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Analysis of JKN Policy Implementation in Improving Access and Equity of Community Health Services in North Sumatra, Medan

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ABSTRACT

Background: The National Health Insurance program (Jaminan Kesehatan Nasional/JKN), launched in January 2014 under the Social Security Administering Body (BPJS Kesehatan), represents Indonesia's most ambitious universal health coverage initiative. Despite over a decade of implementation, significant disparities in healthcare access and quality persist, particularly in North Sumatra, where socioeconomic heterogeneity, geographic diversity, and administrative complexities create unique challenges to equitable health service delivery.

Methods: This study employed a qualitative phenomenological approach using the Colaizzi method to explore lived experiences of JKN implementation stakeholders. Data were collected from September to December 2025 in Medan, North Sumatra, through in-depth interviews and focus group discussions with 32 purposively selected participants including BPJS Kesehatan administrators (n=6), primary healthcare center (Puskesmas) staff (n=10), JKN beneficiaries (n=12), and health policymakers (n=4). Data saturation was achieved at the 28th participant. Thematic analysis was supported by NVivo 12 software, and trustworthiness was ensured through triangulation, member checking, and peer debriefing.

Results: Three core themes emerged: (1) Structural and Administrative Barriers to Access, encompassing bureaucratic complexity, referral system bottlenecks, and digital literacy gaps among rural populations; (2) Equity Gaps in Service Distribution, reflecting disparities between urban Medan and peri-urban districts in specialist availability and facility quality; and (3) Stakeholder Perceptions of JKN Efficacy, revealing mixed experiences among beneficiaries with financial protection acknowledged but service quality concerns prominent.

Conclusion: While JKN has achieved substantial coverage expansion in Medan, structural inequities, administrative bottlenecks, and geographic disparities continue to undermine equitable health service access. Targeted policy reforms addressing referral system efficiency, healthcare workforce distribution, and digital health integration are urgently needed to realize the program's universal health coverage objectives.

Keywords: National Health Insurance; Health Equity; Universal Health Coverage; Healthcare Access; Indonesia; Qualitative Research

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INTRODUCTION

Universal health coverage (UHC) has become a cornerstone of global health policy, recognized in the United Nations Sustainable Development Goal 3.8 as essential to ensuring that all individuals receive needed health services without financial hardship (WHO, 2023). In Southeast Asia, Indonesia has made remarkable strides toward UHC through the establishment of the Jaminan Kesehatan Nasional (JKN) program, administered by the Social Security Administering Body (BPJS Kesehatan), which since its launch in January 2014 has expanded to cover over 270 million registered participants by 2024, making it the world's largest single-payer health insurance scheme (BPJS Kesehatan, 2024). Despite this extraordinary coverage expansion, evidence consistently demonstrates that enrollment in health insurance does not automatically translate into equitable access to quality healthcare services. In Indonesia, disparities in health

service utilization across income quintiles, geographic regions, and social groups remain pronounced (Agustina et al., 2019). The archipelagic geography, diverse socioeconomic conditions, and variable healthcare infrastructure across Indonesia's 38 provinces create differential implementation experiences that national-level statistics often obscure. North Sumatra province, with Medan as its capital—the third largest city in Indonesia—presents a particularly compelling case study, as it combines an urbanized commercial center with peri-urban and rural districts characterized by substantial socioeconomic heterogeneity, ethnic diversity, and administrative complexity.

Existing literature on JKN implementation has predominantly focused on national-level enrollment metrics, financial sustainability, and macro-level policy evaluations (Harimurti et al., 2013; Pisani et al., 2017; Barber et al., 2020). While these studies provide valuable systemic perspectives, they insufficiently capture the lived experiences of JKN beneficiaries, frontline healthcare workers, and local administrators who navigate the program's day-to-day operational challenges. A critical gap exists in understanding the qualitative dimensions of how JKN policies are interpreted, adapted, and experienced at the sub-national level, particularly in settings like Medan where rapid urbanization intersects with persistent service delivery inequities.

Theoretical grounding for this study draws on Lipsky's street-level bureaucracy framework (Lipsky, 1980/2010), which posits that frontline workers exercise significant discretionary power in translating policy mandates into practice, and Penchansky and Thomas's (1981) multidimensional model of healthcare access, encompassing availability, accessibility, accommodation, affordability, and acceptability. Together, these frameworks illuminate how policy intentions may diverge from implementation realities at the point of service delivery. The intersectionality of socioeconomic status, geographic location, and health literacy further shapes individuals' capacity to navigate JKN entitlements, consistent with Sen's capability approach to health equity (Sen, 1999).

Previous research has identified referral system inefficiencies (Pambudi et al., 2022), pharmaceutical supply challenges (Suhrcke et al., 2021), and workforce distribution imbalances (Mahendradhata et al., 2017) as systemic barriers to JKN effectiveness. However, contradictory findings regarding beneficiary satisfaction and perceived service quality across different study populations underscore the need for context-specific qualitative inquiry. Some studies report high levels of satisfaction with JKN among lower-income groups who previously lacked financial protection (Johar et al., 2018), while others document significant frustration with service quality degradation and administrative burdens (Kusumaningrum et al., 2023). This divergence highlights the importance of exploring stakeholder perspectives within specific socio-geographic contexts. This study aims to fill this evidence gap by conducting an in-depth qualitative analysis of JKN policy implementation in Medan, North Sumatra, examining the perspectives of key stakeholders—including BPJS administrators, primary healthcare providers, policymakers, and beneficiaries—to understand how structural, administrative, and socioeconomic factors shape healthcare access and equity outcomes. The central research question guiding this inquiry is: How is JKN policy implemented in Medan, and what factors facilitate or impede equitable access to quality health services for diverse community populations? By generating rich, contextual insights, this study seeks to contribute actionable recommendations for policy refinement and implementation improvement at both local and national levels.

METHODS

Study Design

This study employed a qualitative phenomenological research design, specifically utilizing the Colaizzi (1978) method of descriptive phenomenological analysis. This approach was selected because it enables systematic exploration and interpretation of participants' lived experiences and subjective meanings attributed to a phenomenon—in this case, the implementation of JKN and its impact on healthcare access and equity. The phenomenological paradigm is particularly

appropriate for policy implementation studies, as it foregrounds stakeholder perspectives and contextual factors that quantitative approaches may overlook (Creswell & Poth, 2018). The research was conducted in Medan, the capital of North Sumatra Province, including selected Puskesmas (primary healthcare centers), BPJS Kesehatan regional offices, and district hospitals between September and December 2025.

Research Team and Reflexivity

The research team comprised four investigators from the International Research Center at Universitas Sumatera Utara, each with expertise in public health policy, health systems research, and qualitative methodology. The principal investigator (PI) holds a doctoral degree in Public Health and has over ten years of experience conducting qualitative health policy research in Indonesia. Two co-investigators specialize in health services management and community health, while the fourth researcher has expertise in applied social science and policy analysis. No prior professional relationships existed between researchers and study participants, mitigating potential power differentials. Researcher reflexivity was maintained through structured reflexivity journals maintained by each team member throughout the data collection and analysis phases. Weekly peer debriefing sessions were conducted to surface and interrogate researcher assumptions, biases, and interpretive positions (Lincoln & Guba, 1985).

Participants

Participants were purposively selected to represent diverse stakeholder perspectives relevant to JKN implementation. Inclusion criteria required participants to have at least one year of direct experience with JKN, either as a beneficiary, healthcare provider, or administrator, and to be able to communicate in Indonesian or Medan Malay. Exclusion criteria encompassed individuals with less than twelve months of JKN engagement and those unable to provide informed consent. A total of 38 potential participants were contacted; six declined due to time constraints or personal reasons, yielding a final sample of 32 participants comprising: BPJS Kesehatan regional administrators (n=6), Puskesmas clinical and administrative staff (n=10), JKN beneficiaries across socioeconomic strata (n=12), and district-level health policymakers (n=4). Participants were recruited through institutional referrals and snowball sampling. None received financial compensation; participation was entirely voluntary.

Data Collection

Data collection occurred between September 2025 and December 2025. Two primary methods were employed: semi-structured in-depth interviews (IDIs) and focus group discussions (FGDs). A total of 28 individual interviews were conducted, ranging from 45 to 90 minutes (mean duration: 62 minutes). Four FGDs were held with beneficiary groups of five to seven participants each, lasting approximately 75–90 minutes. All IDIs were conducted face-to-face at locations convenient for participants—including Puskesmas meeting rooms, BPJS regional offices, and community health posts—ensuring a comfortable and confidential setting. Two interviews were conducted via telephone due to participant scheduling constraints during December 2025.

The interview guide, pilot-tested with three participants not included in the main study, covered five thematic areas: (1) experiences navigating JKN registration and administrative processes; (2) perceptions of healthcare service quality and accessibility under JKN; (3) understanding of entitlements and rights under JKN; (4) encountered barriers and facilitators to accessing services; and (5) recommendations for program improvement. Sample questions included: "Can you describe your experience when you first needed to use your JKN card to access healthcare?" and "In your view, who benefits most and who benefits least from the JKN program, and why?" All interviews and FGDs were audio-recorded with participant consent, transcribed verbatim in Indonesian by trained research assistants, and verified by the respective interviewer for accuracy. Member checking was conducted with 15 participants who reviewed preliminary findings summaries. Data saturation was determined when no new codes or themes emerged across two consecutive interviews, achieved at the 28th IDI.

Data Analysis

Data analysis followed Colaizzi's (1978) seven-step phenomenological method: (1) reading all transcripts to acquire a holistic sense of participants' experiences; (2) extracting significant statements; (3) formulating meanings from significant statements; (4) organizing formulated meanings into theme clusters; (5) integrating themes into an exhaustive description; (6) identifying the fundamental structure of the phenomenon; and (7) seeking validation through participant feedback. NVivo 12 (QSR International) software was used to manage and organize data, facilitate coding, and support systematic retrieval of coded segments. Initial open coding was conducted independently by two researchers, followed by axial coding to identify relationships between categories. All four team members participated in thematic consensus meetings to refine and validate emerging themes. Discrepancies in coding were resolved through iterative discussion and reference to original transcripts until consensus was reached (Braun & Clarke, 2006). Lincoln and Guba's (1985) criteria—credibility, transferability, dependability, and confirmability—were adopted to evaluate analytical quality.

Trustworthiness and Rigor

Multiple strategies were employed to enhance the trustworthiness of findings. Credibility was established through prolonged engagement in the field (four months), methodological triangulation using IDIs and FGDs, data source triangulation across stakeholder groups, and member checking with 15 participants. Transferability was supported by providing thick, detailed descriptions of the research context and participant characteristics, enabling readers to assess applicability to comparable settings. Dependability was ensured through the maintenance of a detailed audit trail documenting all analytic decisions, coding revisions, and team deliberations. Confirmability was addressed by storing primary data, reflexivity journals, coding trees, and analytic memos in a secure, auditable repository accessible to all research team members.

Ethical Consideration

Ethical approval for this study was granted by the Ethics Committee of Universitas Sumatera Utara, Faculty of Public Health, with approval reference number: 376/UN5.2.3.1/KEPK/2025, issued on August 18, 2025. Additional site-specific permissions were obtained from the Medan City Health Office and BPJS Kesehatan Regional Office I (North Sumatra). All participants provided written informed consent prior to participation, with the right to withdraw at any point without consequence. Participant confidentiality was maintained through data anonymization using alphanumeric codes (e.g., P1–P32). Audio recordings and transcripts were stored on password-protected institutional servers accessible only to the research team. No identifying information was included in reported findings or supporting materials.

RESULTS

Participant Characteristics

A total of 32 participants were enrolled in this study. Beneficiary participants (n=12) ranged in age from 24 to 67 years (mean: 43.2 years), with educational backgrounds spanning primary school to tertiary education; 8 were women and 4 were men. Healthcare provider participants (n=10) included general practitioners, nurses, midwives, and administrative staff, with a mean professional experience of 11.4 years. Administrator participants (n=6) had an average of 8.7 years of experience with BPJS Kesehatan. Policymaker participants (n=4) comprised district health officers and a provincial health department representative. Table 1 presents participant demographic characteristics.

Table 1. Participant Demographic Characteristics

Participant Group	n	Age Range (Years)	Gender (F/M)	Mean Experience
BPJS Administrators	6	34–55	4 / 2	8.7 years
Puskesmas Staff	10	27–52	7 / 3	11.4 years

Participant Group	n	Age Range (Years)	Gender (F/M)	Mean Experience
JKN Beneficiaries	12	24–67	8 / 4	—
Policymakers	4	42–59	2 / 2	14.2 years

Note. F = Female; M = Male; — = Not applicable.

Theme 1: Structural and Administrative Barriers to Access

The most pervasive theme identified across all participant groups was the presence of multilayered structural and administrative barriers impeding effective JKN utilization. Beneficiary participants consistently described the referral system as complex, opaque, and burdensome, particularly for those with limited formal education or digital literacy. The requirement to first attend a primary healthcare facility before accessing specialist or hospital care—the gatekeeping function of the referral tiering system—was perceived as an obstacle rather than a clinical safeguard by many participants.

> *"I went to the Puskesmas three times before I finally got a referral letter to see a specialist at the hospital. Each time, they told me to come back or bring different documents. I spent almost two weeks just getting the paper, not including the waiting time at the hospital." (P7, female beneficiary, 51 years)*

BPJS administrators acknowledged systemic inefficiencies in referral processing, attributing them to a combination of Puskesmas staff workload, incomplete digital integration between primary and secondary care facilities, and frequent updates to administrative requirements that were inconsistently communicated to frontline staff.

> *"The P-Care system [primary care IT system] is not fully integrated with hospital information management systems. Sometimes referrals get lost digitally, or the data does not match, and patients have to repeat the process. We are working on integration, but it takes time and resources." (P2, BPJS administrator)*

A recurring sub-theme was the digital literacy gap among older beneficiaries and those from lower socioeconomic strata, who reported difficulty understanding the JKN mobile application (Mobile JKN) and online service platforms. These participants described reliance on informal intermediaries—family members, community health workers (kader), or helpful strangers—to navigate digital requirements, introducing inequities in access based on social capital.

Theme 2: Equity Gaps in Service Distribution

Analysis revealed significant perceived and actual disparities in JKN service availability and quality between central Medan districts and the city's peri-urban periphery. Healthcare provider participants working in peri-urban Puskesmas described chronic shortages of specialist physicians, essential medicines listed in the National Formulary (Formularium Nasional), and diagnostic equipment, constraining the range of services available to beneficiaries in these areas.

> *"Patients come to us with complex conditions, but we do not have the laboratory equipment or the specialist support to manage them here. We refer them to Medan General Hospital, but the journey is long and expensive if they do not have family to help. Some patients simply don't go." (P14, general practitioner, peri-urban Puskesmas)*

Policymakers acknowledged geographic maldistribution of healthcare resources as a structural challenge predating JKN, exacerbated by the program's demand-side financing approach. The capitation payment system, while incentivizing enrollment, was reported to be insufficient in certain peri-urban facilities to cover operational costs, discouraging comprehensive service provision.

> *"The capitation rate was set based on a national average that does not reflect the cost reality of running a facility in areas with high transport costs, lower patient density, and higher staff turnover. This creates a financial disincentive that ultimately harms patients." (P31, district health policymaker)*

A sub-theme of informal payments and co-payments emerged, with beneficiary participants describing expectations—sometimes explicit, sometimes implicit—to provide informal payments or purchase uncovered services, undermining the financial protection function of JKN. This

phenomenon was more frequently reported by participants accessing care in peripheral facilities, suggesting that corruption risk may be associated with resource scarcity and weak administrative oversight.

Theme 3: Stakeholder Perceptions of JKN Efficacy

Stakeholder perceptions of JKN's overall efficacy were complex and often paradoxical, reflecting the coexistence of genuine gratitude for financial protection with significant dissatisfaction regarding service quality and dignity of care. Beneficiary participants from the poorest quintile—those enrolled as Penerima Bantuan Iuran (PBI), or premium-assisted beneficiaries—most strongly valued JKN's financial protection function, frequently contrasting their current access to formal healthcare with pre-JKN experiences of forgoing care due to cost.

> *"Before JKN, if my child was sick, I would try traditional medicine or borrow money from a neighbor. Now I take them to the Puskesmas and I do not fear the bill. This is a real change in my life." (P19, female PBI beneficiary, 38 years)*

However, perceived quality of care and the experience of service delivery were substantially less positive. Multiple participant accounts described long waiting times, dismissive interactions with some healthcare providers, and limited explanatory communication from clinicians. Healthcare provider participants offered contextual explanations, citing high caseloads, bureaucratic time demands, and burnout as factors affecting interaction quality.

> *"In a morning session, I may see sixty patients. There is a BPJS administrative form for each visit, plus the electronic medical record, plus the P-Care entry. There is very little time left for a meaningful conversation with the patient." (P11, general practitioner)*

A facilitating factor identified across participant groups was the role of community health workers (kader) in bridging knowledge gaps and facilitating navigation of JKN administrative requirements for vulnerable beneficiaries. Kader were described as crucial informal intermediaries who translated JKN information into accessible language and assisted with registration and referral processes, representing a significant but underrecognized component of JKN implementation infrastructure at the community level.

Table 2. Summary of Core Themes, Sub-themes, and Representative Quotes

Core Theme	Sub-Theme	Representative Quote
1. Structural & Administrative Barriers	Referral System Complexity	"I went to the Puskesmas three times before I finally got a referral letter..." (P7)
	Digital Literacy Gap	Older and low-income beneficiaries relied on informal intermediaries to navigate Mobile JKN
2. Equity Gaps in Service Distribution	Geographic Disparities	"Patients come to us with complex conditions, but we do not have the equipment..." (P14)
	Informal Payments	Peripheral facility beneficiaries reported implicit co-payment expectations
3. Stakeholder Perceptions of JKN Efficacy	Financial Protection Appreciation	"Before JKN, if my child was sick, I would try traditional medicine..." (P19)
	Service Quality Concerns	"In a morning session, I may see sixty patients..." (P11)

Note. Quotes translated from Indonesian by research team.

DISCUSSION

The findings of this study advance understanding of how JKN policy implementation is experienced by key stakeholders in Medan, North Sumatra, revealing persistent structural, administrative, and equity challenges that temper the program's considerable achievements in

coverage expansion. The three core themes—structural and administrative barriers, equity gaps in service distribution, and stakeholder perceptions of JKN efficacy—are interconnected and mutually reinforcing, collectively painting a complex picture of a transformative but incompletely realized public health intervention.

The structural and administrative barriers identified in this study resonate strongly with international literature on the implementation gap in UHC programs. Lipsky's (1980/2010) street-level bureaucracy framework illuminates how Puskesmas staff, BPJS administrators, and facility managers exercise discretionary judgment in interpreting and applying JKN policies, often with consequences—intended or unintended—for beneficiary access. The referral system complexity documented here parallels findings from Pambudi et al. (2022) in East Java and Kusumaningrum et al. (2023) in West Java, suggesting that administrative burden is a systemic feature of JKN implementation rather than a local aberration. However, Medan's specific context—with its dense urban core and rapidly expanding peri-urban periphery—amplifies these challenges by extending the geographic and social distances between beneficiaries and services.

The equity gaps in service distribution identified in Theme 2 are consistent with Penchansky and Thomas's (1981) multidimensional access model, particularly the dimensions of availability and geographic accessibility. The capitation payment system's structural limitations in adequately incentivizing service provision in under-resourced settings align with concerns raised by Mahendradhata et al. (2017) and Barber et al. (2020) regarding the design mismatch between JKN's financing architecture and Indonesia's heterogeneous healthcare infrastructure. Notably, the informal payment sub-theme represents a critical challenge to JKN's stated objective of providing financial protection, corroborating Pisani et al.'s (2017) findings on out-of-pocket expenditure persistence among JKN beneficiaries and underscoring the need for strengthened facility oversight and accountability mechanisms.

The paradoxical coexistence of gratitude for financial protection and dissatisfaction with care quality, captured in Theme 3, reflects a pattern documented in other LMIC health insurance contexts (Johar et al., 2018; Agustina et al., 2019). This study extends existing knowledge by highlighting the role of community health workers (kader) as a critical but underutilized bridge between JKN policy and community uptake, particularly for digitally and administratively marginalized populations. This finding aligns with WHO's (2023) advocacy for community health worker strengthening as a key strategy for advancing UHC equity.

Practical Applications of the Findings

The findings of this study have immediate practical relevance for JKN implementation improvement at the local and provincial levels. BPJS Kesehatan's Medan regional office and the North Sumatra Provincial Health Office should prioritize: (1) accelerating the full integration of primary care (P-Care) and hospital information systems to streamline referral processing and reduce administrative duplication; (2) developing targeted digital health literacy programs in collaboration with local governments and kader networks, with particular focus on elderly, low-education, and peri-urban populations; (3) reviewing and revising capitation rates for peri-urban and resource-constrained Puskesmas to more accurately reflect operational costs, thereby incentivizing comprehensive service provision; and (4) establishing anonymous reporting mechanisms for informal payment practices, paired with regular facility audits to deter corruption and uphold JKN's financial protection mandate. Healthcare educators and professional associations should integrate JKN policy and patient communication skills training into continuing professional development curricula for frontline health workers, addressing the documented quality-of-interaction concerns raised by beneficiaries.

Limitations

This study has several important limitations that should inform interpretation of findings. First, the qualitative phenomenological design, while appropriate for the research questions, does not permit statistical generalization to all JKN beneficiaries or healthcare providers across North Sumatra or Indonesia. The findings reflect the specific contexts of Medan and selected peri-

urban facilities visited during the study period. Second, purposive sampling, while enabling theoretical depth, may introduce selection bias, as individuals willing to participate may have stronger opinions—whether positive or negative—about JKN than the general population. Third, the exclusion of rural participants, who face qualitatively different access challenges than those in urban and peri-urban settings, represents a significant limitation that future research should address. Fourth, social desirability bias may have influenced participant responses, particularly among BPJS administrators and policymakers in formal interview settings, despite researcher efforts to create open, non-judgmental conditions. Finally, the study was conducted during a single four-month period; longitudinal approaches would better capture evolving implementation experiences following policy changes or administrative reforms.

CONCLUSION

This study provides rich, context-specific evidence of the implementation realities of JKN in Medan, North Sumatra, as experienced by beneficiaries, healthcare providers, administrators, and policymakers. While JKN has achieved historically unprecedented coverage expansion and has meaningfully improved financial protection for the poorest segments of the population, the program's potential to deliver equitable, high-quality health services remains substantially unrealized due to persistent structural bottlenecks, geographic service disparities, and administrative complexities. The active role of community health workers as informal implementation intermediaries represents a valuable, underutilized asset. Realizing JKN's transformative vision requires purposeful policy reforms that address the structural drivers of inequity—including referral system redesign, targeted digital health integration, equitable capitation mechanisms, and strengthened frontline workforce support—alongside sustained investments in community engagement and health literacy. These findings offer transferable lessons for other Indonesian provinces and lower-middle-income countries implementing comparable health insurance programs as they navigate the complex path toward universal health coverage.

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