"No Mother Is Left Behind"
Enhancing Maternal Health in Indonesia: Impact of Move Towards Universal Health Coverage

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List of Acronyms

ANC	Antenatal Care
APBD	*Anggaran Pendapatan dan Belanja Daerah* (Regional Income and Expenditure Budget)
APBN	*Anggaran Pendapatan dan Belanja Negara* (State Budget)
BPJS	*Badan Penyelenggara Jaminan Sosial* (Social Security Agency)
FKTP	*Fasilitas Kesehatan Tingkat Pertama* (First-Level Health Facilities)
IDHS	Indonesia Demographic Health Survey
IMR	Infant Mortality Rate
IUD	Intrauterine device
Jamkesda	*Jaminan Kesehatan Daerah* (Regional Health Insurance)
Jamkesmas	*Jaminan Kesehatan Masyarakat* (Community Health Insurance)
Jampersal	*Jaminan Persalinan* (Childbirth Insurance)
Jamsostek	*Jaminan Sosial Tenaga Kerja* (Workers Sosial Protection)
JKN	*Jaminan Kesehatan Nasional* (National Health Insurance)
MDGs	Millenium Development Goals
MMR	Maternal Mortality Rate
PBI	*Penerima Bantuan Iuran* (Beneficiaries of Health Insurance)
PHC	Primary Health Centre
PNC	Post-natal Care
PONEK	*Pelayanan Obstetri Neonatal Emergency Komprehensif* (Comprehensive Emergency Obstetric and Neonatal Care)
SDGs	Sustainable Development Goals
UHC	Universal Health Coverage
UN	United Nations
UNFPA	United Nations Population Fund
WHO	World Health Organization

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Abstract

Maternal healthcare is part of the health security guaranteed under the National Health Insurance (*Jaminan Kesehatan Nasional*, JKN) to improve maternal health in Indonesia. The objective of this health security is in line with the UN's vision of sustainable development (Sustainable Development Goals) which is to ensure equity of access to health services for every woman. Although the JKN program has run for four years, the health status of pregnant women in Indonesia has not experienced significant progress. This thesis aims to examine and evaluate the pattern of maternal healthcare used by JKN users in 2017-2018.

The study uses qualitative descriptive methods by conducting individual interviews with 17 respondents consisting of JKN users and non-JKN users, health workers, *BPJS Kesehatan*'s staff, and expert staff from government agencies across Indonesia. Based on the interviews, the study identified that the variable utilization of maternal healthcare has a close relationship with the capabilities and availability of resources from the health care providers. The results of the study found that only 4 out of 10 women who hold JKN used the whole maternal healthcare. The most frequent obstetric service used by JKN holders is delivery services. The factors that influence the preference of users to conduct antenatal care of JKN are the extensive availability of the primary health care facilities and the quality of medical personnel in health facilities. Also, the dissemination of information on the mechanism of the JKN program in general and the type of maternal healthcare covered by JKN play an important role in increasing public understanding of social security and maternal and child health, especially for low-income communities in rural areas. The results of this study can be a useful resource for *BPJS Kesehatan*, health service providers and health professionals to improve the quality of JKN maternal healthcare services.

Relevance to Development Studies

This research contributes to studies on the implementation of universal social policy in developing countries with regards to the Universal Health Coverage. Moreover, it is a contribution to the limited literature maternal health and health development in Indonesia from the social studies perspective.

Keywords

Maternal health, healthcare utilization, health insurance, *Jaminan Kesehatan Nasional*, maternal healthcare, Universal Health Coverage

Chapter 1 : The Introduction of Maternal Health in Indonesia: Past and Present

1.1 Background

> "Investing in health has stimulated shared economic growth as citizens live longer and with greater capacity to pursue the lives they value" (Sen 2015:3)

Health care is a fundamental need of human being. It is to ensure that every human being can improve his/her quality of life (WHO 2018). In Indonesia, health is constituted as a human right (Ministry of Health 2009) to which every citizen is entitled. Therefore, the government seeks to work through social security. For these past three decades, Indonesia has launched a wide array of social securities, namely *Askes* (Health Insurance)*, Jamsostek* (Workers Social Protection)*, Jamkesda* (Regional Health Insurance) and *Jamkesmas* (Community Health Insurance) to guarantee the citizens' rights to health. However, the existing social security system has not been able to answer the issue of inequality in access to health services. In early 2014, the government introduced the National Health Insurance (JKN), a new social security system that integrates all preceding social security systems that are universal for all Indonesian citizens. JKN aims to provide access and improve health service standards to the community. By putting all together, JKN is designed to provide cover for prevalent health issues, including maternal health.

The provision of maternal health care through JKN is a form of government commitment to improve access to health services for pregnant women in Indonesia. Inequality of access to health services is the cause of the low uptake of maternal healthcare (UNFPA 2013). It is likely to be the main factor of the increasing number of maternal mortality, especially among social-economically disadvantaged women (Kunst and Houweling 2001: 294) as this issue has been prevalent since the late 1980s. Indonesia has not experienced a significant decline in the Maternal Mortality Rate (MMR). In 1991, MMR had decreased from 390 per 100,000 live births to 305 per 100,000 live births in 2015 (Ministry of Health 2016). Although the MMR in 2015 had achieved the 2015-2019 National Medium Term Development Plan's target (Bappenas 2014: 6-74)[1], the number was still far from the 2015 Millennium Development Goals global target of 102 per 100,000 live births (Ministry of Health 2014), hence by the end of 2015 Indonesia was not able to meet MDG targets. The development of maternal health in Indonesia is far behind on Thailand and Malaysia[2] (World Bank 2018).

Indications of inequality in access to health care have also increased. The indications can be seen in urban communities who live in Java and Bali that are getting better and more diverse health services. For instance, in the eastern part of Indonesia, access to health services remains a challenge. Statistical data in 2010 showed that MMR in Papua Province was 573 per 100,000 live births. It was two times higher than the national MMR (Nababan et al. 2018: 12).

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[1] According to 2015-2019 National Medium Term Development Plan (*Rencana Pembangunan Jangka Menengah Nasional* or RPJMN), Indonesia aims to decrease MMR to 306 per 100,000 live births by 2019.

[2] Thailand and Malaysia managed to reduce MMR to 40 and 60 per 100,000 births in 2015, respectively (World Bank 2018).

As of October 2018, the number of JKN participants has reached 203,284,896 people (BPJS Kesehatan 2018). That means 75% of Indonesia's population has been registered as part of the JKN program. Government's achievement is extraordinary compared to the previous social security program. However, an unofficial document reports there were only over 700,000 births out of 4,8 million births in 2017 that registered in JKN, meaning the rest of the new-born babies did not receive health protection (KBAI 2018). While striving for health coverage is vital, achieving health equity is more essential to ensure that everyone receives equal opportunity access to health services. From the existing discourse and study of JKN, health policy observers need to analyse further to what extent the membership coverage guarantees an improvement in maternal health status and the uptake of maternal health services is maximally utilized by the users.

Before the establishment of JKN, United Nations Population Fund (UNFPA) and research teams from several Indonesian universities conducted a study on the level of use of maternal health services for participants before and after joining the Childbirth Insurance (*Jaminan Persalinan* or *Jampersal*) program. Launched in 2011, *Jampersal* was a government health insurance program specifically for maternal health (UNFPA 2013: 2). *Jampersal* aimed to guarantee financial protection for every woman regardless of her economic status. The results of research in ten districts showed that the use of the *Jampersal* program was still below expectation, both regarding antenatal care (ANC) and family planning (UNFPA 2013: 3). Systemic problems identified during the research process conclude that health protection guarantees do not address the issue of the low uptake of health services in Indonesia. Inadequate facilities and insufficient support from the health provision system and management can even lead to new problems in the health provision process.

With regards to the shortcomings that occurred in previous social policies, the study of maternal health care by investigating JKN aims to shed light on:

- whether the establishment of JKN contributes a gradual change to maternal health in general
- whether the uptake of maternal health care in JKN has been effective or not
- the determinant factor that drives the uptake of maternal health care in Indonesia

The lack of comprehensive empirical evidence about the use of maternal health services provided by the government raises the question about the effectiveness of health protection in improving the maternal health status in Indonesia. In fact, putting one major health agenda like maternal health into JKN is debatable too because it has never been done before. There are still few empirical studies about the relationship between these issues have been conducted in Indonesia. Therefore, this study contribute to understand the dimensions and gaps in addressing maternal health on the Universal Health Coverage (UHC) agenda.

1.2 Research Question

How significantly does the maternal health services' uptake within JKN in respect to the maternal health status in Indonesia?

Sub-Questions:

- How do urban and rural women socio-economic condition affect the process of maternal health care utilization?
- To what extent has JKN addressed the coverage dimensions of UHC in the maternal health services?
- What are the challenges in the current maternal health care provision process?

1.3 Organisation of the Research

The paper will encapsulate the research in six chapters. The second chapter provides a theoretical framework of maternal health, the universal principle of social policy in the global level and the transformation of health protection in Indonesia. The chapter comprises the debates on measuring the effectiveness of health care policy in the welfare regime, to achieve health equity. It also elucidates the trajectories of maternal health care provision from the late 1980s until the JKN, to give a clear understanding of the health system and protection in Indonesia.

Chapter three will present the research methodology for primary data collection. It includes the reasons, methods of interview, limitations, and reflexivity of the author in respect to the main theme of the study. Chapter four discusses the findings of the primary data collection based on qualitative interviews with participants. The findings is categorized into two groups of participants with several key points from their opinion. Chapter five will discuss an analysis by the findings and analytical framework from Chapter two and Chapter four on the factors that influencing the uptake of maternal health care. Finally, chapter six will summarize the entire study by present a conclusion and a recommendation to the government and health institution for further evaluation of the maternal care utilization in JKN program.

Chapter 2: Addressing Maternal Health in the Era of Universalism

2.1 The Global Discourse on Maternal Health

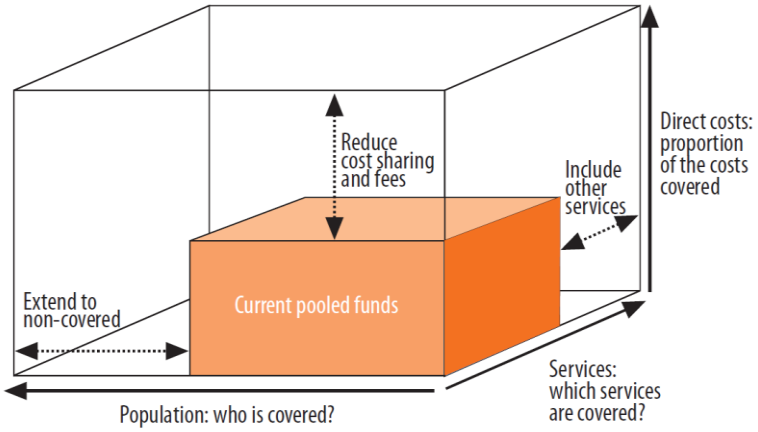
Global discourse on maternal health has been discussed since the 17th century along with the development of medical science in England (Loudon 1986). For a long time, the focus of maternal health discussion concentrated on efforts to handle maternal deaths during pregnancy, birth, or postpartum (AbouZahr 2003: 13). At the beginning of the 20th century, the global community took concrete steps to respond to the prevalence of maternal deaths in various countries. In 1987 in Nairobi, World Health Organization (WHO) introduced the Safe Motherhood Initiative (SMI) as a manifestation of a global commitment to provide a healthy and safe pregnancy process for all women (Maine and Rosenfield 1999). SMI seeks to emphasize the importance of improving maternal health as a key to improving children's health. The SMI consists of family planning, antenatal care, clean and safe delivery, obstetric care, basic pregnancy care, primary health care and equality for women (Maine and Rosenfield 1999: 481). Through SMI, the global community wants to emphasize that maternal health is a right for every woman. Maternal death is unlike other deaths caused by certain diseases. Maternal death is a "part of the physiological process that women must face for humanity" (AbouZahr 2003: 18). Therefore, establishing maternal health as a major health development agenda opens up the opportunity for women to exercise their choices and to achieve their full humanity.

To ensure women can fulfill their resilience, the discourse on maternal health should go beyond the health status and mortality issue. Medical studies proof that around 75% of maternal deaths are due to direct obstetric causes such as haemorrhage, pre-eclampsia or eclampsia, infection, complications from delivery and unsafe abortion (WHO 2018). Though all these causes are a mere tip of the iceberg because there is the actual complexity of pregnancy-related health problems and consequences below it, which is poor maternal health care. SMI proposes a variety of health interventions such as improving women's access to health service and the quality of maternal health care during and after pregnancy (Thaddeus and Maine 1994:1091). The concept was soon adopted and developed into national social policy and health care reform in many countries including China, Egypt, and Indonesia (Koblinsky 2003).

The debate of measuring the effectiveness of social policies for maternal health is still an ongoing process. Developing countries approach this issue by experimenting with different types of policy such as subsidies, vouchers, cash transfers or health insurance schemes. For instance, India has Janani Suraksha Yojana (JSY), a cash transfer program which aims to improve facility-based births as well as to reduce infant and maternal mortality rates in rural provinces (Balarajan et al. 2011:511). The subsidy, voucher, and cash transfers program specifically target mother's and children's health, but health insurance intends to reach improvement of health sector holistically (Hartwig et al. 2015:3). The results of the policies vary. In general, the study shows a positive connection between the utilization of maternal health care and the reduction of MMR in developing countries. Intervention, particularly in the community health center is strategically cost-effective to decrease maternal and neonatal mortality rate (Adam et al. 2005:5). The New Co-operative Medical System in China which provides financial risk protection for women in rural areas also experience a dramatic increase in the utilization of maternal health care. The use of antenatal care and facility-based deliveries rose from 45% to 80% (Long et al. 2010:1211-1217).

In recent years, the initiation of SMI in improving maternal health is encapsulated within Universal Health Coverage (UHC). It is the goal where everyone receives the essential health services, "without being exposed to financial hardship, and is central to the health-related targets of the Sustainable Development Goals (SDGs)" (Hogan et al. 2018:e152). Despite remarkable development progress after MDGs 2015, many developing countries did not achieve the goals for it only reflected the aggregate targets and indicators (WHO 2015:7). Health inequities remain persistent as the health interventions focused on meeting the MDGs instead of designing extensive health systems and resolving other health priorities (The Elders 2016). Regarding maternal health context, the key interventions were made to against infectious diseases (WHO 2015:41). SDGs by then aims to resolve the wider issues with the fundamental assumption that health is a crucial instrument and beneficial the sustainable development policies. It is universal and intertwined with the other development agendas, including but not limited to eradicate extreme poverty and create inclusive economic growth (WHO 2015: 7-8). Through UHC, it embarks broader level of discourse in analyzing the dimensions within maternal health inequity.

Figure 1 Three Dimensions of UHC
Source: WHO 2015



There are two components in UHC: health service coverage and financial protection coverage. Both components need assessment at the level of the whole population. Thus it requires a framework to envisage the choices policy of each country in implementing the health reform (WHO 2015:42). The UN and WHO propose "coverage box" that consists of three dimensions of UHC: health services, finance, and population (WHO 2015:42)(See Figure 1). The coverage box is designed based on the notion that every policy always involves trade-offs. When the state wants to extend the health coverage to those who are not covered, a decision should be made by rationing the benefits and likelihoods of the outcomes in respect to the three dimensions (WHO 2018). The most-fitted policies will be those which able to address their objectives efficiently by the financial resources, organization and political context. In this regard, the coverage box is an essential tool to evaluate the policy implementation as the state works to "fill" every corner of the box.

2.2 Universalism and Decommodification of Health Care

The agenda of UHC is made based on the principle of universalism. Universalism is developed as a model of social protection in reaching social equity. Many policy-makers and international organizations such as the WHO and the United Nations, as well as Latin

America countries, introduce their policy as universal as a form of their commitment to fulfill the equal access for all. Franzoni and Sanchez-Ancochea (2016:3) identify that it emerges from the improvement in economic growth and wages, which encourage middle-income society demands of better and more affordable health care. Despite having higher purchasing power, they are still vulnerable to fall into poverty. While economic growth gives an opportunity to invest in improving people's lives, it will not bring benefit to people if there are no proper social policies (WHO 2008:37).

Defining social policies in the context of universalism may vary due to the heterogeneity of vulnerabilities among people. Cook and Kabeer point out three sets of dimensions vulnerabilities: deficits, exclusion, and traps (2010:14). These dimensions intertwine to each other and may increase the poverty traps (Cook and Kabeer 2010:19). As a result, states intervene by designing comprehensive policy to mitigate the insecurities as well as securing the marginalized community in attaining their rights.

Esping-Andersen (1999) proposes the term "regime" refers to "how welfare production is allocated between state, market, and households." It posts for more than one single social policy dimensions. The social welfare regime paradigm constitutes the interaction of states, market, family, and community which constructs risks and protection (Cecchini et al. 2015:33). The societies distribute social risks and problems in ways that differ between one to another. Through the power and resources, the risks and problems produce and distribute wealth, security and opportunities in various ways depending on the inherent and acquired attributes of the population. Both decentralized and centralized logics drives these three aspects. Decentralized in essence where individuals utilize their human and social capital. Centralized means that the state owns an authority to manage those aspects based on three functions: extracting resources from the community, distributing and allocating resources to the community and prescribing what actions are acceptable and unacceptable while creating incentives and disincentives in the decentralized sphere of action. The states' capacity and response determine the result of vulnerability and the construction of protection and its distribution.

From his explanation, Esping-Andersen reiterates to go beyond the aggregate measures of welfare. Thus, it is important to acknowledge the concept of decommodification in constructing the health care typology (Bambra 2005:32-33). Decommodification refers to "the degree to which individuals, or families, can uphold a socially acceptable standard of living independently of market participation" (Esping-Andersen 1990:37). While his idea of decommodification is associated with labor, decommodification of health is a degree which "individual's access to health care is dependent upon their market position and the extent to which a country's provision of health is independent of the market" (Bambra 2005:33). By espousing the thought of decommodification, universal health coverage is constructed based on the perspective that health care is a common good instead of the market commodity. It recreates the division of over- and under- consumption of health care due to the commercialization of health.

However, the critiques argue that Esping-Andersen's welfare typology has flaws. First, it marginalizes women in its analysis (Bambra 2009:202). It does not put women and family in the provision of welfare (ibid) and consider gender as a form of social stratification (Bussemaker and Kersbergen 1994 in Bambra). Second, the idea of de-commodifying health care and ways to measure its effectiveness in improving people's access are still debatable. Jensen (2008:154) argues that aggregate measures, or in Esping-Andersen's context refers to the expenditure, is not the only parameter to analyze as diverse as transfer and welfare services. While he does not put aside the indicator, he notes there should be a dependent variable that can speak equally to both aspects. He takes social spending of GDP as an example to measure

transfer and welfare services (Jensen 2008:154). At this point, it is vital to look deeper into the other aspects that articulate the situation of people as the beneficiaries of the welfare.

Moreover, when states intend to intervene in health security through universalism, they should acknowledge that it will not lead to the "one size fits all" program. The idea of "one size fits all" can undermine the real health inequities as it obscures the position of the most deserving group. Although the program is universal, it only benefits the marginalized groups who are the target of every developmental program. Dahlgren and Whitehead define this situation as "three-tiered system, whereby the richest pay out of pocket, the very poor receive free services, and the middle group receives nothing" (Thomsen et al. 2011: 179-180). Hence, the idea of providing universalism is questioned whether it has given proportionate benefits and not excluding the other groups.

Several successful trajectories of UHC from Costa Rica, Thailand, South Korea and state of Kerala in India, prove that universalism can be achieved without becoming high wealth nation (WHO 2008; Franzoni & Sanchez-Ancochea 2016). In Costa Rica, through *Caja Costarricense de Seguro Social* (CCSS), salaried and non-salaried workers are mandated to be part of the insurance scheme. Mothers, children, indigenous, older adults and people with disabilities receive free health service provision (PHC Performance Initiative 2017). The government of Costa Rica tries to break the social insurance stratification by delimiting the service available, meaning that it includes expensive medical treatment for the rare disease (Franzoni & Sanchez-Ancochea 2016:60). By positioning primary health care as the core of the health provision, Costa Rica experiences improved service coverage and health outcomes. In 2010, achievements in health outcomes included "low infant mortality rate (9.46 per 1,000 live births), low maternal mortality 2.11 per 10,000 live births) and higher life expectancy (81.8 years for female and 76.9 for male)"(PAHO 2012:224).

Nevertheless, there are always trade-offs that government should accept with regards to the designation of the health programs. The nature dimension of UHC leads to the ongoing struggle within government and health institution in balancing the elements of UHC coverage box. This downside can affect the quality of the output which is crucial in the context of public and health service provision. As a consequence, it creates a dichotomy which people will keep comparing the low quality of public health service which provided tax-finance health service without co-payment with high-quality provision from private health services (Yi 2017:14). Although the health program is a pro-poor policy, the program will face a long-term challenge in public health provision when it loses national support due to the low-quality (ibid). This situation occurs in the case of Thailand's UHC which took three decades of trials and errors until the country succeed to tackle health inequalities(as discussed by Mongkhonvanit & Hanvoravongchai 2017:119-154).

2.3 Maternal Health Programs in Indonesia: A Brief Picture of JKN

2.3.1 Pre-JKN Era

Indonesia began adopting the concept of SMI after suffering a high rate of maternal mortality in 1988 (Koblinsky 2003). Before the UHC era, the government had several health programs which concentrated more on providing training for traditional birth attendants and preventive activities for mothers and children in *posyandu* (health post). Under SMI, the government encouraged health programs such as minimum four antenatal care visits during the pregnancy, identification of pregnant women residence, record the estimated time of childbirth, encouraging childbirth at health facilities and blood donation from the pregnant

woman relatives when it is needed (Soedarmono 2017:275). To increase the number of the skilled birth attendant, the government also managed more training for the village midwife program (*Bidan di Desa* or BDD) (Koblinsky 2003:114). The effort made by the government was due to the high birth rate carried out by traditional birth attendants which reached to 58% according to Indonesia Demographic Health Survey (IDHS) in 1991 (IDHS 1991:13). This situation remained prevalent until 1997 (IDHS 1997) and showed a decrease in the following health survey.

Besides the BDD program, the maternal health protection was covered in various government social security namely *Askes* (*Asuransi Kesehatan* or Health Insurance) and *Jamkesmas* (Community Health Protection). However, despite vast array options of social security, the prevalence of maternal health issues in Indonesia persisted. Albeit the health survey showed significant number utilization of antenatal care throughout years, it was not until 2012 health survey released the data of health insurance coverage which exposed that only 63% of women in Indonesia did not have health insurance (IDHS 2012:35) (See Appendix 1).

The condition leads to three assumptions. First, despite the utilization of maternal health care, particularly ANC, experiences progress, most of the healthcare service derives from out of pocket expenditure. Second, health disparities regarding distribution access and protection become a problem. Women in rural areas have a bigger tendency not covered by health insurance compared to women in urban areas (IDHS 2012:35). It is due to the preceding health insurance only dedicated to formal workers while women in rural areas mostly work in the informal sector. As a result, it is likely that women are marginalized inadvertently because of the eligibility of the health insurance. Third, a part of Indonesian women is disadvantaged of society, economy, and education which leads to the three 'delays'. According to Soedarmono (2017), this is the indirect reasons that hamper the improvement of maternal health which consist of "delay in recognizing danger signs and making a decision, delay to reach health facilities and delay to get services at the health facilities" (Soedarmono 2017:274).

Likewise, the pre-existing health programs had its focus less on women as the users of maternal health care but more on children's health (reference). The situation becomes more challenging because the health system of Indonesia, in general, is decentralized and fragmented (WHO 2017, Hartwig et al. 2015, Soedarmono 2017) with a limited budget allocation for public health provision in the subnational level. Realizing the importance of health equity for everyone, Indonesia took a step for institutional reform of social security agency in 2004 by issuing Law No.40/2004 of the National Social Security System (Putri 2014:7). Through the constitution, the government authorized the new social security agency that integrates the entire preceding social security to accelerate social protection for everyone. All memberships, programs, liabilities, rights, and obligation are diverted into two new bodies of social security, BPJS *Kesehatan* dan BPJS *Ketenagakerjaan* (Health Social Security and Employment Social Security). Also, those who were not part of the earlier social security are included in the new system for it addresses universalism principle.

In the process of preparing a greater scale of health insurance system, the government introduced *Jampersal* in 2011. It was a government-sponsored program for maternity care, specially targeted for pregnant women regardless of their socio-economic status (Achadi et al. 2014:8). *Jampersal* aimed to provide extensive coverage of maternal health care to those not covered by the other government health insurance schemes. A study by World Bank in 2014 showed that *Jampersal* utilization was high among underprivileged women, 26.2% of those have low education. Women who had a complication during pregnancy were likely to use *Jampersal* (Achadi et al. 2014:43). However, similar to UNFPA (2013) finding, other health services utilization displayed less impact albeit after three years of implementation. According to Statistics Indonesia, *Jampersal*'s coverage only reached 0.67% of women's population

in 2014 (See Table 1). The low utilization of *Jampersal* was likely due to the low awareness about the health insurance among women. The government discontinued *Jampersal* in 2014 and integrated the health service into JKN.

Table 1 Percentage of Households which One of the Household Members Has Health Insurance in Last Year (%)

Jamkesmas			Jamkesda			Jaminan Persalinan			Other Health Insurance		
2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015
27.38	28.41	25.05	6.24	6.91	13.98	1.07	0.67	-	3.88	5.83	2.47

2.3.2 Entering The Universalism Era

JKN is a government social insurance which designed to cover health protection for Indonesians citizens. The system is operated under the Health Social Security Agency (*Badan Penyelenggara Jaminan Sosial Kesehatan* or BPJS *Kesehatan*). It was introduced in January 1st, 2014 after a long-term "design process assisted by the Australian government, European Union, Asian Development Bank, and International Labour Organization" (Joedadibrata 2012).

JKN program is designed to address the unequal proliferation of health service in Indonesia regardless of their social status. Unlike its predecessor programs which particularly targeted for civil servants and pro-poor groups, JKN has an integrated system that allows everyone to has the same access to health care. It is the solution for the pre-existing social provision programs that had been managed separately. Former Indonesia Minister of Health, Nafsiah Mboi, said JKN connects the government message in achieving universal health care (UHC) while it adopts the private insurance management (Mboi 2015:93).

2.3.3 Map of JKN[3]

The study identified the features of the health scheme by using the policy architecture of social provisioning from Franzoni and Sanchez-Ancochea (2016:56-57) which comprises four elements: eligibility, funding, benefit, and provisioning.

Eligibility

JKN is an obligatory health program that all Indonesian citizens should have. It includes foreign workers who have worked for at least six (6) months in the country (Jamsos 2018). Participants obtain access to the health benefit once they start to pay the monthly premium based on the selected class. According to Presidential Decree No. 12, 2013 replaced by the Presidential Decree No. 111, 2013, JKN is divided into two types of participants. This classification is based on the financial capability and working sectors.

1. Beneficiaries of Health Insurance (*Penerima Bantuan Iuran Jaminan Kesehatan* or PBI)

   The poor and marginalized people who are determined by the provisions of the legislation. They receive free access to health care from the government. State Budget (APBN) or Regional Income and Expenditure Budget (APBD)
2. Non-Beneficiaries of Health Insurance (Non-PBI)

   The Non-PBI is classified into three sub-categories of participant:

[3] This sub-chapter is summarized based on the essay "Analyzing the Indonesia Health Care System"my essay for ISS Course 4154 Critical Social Policy for Transformative Development.

Table 2 Non-Beneficiaries Participants of JKN

No	Salaried employee participants and family members	Non-salaried employee participants and family members	Non-labors and family members
1	Civil servants	Independent workers	Investors
2	National Armed Force members	Workers who are not included from abovementioned, including foreign workers who have worked in Indonesia at least for six months	Employers
3	National Police members		Recipients of the pension
4	State officials		Veterans
4	Government employees' non-civil servants		Independent pioneers
5	Workers who are not included from above mentioned and receive a salary, including foreign workers who have worked in Indonesia at least for six months		Widow, widowers, and orphans of the independent pioneers
6			Non-workers who are not from abovementioned that can pay the premium

Source: *BPJS Kesehatan*, 2017

Funding

Two agencies contribute to sustaining the financial of JKN: the participants and government institutions. As the public legal entities (*publikrecht*), BPJS *Kesehatan* earns income through monthly contribution. The amount of premium may vary based on the benefit they selected. BPJS *Kesehatan* incorporates with multiple partners to expand easy access to payment methods. For instance, participants can pay the monthly premium through mobile banking or local mini market. As of 2016, it is reported BPJS *Kesehatan* earned 67.4 billion IDR which equals to 4.82 million USD. This number has increased significantly along with the growing number of participants (BPJS Kesehatan 2016).

The system also receives budget funding from the Ministry of Health and Ministry of Finance based on the annual state budget. Albeit the competition among ministries, the central government manages to increase the expenditure for improving the quality in the health sector in recent years (Mboi 2015). According to State Budget 2017, the expenditure for health sector took 61.7 billion IDR or equals to 4.7% of the total (Ministry of Finance 2017:20) with 32.4 billion was allocated for development of JKN (Ministry of Health 2015:160).

Benefit

Table 2 shows the coverage of benefits that the participants acquire from JKN.

Table 3 Contribution & Benefits of JKN

Participants	Contribution (amount or % salary)	Class of Benefits
-Poor households (PBI)	Rp 22,000-Rp 27,000	Hospitalisation class III

-Civil servants -TNI -Polri -State officials -Government employees non-civil servants	3% government 2% employee	Hospitalisation class I or II
-State-owned enterprises -Regional state-owned enterprises -Private companies	4% employer 1% employee	Hospitalisation class I or II
Family members of the salary workers (4 children, father, mother, in-laws)	1% employee	Hospitalisation class I or II
Individuals (non-salary workers)	Rp 25,500 Rp 51,000 Rp 80,000	Hospitalisation class III Hospitalisation class II Hospitalisation class I
-Veterans -widow/widower -orphans	5% out of 45% basic salary of civil servant's type III a	-

Source: BPJS Kesehatan 2017

With the categorization of the contribution, participants will receive equal access to primary health care (non-specialist), outpatient, and inpatient service (BPJS Kesehatan 2017). These are including but not limited to medical consultation, promotive and preventive services, drugs, operation, investigation laboratory diagnosis, and hospitalization.

Provisioning: How JKN Functions

The registration process differs on the category of participants. PBI participants are registered automatically by the Ministry of Social based on the statistical data from the Central Bureau of Statistics. When they have finished the administration process, PBI participants receive the Indonesia Healthy Card (*Kartu Indonesia Sehat* or KIS) from Regional Social Services. For Non-PBI, registration can be conducted individually or collectively from the employers. To ease the efficiency, BPJS *Kesehatan* provides online registration for both individuals and employers. Through the online registration, participants can get information vary from the location of primary clinics into the status of the registration process. Once participants have submitted the required documents, the membership will be active in the following month.

The medical service is implemented by using a multi-stage system. Participants who need medical service should come to the authorized primary clinic which written on their insurance card. After the consultation, the doctors will diagnose whether the patients require further examination. In case the doctors consider the patients have a serious health issue, the doctors will refer to higher health service or specialist in the hospital. The specialist doctor will determine whether JKN users should have inpatient or outpatient treatment. At this stage, the condition will vary and based on the class benefit. For instance, a hospitalized patient who pays class I, he will get the class I room in the hospital. PBI participants only get class III. In an urgent situation, patients can access the emergency service (*Unit Gawat Darurat*, UGD) in any hospital or clinic.

Participants must contribute to the 10th date of the new month. To strengthen the implementation, JKN also regulates penalty for overdue, especially for those who use the inpatient. According to Health Social Security Agency Regulation Number 2 of 2016 (BPJS Kesehatan 2016), when overdue exceeds one month, BPJS *Kesehatan* is entitled to freeze the health security temporarily. Within 45 days after the users have paid the overdue, they will

be charged for the penalty if they manage to use inpatient service. The penalty is 2.5% of the medical cost. The maximum fine is 12 months with a total amount is 30 million IDR (BPJS Kesehatan 2016). The number of overdue months is the reference for the calculation of the penalty and linked with which type of benefit the users registered (See Table 3 for Individuals users).

The explanation below is the illustration case of the overdue and penalty charge for the health service utilization.

Type of JKN Participants	: Individuals		
Class of Benefits	: Hospitalisation class I		
Monthly Contribution	: 80,000 IDR		
Number of months overdue	: 12 months		
Medical Cost	: 15,000,000 IDR		
Calculation			
Overdue	= 12 x 80,000 IDR	= 960,000 IDR	(a)
Penalty	= 12 x (2.5% x 15,000,000 IDR)		
	= 12 x 375,000 IDR	= 4,500,000 IDR	(b)
Total Overdue and Penalty (a+b)		= 5,460,000 IDR	

Challenges and Media Coverage about JKN

JKN is viewed as one of the biggest and ambitious health programs in Indonesia, for it aims to cover Indonesia's population of around 264 million people by 2019. Critics arise among public health policy analysts regarding the feasibility of the program. They even predict that it will be impossible for Indonesia to reach UHC (Razavi 2015). Such critics are vital, considering that the system faces numerous challenges regarding management, quality of service, funding, coverage, discrimination, referral system and regulation (Ihsanuddin 2018; Purba 2018). Albeit the studies of JKN have been evolving since its establishment, the scope of analysis remains limited due to the methodologies and samples. The current national statistics data is also premature to show the significance of JKN utilization among the users. As a consequence, the studies have not resonated the whole challenges of JKN as well as maternal health issues.

Likewise, the media also play an important role in exposing the progress and problems that appear alongside the development of the system. At the beginning of its establishment, JKN faced slow data integration process from the preceding insurances. The data of PBI participant was outdated as well (PATTIRO 2016). Hence, it took another effort by the government to ensure KIS distribute equally. The most crucial challenge is the proportion of PBI participant which far greater than the regular participant since the early phase of the program. This condition likely impacts the increasing deficit and financial loss of BPJS Kesehatan. As of 2018, BPJS Kesehatan's budget deficit has reached 16.5 trillion IDR from 9 trillion IDR in 2017 (Nurfadilah 2018).

Chapter 3: Research Methodology

This research is based on a combination of qualitative methods and desk review. Qualitative methods are important to study the voices, views, and meanings from mothers who are the users of maternal healthcare in Indonesia. I used the content analysis as an analytical tool to interpret the collected data from interview and secondary data.

The data collection process was conducted during one month between late July until August 2018. Due to geographical distance and resource limitations, I used Whatsapp and e-mail to interview respondents. It has been one of the shortcomings of this study. Hence literature study is needed to analyze the findings. Nevertheless, there are several advantages that I have gained through online interviews. With the advancement of technology, many researchers adopt traditional research methods to online research methods. For instance, James (2007) used email interviews to understand the identity construction among academics and Holt (2010) conducted phone interviews to explore the identity-making process of parents involved in their child's alleged criminal offenses. Meho (2006) argues online interviews such as via e-mail provides time and cost efficiency for researchers. Researchers can save time for processing transcripts and editing (Meho 2005: 1288).

3.1 Voluntary and Snowball Sampling

The study obtained the sample through voluntary samplings by reaching out to viewers through the social medium of Instagram. During the initial step, I published a social update explaining the background of my research (See Table 4). I expressed my intention of seeking volunteers who wanted to join the interviews for my study in Indonesian.

Table 4 Public Post about Research and Looking for Volunteers

Hi, friends, my name is Melissa. I am studying M.A. Development Studies at Institute of Social Studies, Den Haag. I am currently writing a thesis about the utilization of maternal healthcare in *Jaminan Kesehatan Nasional*. I am looking for 1-3 JKN and non-JKN holders who have been using the maternal health care of JKN and willing to share their experiences for this thesis.

Are you/wife/relatives/neighbors/friends/colleagues one of the JKN holders that know about the maternal healthcare of JKN? Or do you work in government agencies which linked to the JKN? Are you willing to be my participants?

If you are willing to participate, please do not hesitate to contact me through:
Whatsapp: +31655534662
Instagram: @melminian
Email: mina.melissa93@gmail.com

Your contribution will be very meaningful for the research and the community's understanding of the health programs made by the government of Indonesia. Thank you very much!

Through the public post, I specified several categories of the samples. Some pregnant mothers are JKN and non-JKN users, health professionals, government officials, and NGO workers. I tried to look for specific practitioners who worked with maternal healthcare or JKN issues, but it failed to materialize. I received one participant from the ministry, yet I did not find obstetricians who worked in a public hospital. I used the information from the ministerial level participant in the analysis process of the study.

The first public reaches out was released on July 27th, 2018. I realized that the viewers from my social media account had not reached the desired amount. To engage with wider viewers, particularly pregnant women, I used snowball effects by asking several persons to share my social update. The second reach out was published on 29th July 2018. Four days after the reach out and re-share post from my profile, I received around 22 participants who were interested in contributing to the study. However, due to personal circumstances, four participants could not continue the interviews. Until the end of the data collection process, there were 18 respondents remained in contact and gave information based on the initial mutual consent.

The research processes were conducted ethically. Participants gave me their voluntary consent to being involved with the research. One participant who worked for *BPJS Kesehatan* needed consent from the head branch of BPJS *Kesehatan*. Fourteen participants agreed to the disclosure of their identity, while four participants preferred to keep their identities private. The voluntary nature of the study was unproblematic because all the interviews were in private conversations. Hence, participants did not know about the others answers. Most of the participants had access to internet and mobile phone. Nevertheless, to ensure the privacy of personal information, all the name of the participants were written in initials.

3.2 Conducting Online Qualitative Interviews

At the beginning of the study, I acknowledged that distance and different time zones were the main challenges to engage with my respondents. To resolve these challenges, I decided not to conduct conventional eye-to-eye interview but online qualitative interviews.

Before I started the interview process, I asked the participants about the choice of interview methods they would use. Some options that I gave were video call via Skype, phone calls, emails, and Whatsapp. Two main platforms that commonly used throughout the interview process are email and Whatsapp. Reasons such as working location, having a business trip and the need to take care of babies were the consideration that urged email, and Whatsapp is the most convenient for them. Participants who worked daily opted to have interviews with emails. I sent the list of my inquiries to their emails in private to ensure their privacy and confidentiality. By sending preceding email, participants could have a longer time to understand and reflect the inquiries with their work-related background.

Participants who already had babies preferred to have interview through Whatsapp messenger. The application is widely used among Indonesians. It is not only used for everyday conversation but also business and professionals. Having interviews through this application allowed the participants to have flexibility in answering the interview inquiries. It also alleviated the language barrier as all participants came from different regions and might use local languages for particular terms.

The interview process was in the semi-structured interview. Although there are inquiries that I had made beforehand, I elaborated the interviews by responding to the information provided by the participants. It gave me more chances to explore the context where participants stand in society. The interviews took around 4-7 days due to the time difference.

In gathering information from participants, I used two different types of inquiries list (See Appendix 2). First, for participants who work as health professionals and government officials, the questions focused on understanding their responsibilities with regards to the implementation of JKN program and agencies that linked with their tasks. PD, who worked for *Wahana Visi Indonesia* (World Vision) based in Central Sulawesi and North Maluku, also received the same list of inquiries.

The second type of list of inquiries was more extensive and specifically for mothers. To have explanative information, I divided the inquiries into three parts: pregnancies period; JKN service and utilization; and personal background. Before starting the conversation, I explained the outline of the interview so that participants could anticipate the type of questions that I delivered. Most of the questions were in the form of open-ended questions so that participants felt an openness to express their opinions.

Challenges would always be inevitable in conducting any research methodology. Throughout the online interview process, several practical constraints occurred because of using emails and Whatsapp. The first concern is that all participants were located at a distance, meaning that I could not see the research situation during the interview. While it gave flexibility of time and space for participants without feeling pressure to stay in one location, the interview process took longer compared to one-time interview session (See Table 5). Three participants knew me professionally and personally. Thus, there might be a possibility the interview answers were more elaborative compared to other participants.

Table 5 Advantages and Gaps of Using Online Interviews

Advantages	Gaps
Flexibility to response the interview questions (18 participants) More thoughtful and reflective answer (7 participants) Fast response (5 participants)	Delayed response due to certain circumstances, e.g., work, taking care of babies (8 participants) Discontinued response (1 participant) Technical problems with network and communication (4 participants)

The second concern is the interview responses of the participants might not have been entirely their thoughts (Chen & Hilton 1999 in James & Busher 2006:412) to meet my expectation towards them. Such an issue would not happen if there were visual evidence through eye-to-eye interview. The time lapses were understandable due to the daily tasks that they had to do. Most participants apologized for not replying the conversation quickly and explained the reason. To ensure the participants remembered with their conversation, I made the confirmation or follow-up about details they had explained before continuing to other questions. By making this approach, participants felt 'sense of ownership' (James & Busher 2006:411) with the research conversation.

3.3 Reflexivity and Positionality

As a researcher, I am constantly aware of the importance of doing reflection and evaluation regarding the interview process that I conducted with my participants. Throughout this research, I faced the dilemma of being outsider and insider in respect to the JKN program and the Indonesian society. As a JKN holder and woman, I have never used the health service in general despite I regularly pay for the contribution. The fact that the registered primary health

clinic is far from my current residence in Jakarta discouraged me from going for distant. On the other hand, I was in charge of handling the practical problem of using JKN faced by my colleagues in my previous work. It was also included the case which I helped to consult the administration process when the wife of my colleague delivered their first child. These experience might influence the way I analysed the information from the participants.

Among 18 participants that joined this study, three of the participants know me as their friend or colleague. One of my colleagues also helped me to interview two participants from the province of Moluccas by recording the interview session. Albeit they contributed the study voluntarily, there might be possibilities where they were provided the information to meet my expectation. It is the variable that I could not control and influence my knowledge production in the analysis process.

Furthermore, the diversity of location and cultural background of the participants, especially the mothers, created a small gap for me to understand their agency of being the mother in their ethnic culture. As an insider, I lived in Jakarta since I was born; hence, I did not find difficulty to understand the situation faced by participants who resided in Jakarta. However, my positionality was challenged in studying the problem and context faced by respondents in different provinces. I realized there was a gap of a health facility in urban and rural areas. Having grown up in a big city has given me a lot of privileges to have better quality access to health service, while some communities in rural areas still rely on traditional healers for their health.

Chapter 4: Demystifying Dynamics of Maternal Health Care in *Jaminan Kesehatan Nasional*

This chapter explains the data and findings collected from the interviews with 18 respondents. There were 18 participants who comprised of 15 females and three males. They consisted of 10 mothers, three government officers, four health professionals, and 1 NGO worker. The respondents are located in 12 different cities in Indonesia: Batam (Riau Islands Province), West Tanjung Jabung (Jambi), Jakarta, Depok (West Java), Bandung (West Java), Tegal (Central Java), Yogyakarta (Special Province of Yogyakarta), Karimunting (West Kalimantan), Makassar (South Sulawesi), Luwu (South Sulawesi), Palu (Central Sulawesi) and Namlea (Moluccas).

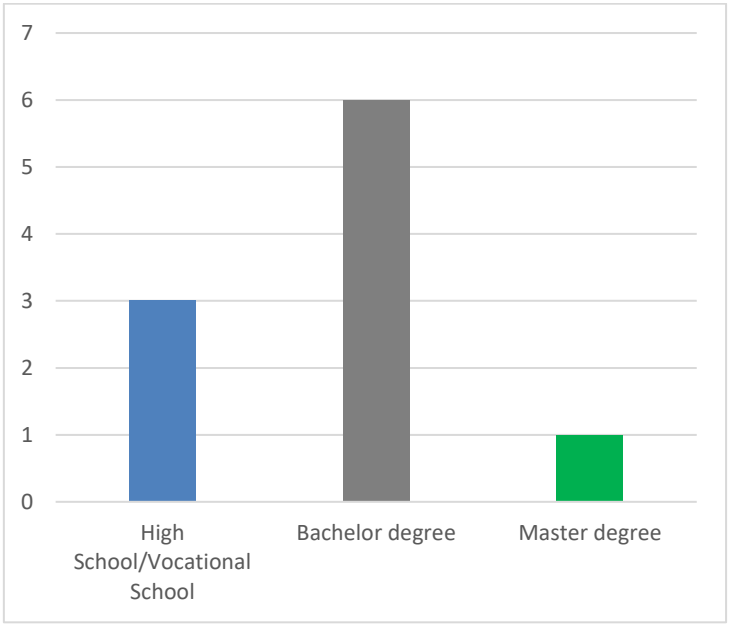
I divided the results of my interviews based on two main groups namely the mothers and the professional's group. This grouping was to differentiate between information coming from JKN users and health service providers or agencies that influence the formation of JKN policies.

4.1 The Mothers

The ten mothers responded to join the interviews through Instagram. Two mothers from North Maluku participated in eye-to-eye interview with the help of a local doctor. The interview was documented by using a voice recorder.

The age range of the mothers who participated in the study was from 22 to 39 years old. Their level of education expanded from high school or vocational school graduates to master degree graduates, with the majority being graduates of a bachelor degree (See Figure 1). The number of household income for each respondent varied within a range from Rp. 3,000,000.00 to Rp. 12,000,000.00 by the type of profession and specialization. Nine out of ten mothers had permanent jobs besides carrying out tasks to care for children.

Figure 2 Level of Education of the Mothers (in persons)



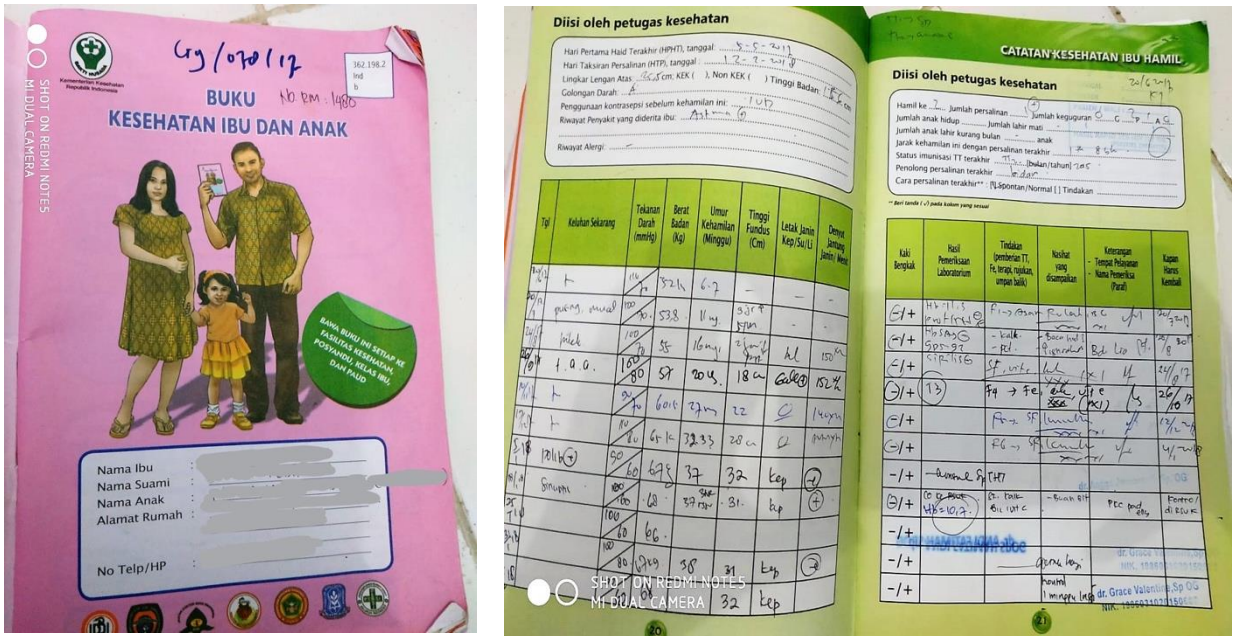
4.1.1 Becoming a Mother in Indonesia

When I had conversations with the mothers, I realized that all mothers were familiar with the *BPJS Kesehatan* instead of JKN as the name of the health security program. Throughout the conversation with the mothers, I had to use the term *BPJS* to refer the JKN amid the fact *BPJS Kesehatan* was the agency who responsible in managing the process of the health provision.

Entering the life phase of motherhood was a blissful moment, yet it also required a greater responsibility to be fully aware of their body and babies inside the womb. As one mother from Namlea (Moluccas), called AR, said, "I felt afraid if something happens to my child." Anxiety was a normal sense because all mothers wanted their children to be healthy and well-nourished. With the advancement of technology information and medical science, mothers had more access to information about pregnancy and maternal health. Each mother's body had a different condition. Thus, it affected how they sought for maternal health service.

When the women had their first examination of their pregnancy, they received a maternal and child's health journal (*Buku Kesehatan Ibu dan Anak* or KIA). The purpose of the journal was to record the health progress of the mother and child throughout the pregnancy. This journal had to be carried to every ANC visit and recorded by the doctor.

Figure 3 Example of Maternal and Child's Health Journal from Participant



All mothers received general information and suggestions from the doctor of how to maintain their health during the pregnancy period. The general information included diets and nutrients to nourish the baby. The first three months of pregnancy were the most vulnerable condition in which the mothers had to be more alert with their health. Morning sickness was dominant. Thus, the doctor prescribed heartburn medicine for the mothers. The mothers were not suggested to do a lot of activities during this period.

Besides, women also needed more iron during pregnancy. To ensure their health, the mothers received Fe tablets[4] from doctors. For mothers who used JKN's service, they obtained 30 Fe tablets every month. The provision of Fe tablets had lasted for around 20 years as government's effort to reduce the prevalence of anemia in Indonesia (Septiani 2017). Other supplements such as folic acid and vitamins were provided based on the health condition of each mother.

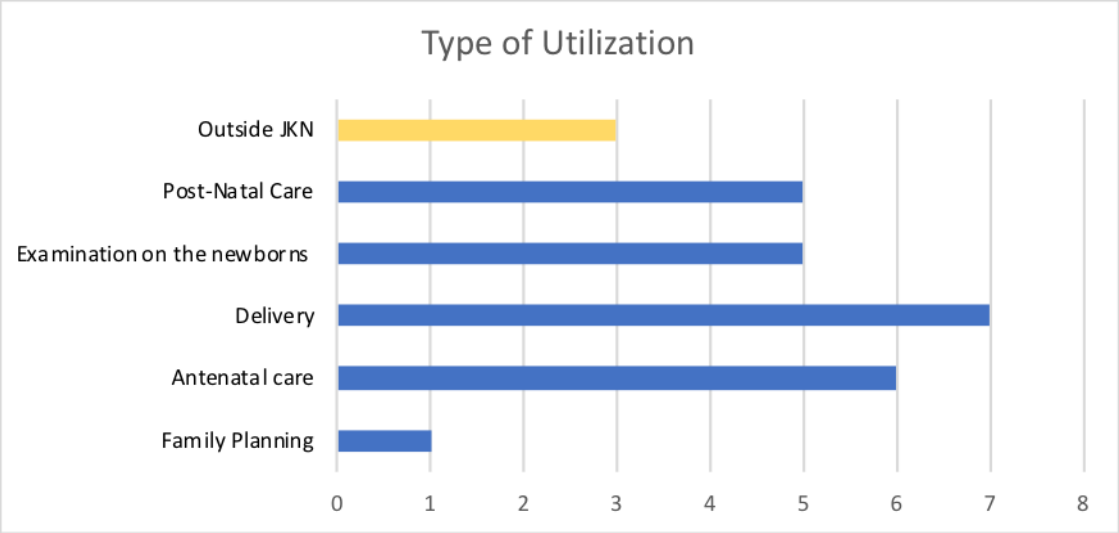
4.1.2 Utilizing Maternal Health Care

In respect to the maternal healthcare utilization, I classified the utilization into five types with one additional category for those who did not use JKN maternal health service (See Figure 4). There was antenatal care (ANC), post-natal care (PNC), examination on the newborns, childbirth delivery and family planning. This classification was based on the coverage benefit of JKN (BPJS Kesehatan 2017).

Three out of ten mothers had had a pregnancy process more than once (see Table 6). All mothers who participated in this study had JKN. However, not all mothers use maternal healthcare from JKN. Three out of ten mothers used maternal health services outside JKN during their pregnancy. The other seven respondents used the full and partial JKN facility. Seven respondents used delivery services (see Figure 4). Pregnancy examinations are the second highest number of six respondents. Postpartum examination services and examination of newborn babies as many as five respondents. While one respondent only uses family planning services. The family planning was the least health service used by the mothers. One participant who used the family planning service was FP from Bandung, West Java. She decided to use contraception after gave birth for she wanted to focus on raising her first child.

Meanwhile, I found several reasons that affected the other nine mother delayed the use of contraception. The most dominant reason was the contraception was not suitable and gave side effects to their bodies. They were afraid of inserting an intrauterine device (IUD) in the uterus due to the side effects experienced by the other mothers.

Figure 4 Maternal Care Utilization (in persons)



[4] Fe tablet is a supplement given to pregnant women to ensure iron needs and to prevent anaemia during pregnancy (Septiani 2017:87).

Table 6 Interview Results with Mothers Group

No	Name	JKN Status	Age	Age of marriage	Occupation	Residence	Level of Education	Husband's Occupation	Household Income (IDR)	Number of pregnancies	Utilization of JKN	Delivery Method	Contraception
1	IP	Family member	30	26	Housewife	Luwu, South Sulawesi	Bachelor degree	Geologist	12,000,000	2	Two times; full JKN (early pregnancy until post-delivery)	Normal	No answer
2	PM	Company	25	22	Employee	North Jakarta, Jakarta	Bachelor degree	Private Employee	10,000,000	1	Not using JKN, using private insurance	Normal	No
3	AA	Individual	25	23	Legal Translator	Yogyakarta (when pregnant)	Master degree	Master Student	8,000,000	1	Full JKN (early pregnancy until post-delivery)	Normal	No
4	MB	Individual	25	21	Teacher	Depok, West Java	Bachelor degree	Private Employee	7,000,000	2	1st pregnancy using JKN for antenatal care but not delivery (the year 2015), 2nd pregnancy when approaching delivery time	Normal, induction	Yes (condom or coitus interruptus)
5	RA	Individual	22	21	Accounting Staff	West Jakarta, Jakarta	Vocational School	IT Support Staff	7,000,000	1	Two visits for antenatal care, delivery process, and post-delivery	Normal	No
6	RD	Individual	28	26	Housewife	Palembang, South Sumatra	Bachelor degree	Private Employee	5,000,000	1	One time antenatal care, using private insurance	C-section	No
7	FP	Individual	28	23	Entrepreneur	Bandung, West Java	Bachelor degree	Private Employee	10,000,000	1	18 times antenatal care without JKN, delivery process by using JKN	C-section	Yes

8	ER	Family member	39	25	Housewife	Namlea, Moluccas	High school	Civil Servant	3,000,000-5,000,000	4	Full JKN (early pregnancy until post-delivery)	Normal	No
9	AR	PBI	28	26	Shop Assistant	Namlea, Moluccas	High school	Driver	husband driver	1	JKN PBI, but not use the service. Only went to the nearest clinic. USG. No blood test and STD test. Certified Midwife. Delivery at home.	Normal	No
10	ST	Individual	27	26	Entrepreneur/shop assistant	Tegal, Central Java	Bachelor degree	Entrepreneur	5,000,000	1	Delivery process	Normal	No

The results of my interviews with mothers showed five patterns and opinions which then explained the pattern of use of midwifery services for each mother.

1. Quality of Service

Nine respondents showed a caring attitude towards the quality of JKN health services. The first concern is related to the attitude, ethics, and professionalism shown by health workers towards the patients. If the health worker in charge looked unfriendly and not informative, patients were hesitant to check their health at the same health facility. It might lead patients to look for alternative health services that match their expectations too. The excerpt below was one of the stories experienced by RA during her delivery time:

> When I gave birth to my child, I was told to push and to give birth quickly because the midwife who handled me had her time to go home. It was at 12.00 midnight. At the time, she had the morning shift, so she supposed to come home at 2:00 a.m. After I gave birth, the on-duty midwife told rudely to my mother to stay out of the room. My mother was the only person who watched over for me. I thought that was very strange because I had watched over for sick people many times, but it had never been like that. I knew that the procedure only required one person to wait. However, my mother still had to go out. Then, other two women were in labor in my room, but the midwife was in the outside chatted loudly like in the forest. (RA, Interview 5, West Jakarta, 2018)

The second concern is the inconsistency between the level of monthly contributions that JKN users pay for the different level of benefits and the actual service they receive. Two participants received downgraded room during labor amid they had paid for a higher class of benefit. Eight respondents received proper treatment according to the standard of procedures. The difference of treatment created a discriminatory feeling among JKN users considering every patient has a right to get equal treatment of health service.

> I pay for the first class benefit user, but I was placed in the third class. They (health workers) only told that after the registration process was complete. I tried to understand, but with that kind of service, I was disappointed because the room I occupied had a lot of mosquitoes. (RA, Interview 5, West Jakarta, 2018)

> The hospital service was not satisfactory even though I have paid for the first class. I feel excluded between general/private insurance patients with BPJS patients. The nurse was not deft and reluctant to assist me. (RD, Interview 6, Palembang, 2018)

Due to the unpleasant experience they received, participants felt discouraged and less convinced to use JKN service again. For instance, RD told me that she would stop paying JKN fees because the quality was not satisfactory compared to the contribution she had spent.

The third concerned is linked to the administrative and management aspects in the health care providers. Two respondents from Jakarta and Depok were overwhelmed with the long queues that often occurred in the PHC, which to some extent motivated them to look for another obstetrician to examine their pregnancies. The other respondents mentioned the referral system aspect in JKN.

> I hope that the queue at the primary health center can be minimized because the queue is very long. It is really a struggle for pregnant women. Sometimes we have to wait for hours since early morning. (MB, Interview 4, Depok, 2018)

> If you move to the primary health center, you have to queue, and the midwifery service is only available on specific days. It is difficult for me to adapt to it. (RA, Interview 5, West Jakarta, 2018)

> When BPJS (JKN) users are sick and happen to be outside the area, we cannot use BPJS cards to doctors who are registered or in hospital polyclinics. Unless in an emergency condition or if there is a referral to the first level of health facility, we should use the regular procedure and pay from our pocket again. (IP, Interview 1, Luwu, 2018)

2. Physical Access to Primary Health Center

This aspect is linked to the distance and time span needed by the participant to get to the nearest health center. AR who lived in Namlea, checked her pregnancy at the nearest pharmacy at her own expense even though she received a subsidy from the government (PBI participants). The location of the PHC listed on her card is further than the location of the nearest pharmacy. MB also did not use JKN services due to the distance of her PHC is located in North Jakarta area. She chose to seek treatment at the nearest health center rather than taking more distance and time to use free health services.

3. The Facility in the Primary Health Center

Participants who had the antenatal care of JKN feel contented with the facilities available at the PHC. There is no shortcoming regarding medicine. All are by standards, such as the provision of Fe tablets to increase red blood cells. Other medicines such as nausea and gastric medication will be prescribed according to the patient's condition. In contrast, two out of three respondents who did not use JKN facilities during their pregnancy thought that equipment in primary health facilities was still inadequate. Examples are the opinions expressed by RD.

> When we are pregnant, surely we want to see our children from USG. We want to see their full condition whether there is a possibility of abnormalities and so on. It is less convincing to have the examination in the PHC because the equipment is inadequate. We cannot know the physical condition of the fetus completely. We can only know the heart rate of the fetus. The position of the fetus is only based on touches in hand. That is why I went to the obstetrician again. The obstetrician looked at the complete organ, abnormalities, windings and amniotic fluid was enough or not. (RD, Interview 6, Palembang, 2018)

PM who lives in Jakarta also chose to use private insurance to consult with a specialist to get complete information regarding the development of her baby.

Regarding the obstetric ultrasonography facilities, ER who used full maternal healthcare of JKN hoped for the procurement of the facility at the PHC level.

> If possible, basic maternal health facilities can be improved by having USG. That's what we (pregnant women) expect because in the previous experience if we wanted to use USG facilities, we had to ask for referrals first from the PHC. (ER, Interview 8, Namlea, 2018)

The information from ER regarding the referral letter for ultrasound examination is different from the information of respondents from Jakarta. Two respondents domiciled in Jakarta understood that obstetric ultrasound examination is only valid if there is an abnormality in the condition of the fetus. They thought the regulation discriminated pregnant women who have a normal pregnancy.

4. Needs of Information

There are two points from respondents that associated with the needs of information. First, four respondents expressed the importance of the role of information in improving good understanding of the health of pregnant women and children. Although in general, they believe women's knowledge of the maternal and children's health has increased, understanding about pregnancy is imperative to be disseminated extensively, especially for women who are living in rural or remote areas. Three respondents thought that pregnant women in rural areas still believed in myths or customary habits related to pregnancy and caring for babies. These myths can increase health risks for babies. One example is feeding bananas to babies who are only one month old.

The second point is information related to JKN. Participants believed that BPJS Kesehatan needs to increase socialization about the system, benefits, scope and method of payment, referral system and how to use JKN. The currently available information is inadequate and has not reached all levels of society.

> I live in the village, some people around me do not know that BPJS have delivery service. I hope that they (BPJS Kesehatan) do not omit the maternal health service because rumors said that we could not BPJS to give birth.[5] I think it is very important, you know, with BPJS, most people will want to go and give birth to a doctor or midwife. That is much more convenient. Even though you do not have to go to the hospital, you can at least go to the health center. (ST, Interview 10, Tegal, 2018)

The certainty of information regarding the new regulations within the JKN system seemed to have a strong connection with a person's willingness to use JKN. The same issue also necessary for the information of health service providers who are partnering with the JKN program. FP believed that some hospitals refuse patients to use JKN cards because the beds are full. It made the hospital seemed to be lying for her because "If we pay for full classes (out of personal pocket), we get a room. But if we use JKN, it will be complicated".

5. Household Income and Cost for JKN

All participants who have used JKN maternal health care argue that JKN helps them in saving health costs, especially for delivery services. Childbirth services within JKN are free of charge. This positive opinion was conveyed by respondents AA, MB, and ST. Six respondents who became JKN participants individually did not express any problems related to the amount of JKN monthly contributions. The amount of monthly contribution depends on the type of care class chosen by each participant. The table below showed the example of the health cost ratio of three participants with their household income.

[5] In July 2018, *BPJS Kesehatan* issued three new policies. One of the policies was the Regulation of the Director of Health Service Assurance Number 3 Year 2018 concerning Guaranteed Delivery Services with Healthy Born Babies (BPJS Kesehatan 2018)

Table 7 JKN Insurance Premium **Ratio with Household Income**

Participant	JKN Class of Benefits	Number of Family Members	Monthly Household Income (IDR)	Monthly Contribution (IDR)	JKN insurance premium contribution per family (IDR)	Insurance Premium Ratio with Household Income (%)
AA	Hospitalization class I	3	8,000,000	80,000	240,000	3.00
MB	Hospitalization class I	3	7,000,000	80,000	240,000	3.43
ST	Hospitalization class I	3	5,000,000	80,000	240,000	4.80

All participants believed that their economic conditions were sufficient to meet their daily needs, health costs and savings. By paying the monthly contribution, the participant can access to advanced health facility based on the class of benefit they register in JKN. The strategy for managing household finances can be done in various ways. Some strategies are being JKN participants, participating in social gathering or *artisan*, creating small businesses or online shops.

4.2 The Professionals

Participants from the professional group consisted of 3 doctors, one pharmacist, one internal verifier in the hospital, one staff member of the Referral Benefit Service Verifier, one professional staff at the ministry level, and one staff member who worked as a Community Engagement Officer at a non-governmental organization (NGO). Their age ranges from 24 to 50 years. For participants who are doctors and pharmacists, they work in sub-district or district level health centers and First-Level Health Facilities (*Fasilitas Kesehatan Tingkat Pertama* or FTP).

Overall, the information I obtained from this profession group tells about individual reflections and their interactions with maternal health care and the implementation of the JKN program both in general and specifically. One thought-provoking finding related to technical implementation, five out of eight respondents, showed concern and skepticism about the JKN system. From the perspective of health workers, they can explain the picture of maternal and child health in more detail and the things that concern them. I categorized their information into two groups.

4.2.1 A Brief Picture of Pregnant Women

Every pregnant woman who examines her pregnancy at a health center will get a Maternal and Child's Health (KIA) book. Participants of health workers argue that the MCH handbook helps in the recording system and provides information about the development of health to each mother. If during the antenatal process they find the particular risks of pregnancy (e.g., complications in premature labor or the age of the mother who is too old), the patient will be referred to the hospital and controlled by a specialist obstetrician and gynecologist. For patients who do not have a risk pregnancy, they can check their pregnancy as usual at the PHC every month. Childbirth can be done at the sub-district PHC.

In respect to people's understanding of the health of pregnant women, in this context represented by women, there are differences between urban and rural areas. YS who served in Jakarta argued that women's understanding of the pregnancy was good. It is because each

mother who has the antenatal care in his PHC must take courses for pregnant women four times as a condition to undergo an examination.

> Regarding knowledge and understanding, pregnant women who come to our PHC is good because they take "courses for pregnant women." There are also sharing sessions from pregnant women who have had previous deliveries. (YS, Interview 12, Jakarta, 2018)

However, according to AD and ZP, there are still many women who do not understand the health of pregnant women and children in rural areas. AD believed that many women in Namlea have children either at a young age (<20 years), too close to children (<2 years), or too old (> 35 years). These factors increase the risk of complications both in the mother and fetus in the womb. AD also noticed local people's habits that could increase the risk during pregnancy.

> One of the risky behaviours that I often find here is the habit of massaging the stomach at a certain gestational age. It often causes problems in the form of early contractions that occur before its due. (AD, Interview 11, Namlea, 2018)

ZP also thought that women's awareness to have a pregnancy check-up at the *puskesmas* was poor. People who are social-economically underprivileged prefer to go to shaman or *dukun* while the people have higher income prefer to spend their money on better health service.

> The number of childbirth in a shaman in my area is still high. People perceive childbirth in public health facilities is expensive, while in shaman it is cheaper. (ZP, Interview 13, Jambi, 2018)

4.2.2 JKN System and Information

Participants from the professional group agreed that the current JKN achievement should be appreciated. Community access to health facilities is progressing. However, they recognized the existing challenges in the implementation of JKN, especially related to readiness and availability of information.

> I think JKN is like a double-edged sword. On the one hand, this facility helps many people who were previously impossible to reach health facilities. But on the other hand, I think the government is not quite ready to run this program throughout Indonesia. With the limited funding and the increasing number of patients, health professionals have to think hard to manage the funding. (AD, Interview 11, Namlea, 2018)

As health workers who frequently interact with patients, they also try to provide socialization and advice to use midwifery services in JKN. ZP also often finds problems with patients who are delinquent, which in the end gives a hard time to the patients.

> Midwives often advise pregnant women to immediately register for BPJS to help them at the time of delivery. But there are still many who are skeptical, most of them will take care

> of it (BPJS) when they know their pregnancies are at high risk. If their pregnancy is normal, they do not want to take care of it. The reason is that it is complicated. If they are sick, then they will use BPJS. Later, if they are already healthy, they do not want to pay a monthly contribution anymore. As a result, if one day they become ill, they will be troubled because they have been fined for the overdue of BPJS. (ZP, Interview 13, Jambi, 2018)

The same thing was also expressed by MC in Batam. Although JKN provides many benefits to the community, the BPJS is considered necessary to evaluate the dissemination of information.

> BPJS is not active enough in providing information services to the community and patients because they do not place their officers in hospitals (health facilities). Also, BPJS is not yet open about the regulations regarding the rights of participants by existing regulations. (MC, Interview 17, Batam, 2018)

Chapter 5: Enhancing Maternal Health in Indonesia through JKN

The presence of JKN seems influential in saving the household expenditure of health. Based on the opinion of the participants, JKN has contributed to reducing the cost of medical service throughout the pregnancy. For instance, ST estimated she would spend around seven until eight million rupiahs for the whole pregnancy if she were not part of JKN. In her residing area, one ANC visit in the public or private hospital might cost 114,000 IDR. Pregnant women who wanted to use obstetric ultrasound would be charged an additional fee for 40,000 IDR. For vitamins and supplements, pregnant women had to pay separately and varied based on the condition of each. When the pregnant women experienced complication such as spots or bleeding during pregnancy, they paid more fees for the additional medical assistance.

Compared to the latest health statistic, there were several results of the finding which in line and not reflect the national condition. First, all participants in the study had their ANC visit more than four times. It had exceeded the minimum standard regardless of the trisemester period, and the National Health Profile of Indonesia in 2015 presented the ANC coverage reached 87.48% (MoH 2015:107) (See Appendix 5).

Secondly, all mothers participated in the study had their delivery either in the hospital or PHC. The 2013 data showed that 70.4% of deliveries occurred in health providers (MoH 2013:177). In 2015, the number increased to 79.72% (MoH 2015:113). It may indicate a positive sign of improvement in institutional deliveries though provinces such as West Kalimantan (56.4%), Jambi (56.27%) and Maluku (30.08%) were below the national number (ibid). There is a similarity between the actual data with the information given by the participants as they mentioned their concern about the prevalence of unattended skilled birth in the area they resided.

Another intriguing fact that the most expensive maternal care in Indonesia is the delivery service, and incidentally, it was the most used health service by the mother's group. One positive major demand factor that influences the frequency of the utilization is because participants feel more beneficial by using JKN. The cost of childbirth service is diverse based on the locations, the health providers, and delivery methods. In urban areas like Jakarta, the service for normal delivery in the PHC is around 300,000 IDR. In the hospital, price ranges from 3,000,000 IDR until 30,000,000 for three days hospitalization (Primastika 2018). The cost is usually double when the patients have caesarean section operation. The cost of delivery service in rural areas is lower than in urban areas. For the normal delivery service attended by the midwives or in the PHC, the health service fee will be around 1,000,000 IDR.[7] The price is higher if women have their delivery at the hospital as for first class bed it will be around 5,000,000 IDR. Meanwhile, from the supply side, institutional delivery has become health policy priority as a strategy to achieve 85% delivery at health facilities by 2019 (Mukhlisa & Pujiyanto 2018:149).

It is too early to conclude that JKN has significant contribution in reducing the financial burden as well as improving the health access for its users. The financial capacity of the users takes important roles in determining the maternal care uptake. From the context of the socioeconomic background of the participants, it can be inferred that most of the mothers participated in the study were from middle-income society with higher educational level. They also contributed to the finance of their households. Whether it is through a formal job or small

[7] (ZP, Interview 13, Jambi, 2018) (See Appendix 3)

business, the impression reveals they did not experience financial hardship to pay for JKN premium. They also added that they preferred to use their out-of-pocket money for less serious illness instead of using JKN. Normally, they would go to the pharmacy to buy drugs without a prescription. It might vary based on the condition of each individual. In Indonesia's Basic Health Research 2013, urban residents tend to have more out-of-pocket service to buy drugs in pharmacy or stalls (28.5%) than rural residents (24.2%). The average spending in urban areas is higher, which is 5,000 IDR per month, while in rural areas is 3,000 IDR (MoH 2013:154).

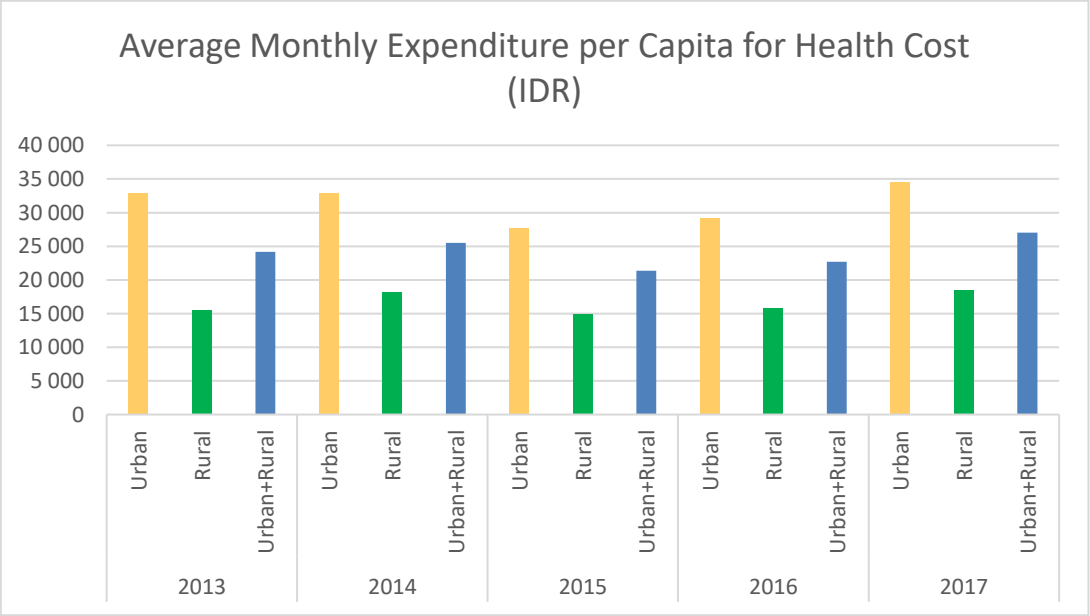
Compared to the national data, there is a steady increase in minimum wage in every province. Through the Ministry of Manpower, the government set an 8.71% increase for the minimum wage in 33 provinces in 2018. Four provinces raised the minimum wage over 8.71% were West Papua, West Nusa Tenggara, East Nusa Tenggara and Moluccas (Sugianto 2017). Jakarta as the capital city has the highest Provincial Minimum Wage (3,648,035 IDR) while the Yogyakarta has the lowest (1,454,154 IDR) (See Table 4).

However, the health cost shares around 1% of the total household compared with the average monthly expenditure for health cost from 2013-2017 (See Figure 3). The comparison leads to two assumptions: one, citizens' awareness to allocate their budget on health is low; two, citizens cannot afford to obtain better access to health services.

Table 8 Provincial Minimum Wage 2017-2018
Source: Sugianto 2017

Province	Percentage of Increase (%)	Provincial Minimum Wage (IDR)	
		2017	2018
Jakarta Great Capital	8.71	3.355.750	3.648.035
Yogyakarta	8.71	1.337.645	1.454.154
Moluccas	15.44	1.925.000	2.222.220

Figure 5 Average Monthly Expenditure per Capita for Health Cost (IDR)
Source: Indonesia Statistics 2017



The second assumption has a similarity with the information from participant ZP. She noticed there is a quite high number of child delivery without birth attendants. As ZP worked in the poorest district in Jambi Province, the number of delivery without professional birth attendants was 7.52% in 2015 (District Health Office of Jambi Province 2015:77). The number might indicate that 7.52% of women have not obtained maternal health access for their deliveries. Women who have lower income usually prefer to ask baby soothsayer for helping them during the delivery process at home. It is due to the service of baby soothsayer is cheaper than the service fee of midwives. The service fee of baby soothsayer ranges from 300.000-500.000 IDR while the service fee of midwife without JKN ranges from 800.000-1.000.000 IDR.[8]

Even so, the health coverage measurement cannot rely only on through the nominals of the health cost. JKN program should consider a guarantee for patients who have extraordinary condition during delivery too. A clearer regulation and coverage for emergency assistance and complication are necessary because they are more costly compared to normal delivery; it can be burdensome for patients who come from a low-income society. It is also crucial to reduce the mortality risk because a part of maternal deaths in Indonesia occurs due to late medical assistance during an emergency (Achadi et al. 2014:4) or the first three days of post-partum period (MoH 2013:178-179).

Besides regulation, JKN has an obstacle in the availability of maternal health care equipment. There were several cases exposed in the media where patients being denied by the hospitals for having childbirth due to limited availability of beds. The patients were rejected regardless of their participation as JKN users. It led to the death of the mother or baby. In 2017, one pregnant woman died because of delayed response from the hospital in handling the childbirth (Ponge 2017). In the same year, three alarming cases reported about the death of the babies for being rejected by hospitals (Niman 2017, Salim 2017). A study conducted by Women Research Institute also discussed the inadequate health care equipment Comprehensive Emergency Obstetric and Neonatal Care (PONEK) in hospitals in Jakarta and Bandung (West Java). "Several patients who need to undergo surgeries had to wait for month for their schedule" (WRI 2015:2). The issue is alarming because many cases of maternal death occur in the hospitals (MoH 2013).

5.1 Determinants of Maternal Health Care Utilization

Although the provision of maternal health care has been established for a long time, the process of health provisioning becomes slower and problematic with the integration under JKN. As a result, it affects not only the quality of the health service but also the preference of users to utilize the benefit. Based on the explanation from the participants, I noticed a number of influencing factors derived from health providers, users, and BPJS *Kesehatan* which all are related to each other.

5.1.1 Health Providers: Inconsistent Quality of Service and Inadequate Information

The health providers are overwhelmed in balancing their duty to provide health service as well as the "marketing" the benefit of utilizing JKN. Based on the information from the professional group, the health professionals expect BPJS *Kesehatan* should be more dominant in disseminating the information related to JKN, especially issues linked to the referral

[8] (ZP, Interview 13, Jambi, 2018)

system, coverage benefits, and updated regulation. With the absence of officer from BPJS *Kesehatan* in the health institution, health professionals often receive from the users about the administration of JKN too. Due to the lack of understanding about the mechanism, health professionals do not have enough capacity to assist the users effectively. As a result, patients perceive that the health providers under JKN are inattentive with regards to their needs.

A study by Australia-Indonesia partnership program called MAMPU finds that socialization and information on reproductive health services as well as maternal health services provided by JKN are insufficient. Thus, women still do not understand and utilize these services (Arta 2018). It contributes to the increasing number of MMR and greater cases of cancer-related to female reproductive organs. Here it can be understood that health professionals have not well-acknowledged neither with the system of JKN nor the coverage of maternal health service within the insurance. The division of task can be redundant because the absence of JKN socialization impose the health professionals to act as insurance agents for the health program too.

For the health providers in rural areas, particularly PHC, they face the technical difficulties ranges from limited financial resources delayed supply of vitamins and vaccine. With the limited budget allocation for daily tasks, health providers cannot maximize their service effectively. For instance, in PHC where participant YS worked, the health team had the budget allocation manage to create a course for pregnant women. Meanwhile, in PHC where AD works, the health team even does not get the clinic car which supposed they obtain based on the standard facility of regional PHC. Consequently, doctors should go on foot or using their own money to visit the community for a health check.

Furthermore, the PHC sometimes do not have enough supply of vaccine when it is needed. Distribution can be late around two until three days. As a consequence, the doctors usually will tell the patients to come again when the vaccine is available. This situation can discourage not only pregnant women but also other patients to check their health because going to PHC may spend another cost for transportation. Late reimbursement of capitation fund from BPJS *Kesehatan* contributes financial bottleneck to the health providers. For independent health providers like a general practitioner of first-level health facilities (First-Level Health Facilities (*Fasilitas Kesehatan Tingkat Pertama* or FKTP), they should use their saving to cover the operational cost due to the late payment from BPJS *Kesehatan*. As a consequence, it will affect the quality of the maternal health service crucially because PHC, First-Level Health Facilities and midwives are the main agencies who interact directly with the JKN users.

In the hospital level, JKN users often complain the hospitals do not have enough bed for them. Hence, they reject the patients who need to be hospitalized. This cases also appear among pregnant women who want to deliver in the hospital. However, hospitals will accept users if they pay through their pocket money. Having uncertainty of receiving the service from JKN is not only affecting users satisfactory towards the insurance, but also harming their rights of getting access to health. For users who have more stable income will not bother much as they are intact with wider options for alternatives, but people who are socio-economically less privileged will face hardship in obtaining affordable healthcare.

5.1.2 The Users: Knowledge and Health-Seeking Behavior

There is a strong connection between maternal health care utilization and the socio-economic and geographical background of the users. Through the interviews, there is a tendency that women who have higher educational background incline to have a deeper understanding about pregnancy. They are more aware and selective towards their health pregnancy-related information they receive from their surroundings. For instance, they maintained frequent

communication with their caretaker (health professionals) to have consultancy throughout the pregnancy. The purpose was to build easy communication for consultancy whenever they needed advice, particularly when the women experienced contraction in the stomach or spots.

In contrast, one participant who obtained high school graduate found difficulties in articulating her knowledge about pregnancy. Regarding breastfeeding, nearly the whole participants had their exclusive breastfeeding. Only one participant from a rural area who only gave breastfeeding for one month. Exclusive breastfeeding ideally lasts for six months to ensure the development of infants in early age (WHO 2015). Participants are acknowledged about pregnancy myths that spread among their community, but they managed not to apply as most of them were irrelevant and risky. With the strong influence of religious belief among society, pregnant women are usually encouraged by relatives to pray regularly for having good health throughout pregnancy.

In respect to the understanding about JKN, there is no dominant difference among participants because neither users in urban nor rural areas comprehend about the clear mechanism of JKN. However, both findings and literature study displayed a similar pattern of health seeking behavior among JKN users. Although they acquired JKN, they did not maximize the utility. A study conducted by Kurniawati and Rachmayanti identified several reasons the root causes of low participation of JKN which comprised of being apathetic, lack willingness to understand JKN, do not consider JKN as important (2018: 36). A common misconception among society is that insurance is needed when they are sick. Even those who already been JKN users often pay late for the contribution. National media reported that there were 12 million JKN users were overdue since 2017 (Widyastuti 2018). This condition will disadvantage not only the JKN users but also the involving agencies and the output of the health provider. At this point, the quality served by health providers can decline because they experience financial loss due to the overdue. Pregnant women who have overdue for their JKN will not receive access to maternal care too, and this will be dangerous during an emergency.

5.1.3 Lack of Understanding of JKN among the Citizens

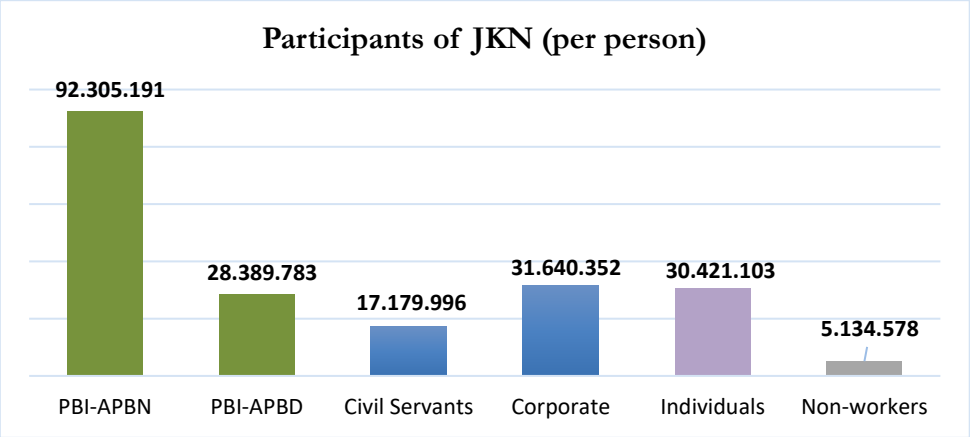
The information circulating through print and internet media seems only accessed by particular groups who have higher levels of education. The socialization carried out became mistargeted because it had not been able to reach several groups of people who were poor or in rural areas and less interaction with technology. Mothers are not aware of JKN maternal care's coverage. A similar finding was stated by Kurniawati and Rachmayanti (2018) that the community in Payaman Village, Bojonegoro Regency, East Java, did not receive information about JKN from health workers in PHC, village midwives, village officials, or BPJS Health officials (2018:37). The head of households also had less awareness about JKN, less motivated to arrange the registration process becoming part of the health scheme (Kurniawati and Rachmayanti 2018:36). Enhancing people's understanding of citizens' right is crucial in the process of universalization (Yi et al. 2017:14). By creating a good flow of information, it will change the public perception about the program and strong the sense of ownership among citizens.

5.1.4 Indirect Determinants

The proportion number of PBI participants and individual participants also becomes a problem. Since JKN's establishment, the number of PBI participants is greater than the number of individuals participants who pay independently (See Figure 4). That indicates individuals

participants also carry the burden of the medical cost of the PBI participants. If this proportion remains the same for the next few years, JKN is more likely to suffer larger deficit for it always becomes the safety for PBI participants for any complication and urgent health risk.

Figure 6 Participants of JKN (as of 1 November 2018)
Source: BPJS Kesehatan 2018



Even if the government considers to increase the fee of the contribution, it will generate higher protest among the individuals if the demand for better quantity and quality of the public health service do not meet expectation. The meanings of free and universal contested because one party is benefited while the other party is enforced to enroll without getting what is promised by the benefit package. What it appears in the process is similar to Mkandawire's idea that there is hardly pure universal or pure targeted policy, it tends to be somewhere between the two poles or hybrid (2005: 1).

Chapter 6: Rethinking JKN towards a Universal Health Coverage

6.1 Conclusion

The utilization of maternal healthcare through JKN has increased the access to health services substantially, yet it has not proven to contribute to the improvement in maternal health status significantly. Some health services are frequently used while others are not. Although access to health has increased after the initiation of JKN, unequal distribution of maternal health facilities is still prevalent, particularly in rural areas. The inequality does not only relate to quantity but also the quality of the health services. Hence, regarding availability, JKN should work hard to improve the resources for providing maternal health services.

There are several dominant factors from the supply and demand sides of health provision which affect the uptake of the health services. First, the study from the primary data collection found the importance of information in enhancing the understanding of maternal health care and JKN. Both the mother and the professional groups share the similar concern that the distribution of information among citizens is still inadequate. Regarding awareness, they believe that there are a lot of people who have not well-informed by the health protection provided by the government. It can be influenced by the level of education and eagerness from the people in seeking health services. As a consequence, people, in this context women, do not realize their rights to health. They do not fully comprehend about their health risk during pregnancy as well as the coverage benefit provided by JKN. Therefore, it leads to the low uptake for maternal care utilization as well as stagnancy of maternal health status.

Second, the socio-economic factor influences the preference of women to choose their access to health services. The study showed a pattern among participants who dominantly from the middle-income group has a positive relationship with wider access to health care. A higher level of education also enhances their understanding of pregnancy and taking care of their health. Through the interaction with information technology, they learn from the other mothers and things they should avoid to reduce health risk. Acceptability to maternal health services through JKN is debatable due to the misconception and personal experiences. The study also identified challenges that hamper the process of achieving better health equity. The incompatible proportion between PBI participants and regular participants indicates the economically dependent population is larger than those who have a stable economy. The impact of the challenges is not only affecting the policy decision-making process of the whole JKN, but also the equality among the users.

Resolving the entire system of JKN and maternal health services require large reform by all agencies who are involved in the implementation of the program. Large-scale reform is crucial because the issues involving JKN are systemic and linked to each other. Likewise, as the biggest health program in Indonesia's healthy development, it needs support from the other sectors that determine the betterment of Indonesia's health status. Institutional capacity and political commitment from all ministries matter for achieving health equity. "Universal health coverage is an objective that countries typically pursue incrementally rather than achieve immediately" (Lagomarsino et al. 2012:941).

6.2 Recommendation

With regards to the current challenge in enhancing maternal health care utilization, this study proposes a set of recommendation that can be implemented by the involving agencies of health provision in Indonesia.

Ministry of Health Level

- Upgrading and benchmarking the basic health equipment in PHC, particularly for maternal care. Further evaluation to reconsider the procurement of advanced facility in PHC to alleviate the slow process of referral system from PHC to the higher level of FKTP.
- Improving health management information system to enhance knowledge resources about maternal health and its services through JKN. The current health information system is fragmented that cause redundancy of the data and the inefficient use of resources, especially for the health service unit (District Health Office of Jambi Province 2016:2).
- Updating collection of data on social determinants of health and health equity periodically (WHO 2008:206). Further improvement relating to the questionnaire and indicator for demographic health survey and national census by specifying the questions about health insurance coverage and utilization.
- Expanding collaboration with the non-governmental organizations and civil society organizations to maximize the education of maternal health among society, particularly the rural and disadvantaged community. For example, the Muslim community organization, called Muhammadiyah, has been incorporating with Ministry of Health through it women's sub-organization, *Aisyiyah*, to support government's effort in socializing actions to reduce maternal mortality (Kusumawati 2014).

BPJS *Kesehatan*

- Maximizing the quality control of BPJS *Kesehatan*'s service and budgeting in respect to the regulation issued by Ministry of Health. Strengthening the human capacity to do 'personal selling' and socialize the JKN scheme to the community structurally and adjusted to the social conditions of the community.
- Coordinating with Ministry of Health for the disseminating the scheme of reproductive and maternal health services within JKN to health workers as a step to minimize the health risks among pregnant women and ensure transparency of information to each party.
- Aligning the socialization of regulation and referral system so that users are not baffled by the dubious information

To the Community Level

- Collaboration between health care providers, regional health offices, and non-governmental organizations to extend the reach of maternal health services to the level of individuals who desperately need health access assistance.

Appendices

Appendix 1

Health Insurance Coverage among Women Age 15-49 (2012)

Table 3.8.1 Health insurance coverage: Women

Percentage of women age 15-49 with specific types of health insurance coverage, according to background characteristics, Indonesia 2012

Background characteristic	Social security	Other employer-based insurance	Privately-purchased commercial insurance	Other	None	Number of women
Age						
15-19	25.8	3.5	1.7	2.2	67.3	6,927
20-24	21.0	9.5	2.7	2.3	65.6	6,305
25-29	21.2	7.9	2.9	2.7	66.2	6,959
30-34	21.9	9.2	4.1	2.8	63.4	6,876
35-39	28.5	8.3	3.6	3.2	58.0	6,882
40-44	29.3	5.4	2.9	2.5	60.8	6,252
45-49	34.1	4.1	1.9	2.4	58.6	5,407
Residence						
Urban	24.6	10.7	4.9	2.9	58.6	23,805
Rural	26.9	2.8	0.6	2.3	67.8	21,802
Education						
No education	29.2	0.6	0.1	1.7	68.7	1,500
Some primary	30.1	1.4	0.3	1.9	66.6	4,870
Completed primary	26.3	2.5	0.5	1.8	69.2	10,254
Some secondary	23.6	5.3	1.4	2.5	67.6	12,753
Completed secondary	20.1	13.7	3.8	3.1	60.5	10,677
More than secondary	35.6	12.3	11.7	4.1	41.0	5,552
Wealth quintile						
Lowest	35.1	1.1	0.3	2.1	61.8	7,767
Second	29.1	2.9	0.4	2.3	65.5	8,784
Middle	23.5	5.3	0.9	2.4	68.3	9,243
Fourth	19.5	10.1	2.6	2.6	66.1	9,743
Highest	23.5	13.3	9.0	3.3	53.9	10,071
Total	25.7	6.9	2.9	2.6	63.0	45,607

Source: IDHS 2012:36

Appendix 2: Interview Questions

1. For Maternal Health Care Users

Age :
Domicile :
Occupation :

1. Are you a JKN user?
   a. If not, can you explain why?
2. Have you ever or been using JKN maternal health services?
   a. If not, can you explain why? How do you get health services outside of JKN?

Pregnancy Period

1. Would you mind to tell me about your pregnancy experience? (first pregnancy or not, from the beginning of pregnancy, the examination process to the doctor/clinic/PHC/hospital, number of examinations, type of examination, doctor's advice, what to do and avoid, etc.)
   a. How was your experience after the delivery process? (e.g. whether you need more examination or not, maternal and infant health conditions)
   b. After the birth process: how do you think about contraception?

JKN service

1. How do you think about the role of JKN during the pregnancy? (e.g., services used, administration processes, benefits, coverage, drugs, etc.)
   a. the number of costs borne and not covered by JKN, coverage of care, quality of excess deficiencies
2. What do you think about the current JKN premiums?
   a. Affordability, quality, facilities, services, distance, administration, systems, information
3. What do you think about the benefits covered by JKN? How can it be improved better, especially for pregnant women and children?

Social Background

1. Could you tell me about your background and your family? (What is the last education, what age have you got, a job, ethnic origin, number of children, what age difference, husband, husband's job, economy, monthly income, finance, how to manage money, etc.)
2. How do you describe your economic condition at this time? Has the government contributed enough to provide social security and health?
3. About understanding maternal and child health:
   a. What did you think when you first learned that you were pregnant?
   b. How did you manage your daily activities during pregnancy? (being active as usual or reduced activities)
   c. Did you make any particular habits during pregnancy? If you had, would you mind to explain it?
   d. Did you have any restrictions that you had to avoid? If you had, would you mind to explain it?
   e. When you had an uncomfortable feeling during pregnancy, how did you respond to it?
   f. How did you feel when the birth process is getting closer?
   g. How do you maintain the baby's health after birth? Are there special things that you do or avoid?
   h. How long do you give breast milk to your baby?
   i. Do you use contraception?

2. For Professional Group

Gender :
Age :
Domicile:
Position:

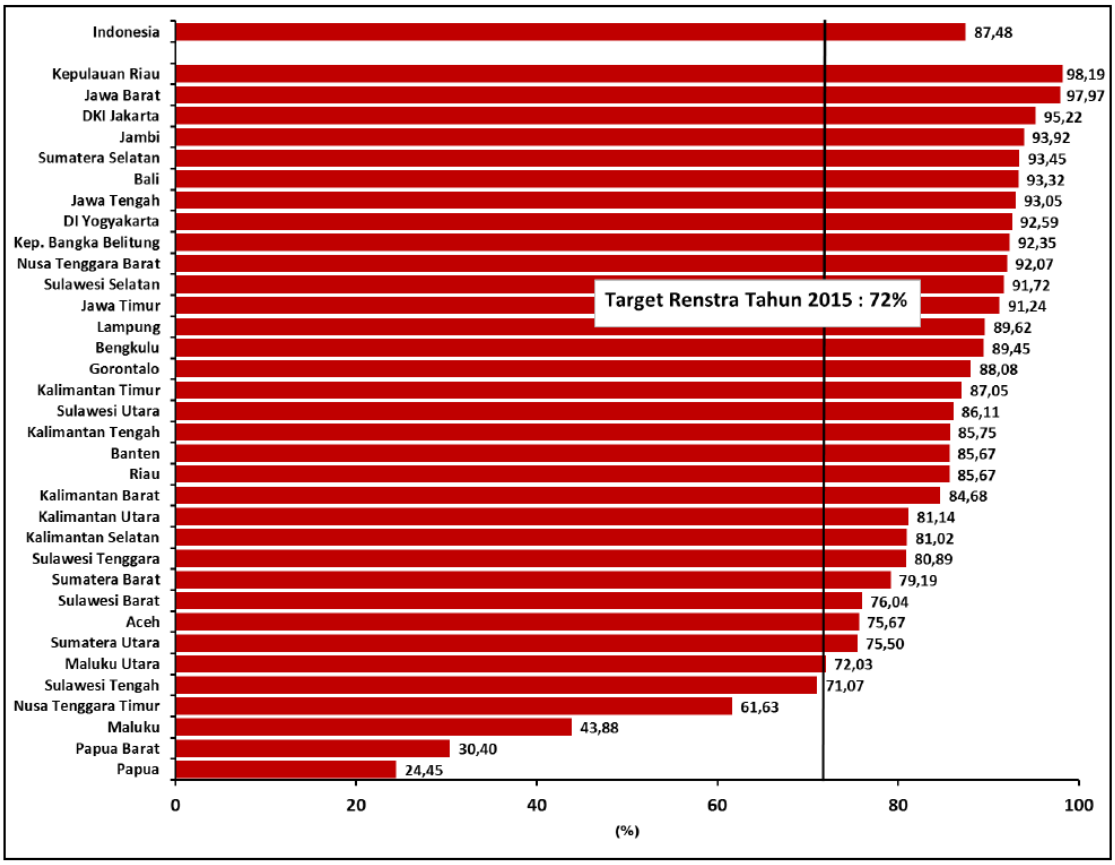
1. Could you tell me about your work and duties regarding the JKN program? (institution, work location, daily responsibilities, self-employment or teamwork, length of work, etc.)
2. What is the organizational relationship between your institution / your duty position with the health department, BPJS *Kesehatan*, the Ministry of Health, or other institutions?
3. As a JKN user, what benefits have you experienced with JKN? (including maternal health services)
4. How do you think about JKN now? (personal and professional opinions: implementation, expectations, job challenges and policies, achievements, etc.)
   a. Regarding the issue of finance and JKN funding which is often highlighted by the media, what do you think about this issue?
   b. In July, BPJS *Kesehatan* issued three new policies, one of which was the Director of Health Services Guarantee Number 3 of 2018 concerning the Guarantee of Maternity Services with Healthy Birth Babies, how do you think about this new policy?
   c. Have there been cases of maternal deaths during labor at your place of duty?
5. How do you think about the patients' (mothers) condition who come for pregnancy check-up at your place of duty? (regarding health, knowledge of understanding, social and economic background, type of examination they do, things that are often asked/experienced if any)

Appendix 3: List of the Interviews

No	Name Participants	Code	Month/Year
1	IP	Interview 1	July-August 2018
2	PM	Interview 2	July-August 2018
3	AA	Interview 3	July-August 2018
4	MB	Interview 4	July-August 2018
5	RA	Interview 5	July-August 2018
6	RD	Interview 6	July-August 2018
7	FP	Interview 7	July-August 2018
8	ER	Interview 8	July-August 2018
9	AR	Interview 9	July-August 2018
10	ST	Interview 10	July-August 2018
11	AD	Interview 11	July-August 2018
12	YS	Interview 12	July-August 2018
13	ZP	Interview 13	July-August 2018
14	AS	Interview 14	July-August 2018
15	JT	Interview 15	July-August 2018
16	FA	Interview 16	July-August 2018
17	MC	Interview 17	July-August 2018
18	PD	Interview 18	July-August 2018

Appendix 4: Antenatal Care Coverage

Antenatal Care Coverage (which exceeds four times visits) in 34 Provinces



Source: Ministry of Health 2015:107

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