-indonesia> Accessed 10.04.2018.
- World Bank, (2017). *The World Bank in Indonesia: Overview*. Webpage, available at <http://www.worldbank.org/en/country/indonesia/overview>. Accessed 2017.09.07.
- World Bank, (2018). *Poverty and Equity Brief: East Asian and Pacific, Indonesia*. Available at [http://databank.worldbank.org/data/download/poverty/33EF03BB-9722-4AE2-ABC7-AA2972D68AFE/Global\\_POVEQ\\_IDN.pdf](http://databank.worldbank.org/data/download/poverty/33EF03BB-9722-4AE2-ABC7-AA2972D68AFE/Global_POVEQ_IDN.pdf). Accessed 17.05.2018.
- World Health Organization, (n.d.). Available at [http://www.who.int/hhr/news/hrba\\_to\\_health2.pdf](http://www.who.int/hhr/news/hrba_to_health2.pdf). Accessed 22.10.2017.
- World Health Organisation, (2017). *The Republic of Indonesia Health System Review*. *Health Systems in Transition* 7(1).
- World Health Organization, (2015). *Health in 2015: from MDGs, Millennium Development Goals to SDGs, Sustainable Development Goals*. Chapter 1: General Introduction, pp. 3-13. WHO Press, World Health Organization, Geneva.

- World Health Organization, (2018a). Available at <http://www.who.int/mediacentre/factsheets/fs310/en/index1.html>. Accessed 26.03.2018.
- World Health Organisation, (2018b). Available at [http://www.who.int/features/factfiles/health\\_inequities/en/](http://www.who.int/features/factfiles/health_inequities/en/). Accessed 26.03.2018.
- World Health Organization, (2018c). Available at <http://www.who.int/healthsystems/topics/equity/en/>. Accessed 10.05.2018.



## 8. Appendices

### 8.1 Appendix 1, List of interviewees

<b>Interviewee number</b>	<b>Date</b>	<b>Place</b>	<b>Type of interview</b>
1	19.01.2018	Jakarta	Key informant interview
2	22.01.2018	Mataram	Group interview
3	22.01.2018	Mataram	Group interview
4	22.01.2018	Mataram	Group interview
5	24.01.2018	Kuta	Pair interview
6	24.01.2018	Kuta	Pair interview
7	26.01.2018	Kuta	Pair interview
8	26.01.2018	Kuta	Pair interview
9	30.01.2018	Kuta	Pair interview
10	30.01.2018	Kuta	Pair interview
11	31.01.2018	Kuta	Pair interview
12	31.01.2018	Kuta	Pair interview
13	17.02.2018	Kuta	Individual interview
14	19.02.2018	Kuta	Individual interview
15	25.02.2018	Kuta	Individual interview

## 8.2 Appendix 2, Coding scheme

Themes	Sub-themes	Indicators	Sample-quotes
<b>Decentralisation</b> (Political structures)	a) Ambiguity of government roles	High number of institutions Mismanagement of subsidy quotas Failure to include informal sector	<p>“We have how many system, how many tier, in the health insurance sector.” (1)<sup>1</sup></p> <p>“For the informal sector there is still big homework for the government how to include them, how to move them to the system.” (1)</p>
	b) Slow, complicated processes	Bureaucracy creates disbelief and disincentives - Lacking socialisation/promotion	<p>“We know already it’s hard with millions of people.” (8)</p> <p>“It’s too complicated and /.../ too much bureaucracy.” (5)</p> <p>“Like BPJS /.../ [if you] pay directly, people are going to think you are like the sweet king and ‘ok ok’ (<i>quickly helped to see doctor</i>). If BPJS, they’re like ‘no no, regulation this, regulation that.’ You see? It’s not really good this BPJS.” (6)</p>
		Corruption	<p>“That is problem I think, there is TOO many step! When the programme come from the government, the government send [money] to the province, and the province send to the</p>

<sup>1</sup> Numbers refer to interviewee number. See Annex 2 – List of interviews.

		<p>Further disbelief in public programmes, not trusting authorities</p> <p>De jure coverage differs from de facto coverage</p>	<p>regency, regency send to... The money is always less. On the top is much money, but when it go down it is less less less (shows with hands). Because too many levels it have to pass.” (13)</p> <p>“[The government] not helping the old people, the poor people. They just think about money and corruption. Also the head of my village too now.” (9)</p> <p>“In here, Indonesia, better you go on your own, not with the government.” (6)</p> <p>“You pay maybe, the same like 50% of, but the rest you have to pay. But I don’t remember that but maybe she stayed 5 or 6 days at the hospital and I paid maybe 12 million for that<sup>2</sup>, operation and everything. That’s when I had BPJS.” (6)</p>
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<sup>2</sup> Participant paid for his wife’s c-section, despite it being covered by BPJS. Possibility: Wife was not insured, and participant was unaware of that the insurance is individual. If so, indicates lack of information.

<b>Social exclusion</b> (Social structures)	a) Social stigma	Inferior care when using of public insurance: Discrimination, feelings of disrespect and low self-worth	<p>“The JKN patient is inferior (to) the general patient.” (1)</p> <p>“If we show the doctor our card: very, very low status! Not easy to find recommendation or agreement from the doctor. /.../ No respect! /.../ Better we don't have any card like that, if we can't have any good respect from the doctor.” (10)</p> <p>“If the people have sickness, like emergently, we cannot going directly, need to waiting even if you die /.../ Better we don't have any card like that, if we can't have any good respect from the doctor.” (6)</p>
	b) Passive exclusion	Unaddressed issue of exceeding quotas excluding beneficiaries from receiving subsidies	“/.../head of the village not give me [subsidised insurance]. Maybe he thinks I'm rich, that's why I don't have it.” (9)
	c) Group belonging	Lack of efforts targeting the Missing Middle: Informal sector, low – middle income  Urbanised programme, marginalisation of rural informal sector	<p>“The problem as well for the poor is to access this programme.” (1)</p> <p>“...rural people might not know how to use it, second one maybe there is no health facilities there and then third one maybe they have no other out of pocket money to go to the health</p>

		Lack of agency/voice	<p>facilities so there are a lot of reason how they rural utilisation of the JKN is less than urban.” (3)</p> <p>“I have no power going to the government, I don't work for the government I don't... It depends. Only people who work for the government can be listened by the government.” (6)</p> <p>“We just want more care, that the government more care to the people. Like local government comes, like ‘Ok what do you think? What happened in this area?’ sometimes. Don't leave us not know what is going on.” (7)</p> <p>“That's why I feel frustration in here, if I was going to tell about my frustration in here, they would make me more down, they would not listen they would make quiet. They don't like when you try to make better, I don't know why.” (6)</p>
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<b>Resources</b> (Individual)	a) Financial	Low, seasonal income in informal sector, affecting what choices are accessible	<p>“If you have number three they will give you generic medication, the cheap medical. It depends on your money. So better bring your money and go to doctor /.../. That’s why the assuransi from the government not helping very much. Money is everything.” (6)</p> <p>“If you pay that amount every month, for ten years...You can count, it is very much money and then maybe you never use [the insurance].” (15)</p>
		Prioritises other expenses	“If for free can [join], but if we have to pay I don’t want. /.../ We are too lazy /.../ It’s better we buy smoke.” <sup>5</sup> (7 and 8)
		Family size, have to register entire family <sup>3</sup>	“I don’t have because have four, five, six people in my family /.../ Not interested in BPJS because too expensive.” (15)
	b) Information	Limited promotion of NHI <sup>4</sup>	“...campaign on TV is kind of expensive maybe so they don’t really often publish it.” (3)

<sup>3</sup> The insurance build on individual premiums, but some participants told the researcher that one has to register either all or no family members. This is however not confirmed in any official information found about the scheme.

<sup>4</sup> NHI – National Health Insurance.

<sup>5</sup> Referring to cigarettes.

	c) Time	<p>Insurance illiteracy IT-illiteracy</p> <p>Have to travel to nearby city to pay monthly fee</p>	<p>““I don’t have because I don’t know how to get it BPJS, I don’t know where I can get.” (14)</p> <p>Also we can do it online also, but we don’t know yet how to register online because we are not so really good in how to use laptop.” (13)</p> <p>“But the thing is, every month we have to go to Praya (nearest city) to pay. /.../, so we need to have the schedule like ‘ok, tomorrow I have to go to Praya to pay’. EVERY month. If you have the personal.”<sup>6</sup> (7)</p>
<b>Supplementary findings</b>	a) Incentives for social security (government level)	External pressure (international organisations, social sciences researchers), intrinsic interest for development, public demand	
	b) Formal sector privileges	<p>Already insured through employment</p> <p>Can afford private insurance to replace/supplement NHI</p>	

<sup>6</sup> This informant states lack of time as reason for not being registered. However, this response also indicates lack of information as it is possible to pay via a cash-machine at the mini-market 50m from their workplace.

	c) Positive aspects of BPJS	Affinity  Economically good choice	R: "What is the good thing with BPJS?" I: "That you do what everyone else does" (5)  "Two weeks ago I little bit sakit <sup>7</sup> , I go there pay 1 200 000 (IDR) <sup>8</sup> for medical, but it's good the medicine is good. (...) It is good with BPJS because it is not all the time we have money like that, just pay little bit [every month], much better I think." (14) <sup>9</sup>
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<sup>7</sup> Sakit is Indonesian for sick.

<sup>8</sup> Expensive compared to paying 25 000 each month according to this participant.

<sup>9</sup> This person is not and has never been registered in BPJS-K insurance.