

Implementation of the health insurance policy at UPTD Puskesmas Ajangale Bone District



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ABSTRACT

This study aims to analyze the implementation of health services for BPJS Kesehatan beneficiaries at UPTD Puskesmas Ajangale and to identify the factors that hinder its implementation. The research uses a descriptive qualitative approach with data collected through in-depth interviews, observation, and documentation. The analysis is based on the implementation theory developed by George C. Edwards III, which emphasizes four main variables: communication, resources, disposition of implementers, and bureaucratic structure. The findings indicate that the implementation of BPJS health services has been carried out administratively but has not yet operated optimally. Basic health services such as outpatient treatment, immunization, and referral services are available, yet several obstacles remain. Communication between health workers and patients is often ineffective, the number of medical personnel and the availability of medicines are limited, and some health workers still lack a humanistic approach in providing services. In addition, bureaucratic procedures, particularly the referral process, tend to be slow and less responsive to urgent situations. The main factors that hinder the effectiveness of BPJS service implementation include the shortage of health workers, limited development of service information systems, insufficient public education about health service procedures, and administrative processes that are still relatively complex. Overall, the study concludes that although BPJS health services have been implemented, improvements in both structural and operational aspects are still necessary to ensure that health services become more effective, efficient, and equitable for the community.

Keywords: Implementation; Health Services; BPJS; Public Health Center; Public Policy



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INTRODUCTION

Health is a universally recognized human right and is guaranteed by the Indonesian constitution (Republic of Indonesia 1945; United Nations, 1948). Without social, economic or geographical discrimination (1945 Constitution; Law No. of 2009). Article 28 H Paragraph (1) of the 1945 Constitution of the Republic of Indonesia states that everyone has the right to live in physical and mental prosperity, to have a place to live, and to have a good and healthy environment. In addition, Article 4 of Law No. 36/2009 on Health states that "Every person has the right to health." (Republic of Indonesia, 1945; Republic of Indonesia, 2009). As of August 2024 BPJS Kesehatan membership coverage had reached 276.52 Million people or approximately 96% of Indonesia's population (BPJS Kesehatan, 2024). In this context, the state has the responsibility to ensure the fulfillment of the right to health for all its people. One of the concrete efforts to fulfill this responsibility is through the National Health Insurance Program (JKN) managed by the Health Social Security Organizing Agency (BPJS). Launched in 2014, this program aims to provide equal, fair, and quality access to health services for all Indonesians without social, economic, or geographical discrimination (Republic Indonesia, 2011; BPJS Kesehatan, 2024).

Nationally, JKN managed by BPJS Kesehatan has covered 96% of the Indonesian population or around 276.52 million participants until August 2024. Of this number, the majority (69.4%) are participants from the Class III category, which consists of low-income people (BPJS Kesehatan 2024). Everyone has the right to a decent life, including health facilities. The government should be encouraged to provide primary health care for all Indonesians regardless of their social status. It is imperative that a country has an obligation to provide services to all citizens to meet basic needs in order to improve social welfare. In accordance with the Law, the implementation of the Social Security Organizing Agency (BPJS) in Indonesia has a strong legal and policy basis, which is divided into various levels of legislation (Republic of Indonesia, 2004; Republic of Indonesia, 2011).

The main basis of the national social security system is Law Number 40 of 2004 concerning the National Social Security System (SJSN), which emphasizes the principles of mutual cooperation, justice, openness, and sustainability in the implementation of social security. The birth of BPJS as a public legal entity is further stipulated through Law No. 24/2011 on the Social Security Organizing Agency, which divides BPJS into two institutions, namely BPJS Health and BPJS Employment, and requires all Indonesian residents to become participants (Republic of Indonesia, 2004; Republic of Indonesia, 2011).

The implementation of health insurance is also strengthened by Law No. 36/2009 concerning Health, which guarantees the right of every citizen to obtain health services. In the labor sector, Law Number 13 Year 2003 and Law Number 11 Year 2020 on Job Creation along with Government Regulation in lieu of Law (Perpu) Number. 2 of Year 2022, include several provisions regarding social security for workers (Republic of Indonesia, 2003; Republic of Indonesia, 2009; Republic of Indonesia 2020; Republic of Indonesia, 2022). The implementation of social security programs is regulated in various Government Regulations, including Government Regulation Number 86 Year 2013 which regulates administrative sanctions for employers who do not register their workers with BPJS, and Government Regulation Number 82 Year 2019 on Health Insurance which replaces Government Regulation Number 101 Year 2012. Strengthening the operational and policy aspects is also supported by Presidential Regulations, such as Presidential Regulation No. 82/2018 concerning Health Insurance which integrates technical provisions related to JKN, and Presidential Regulation No. 64/2020 which

participant contributions, including for the Contribution Assistance Recipient (PBI) group. At the ministerial level, Permenkes No. 28/2014 guides the implementation of JKN, regulating the capitation system, referrals, and INA-CBG's-based service rates. Permenkes No. 71 of 2013 and its amendments Permenkes No. 99 of 2015, and minister of health regulation Number 52 of 2016, further regulate tiered referral procedures and health service tariff standards (Republic of Indonesia, 2013a; Republic of Indonesia, 2013b; Republic of Indonesia, 2014; Republic of Indonesia, 2015; Republic of Indonesia, 2016; Republic of Indonesia 2018; Republic of Indonesia, 2019; Republic of Indonesia, 2020).

National Health Insurance (JKN) is part of a social insurance system that must be followed by the entire population. Technical policies for the implementation of JKN are further elaborated through BPJS Regulations, Circular Letters, and Decrees of the President Director of BPJS Kesehatan which regulate procedures for participants registration, healthservice management, billing mechanisms and contribution sanctions. The government also issued Presidential Instruction Number 1 Year 2022 which emphasizes the optimization of JKN, including the integration of BPJS membership with public services (Republic of Indonesia, 2013; Republic of Indonesia,2022; BPJS Kesehatan, 2024).

The state provides a form of service to the wider community in the form of public services. Public services provided by the state to the community can be divided into three types of services, namely administrative services, goods services, and services delivery services (Sinambela, 2010; Hardiyansyah, 2018). One of the public services is health care or also known as health services. Health problems are an important factor for everyone, therefore the state intervenes in health care. In the 1945 Constitution Article 28H paragraph (1) explains that "Everyone has the right to live in physical and mental prosperity, to live and get a good and healthy environment and has the right to obtain health services "3 and article34 paragraph (3) explains that "The state is responsible for the provision of health care facilities and public service facilities that are feasible Republic of Indonesia 1945).

At the local level, Bone Regency is one of the relevant areas to evaluate the implementation of the BPJS Health program, specifically at the UPTD Puskesmas Ajangale. This health center serves an average of 4,000 patients per month, including BPJS participants and general patients. Of these, the majority of BPJS participants come from the Class III category, which reaches around 80% (UPTD Puskesmas Ajangale, 2024). As a first-level health facility, Puskesmas Ajangale serves as the main focus for rural communities to get basic health services before being referred to the hospital. However, this health center faces a number of significant obstacles, both in terms of human resources, budget, and operational systems. The head of Ajangale Health Center, Dr. Nurmawati, M.Kes, revealed that limited health personnel is one of the biggest obstacles. "We only have three doctors and twenty-two nurses consisting of non civil servant P3K nurses to handle thousands of patients every month. This causes the average waiting time for BPJS patients to reach 2-3 hours, especially during peak hours," she explained

The UPTD Puskesmas Ajangale was chosen as the research location because UPTD Puskesmas ajangale has the largest number of BPJS patients in Bone Regency, with a high dependency on basic health services. In addition, this location faces various operational constraints, such as limited human resources (UPTD Puskesmas Ajangale, 2024; Bone District health office 2024). The referral process to the hospital, which takes 2-3 hours, is also a challenge. These conditions make UPTD Puskesmas Ajangale a representative

location to analyze the implementation of the National Health Insurance Program (JKN) at the first health facility level.

This study aims to analyze the supporting and inhibiting factors for the implementation of health services at UPTD Puskesmas Ajangale, using the George C. Edwards III policy implementation George C. Edwards III theory. The results of the study are expected to make theoretical and practical contributions to improve the quality of health services, especially for rural communities who are highly dependent on the BPJS program.

LITERATURE REVIEW AND RESEARCH FRAMEWORK

Implementation

Implementation is a series of activities in order to deliver policies to the community so that these policies can bring results as expected (Syaukani, 2004). The series of activities include, First, the preparation of a set of further regulations that are interpretations of the policy. Second, preparing resources to drive implementation activities including facilities and infrastructure, financial resources, and determining who is responsible for implementing the policy. Third, how to deliver the policy concretely to the community (Syaukani et al., 2004). The success of policy implementation will be determined by many variables or factors, and each of these variables is interconnected with each other.

Policy Implementation George C. Edwards III theory

In Edwards' view, policy implementation is influenced by four variables, namely: (1) communication, (2) resources, (3) disposition, and (4) bureaucratic structure (Edwards III, 1980). The four variables are also interconnected with each other.

1. Communication

Successful policy implementation requires that implementers know what to do. the goals and objectives of the policy must be clearly transmitted to the target group in order to reduce implementation distortions. If the goals and objectives of a policy are unclear or not known at all by the target group, then there is likely to be resistance from the target group (Edwards III, 1980).

2. Resources

Although the policy content has been communicated clearly and consistently, if the implementer lacks the resources to carry it out implementation, will not be effective. These resources may include human resources., namely implementor competence and financial resources. Resources are an important factor in ensuring effective policy implementation to be effective. Without resources, policies merely remain written documents without proper execution (Edwards III, 1980).

3. Disposition

Disposition refers to the character and characteristics of the implementer. If the implementer has a positive disposition, the policy will be implemented properly in accordance with the objectives of the policy maker. However, when implementers have different attitudes or perspectives from policy makers, the implementation process tends to become ineffective. Various development experiences in developing countries indicate that the level of commitment and honesty among public officials is often low. Cases of corruption in countries such as Indonesia serve as concrete examples of the weak commitment and integrity of implementers in carrying out development programs (Edwards III, 1980; Widodo, 2011).

4. Organizational structure

The organizational structure responsible for implementing a policy has a significant influence on policy implementation. One important structural aspect in every organization is the existence of Standard Operating Procedures (SOPs), which serve as guidelines for implementers in carrying out their duties. An organizational structure that is too long or hierarchical tends to weaken supervision and create red tape, namely complicated and complex bureaucratic procedures, which in turn make organizational activities inflexible (Edwards III, 1980).

Public Services

Public service is defined as any activity carried out by the government toward a group of people that provides benefits and whose results are not necessarily related to physical products (Sinambela, 2010). The purpose of public services is basically to satisfy the public (Moenir, 2010; Sinambela, 2010). Here are the principles of public services:

1. Transparency

Open, easy and accessible to all parties in need and provided in an adequate and easy to understand manner.

2. Conditional

In accordance with the conditions and capabilities of service providers and recipients while adhering to the principles of efficiency and effectiveness.

3. Participative

Encourage community participation in public service delivery by paying attention to the aspirations, needs and expectations of the community.

4. Security of rights

Non-discriminatory in the sense that it does not distinguish ethnicity, religion, race, class, gender, and economic status.

5. Balance of rights and obligations

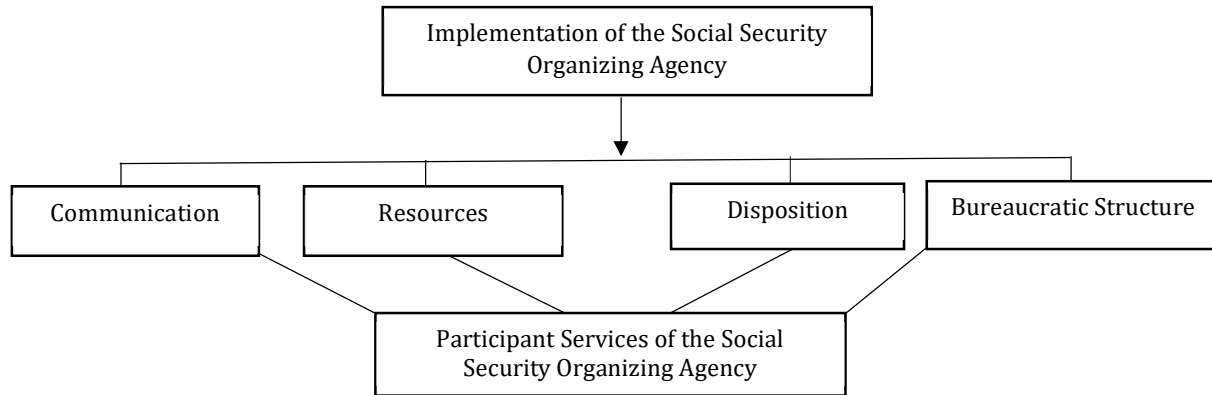
Providers and recipients of public services must fulfill the rights and obligations of each party (Sinambela, 2010; Hardiyansyah, 2018).

Research Framework

This study aims to evaluate the implementation of health services for BPJS recipients at UPTD Puskesmas Ajangale, Bone Regency, using the George C. Edwards III theory to analyze policy implementation. According to Edwards, successful policy implementation is influenced by four main variables, namely: (1) communication, which ensures that policy information is conveyed consistently and understood by health workers, administrative officers, and patients, so that service procedures and the rights of BPJS patients can be fulfilled; (2) resources, which include health workers, medical facilities, medicines, and supporting technology, which if limited can hinder optimal service; (3) disposition, which refers to the attitude and commitment of implementers that determine service quality, where a friendly and professional attitude from officers is essential; and (4) bureaucratic structure, which regulates the flow of registration, claims, and referrals and needs to be evaluated to ensure efficiency and avoid administrative obstacles (Edwards III, 1980).

These four variables are interrelated and will be analyzed to identify obstacles in the implementation of BPJS services at Puskesmas Ajangale and provide comprehensive improvement recommendations. These four variables are interrelated and can be analyzed to identify obstacles in the implementation of BPJS services at Puskesmas Ajangale and to formulate comprehensive improvement recommendations. The analysis

focuses on how communication is delivered to participants, the adequacy of resources such as health personnel and facilities, the disposition or attitudes of implementers in providing services, and the effectiveness of the bureaucratic structure in supporting service delivery. This framework is used to identify gaps between policy design and policy implementation in practice (Edwards III, 1980).



Source : Constructed by authors for this study, 2025

Figure 1
Research Framework

METHOD

This research uses a qualitative approach that aims to understand the phenomenon in depth in the context of health services for BPJS participants at UPTD Puskesmas Ajangale. This research uses data collection techniques through interviews, observation and documentation. This technique is carried out to study and understand the implementation of the BPJS Health policy at UPTD Puskesmas Ajangale.

The data analysis technique used in this study refers to the qualitative data analysis model developed by Miles and Huberman, which consists of data reduction, data display, and conclusion drawing/verification (Miles & Huberman, 1994; Sugiyono, 2018).

RESULTS AND DISCUSSION

Data Analysis

In an effort to realize equitable and quality access to health services for all levels of society, the National Health Insurance Program managed by the Health Social Security Organizing Agency (BPJS). UPTD Puskesmas Ajangale as one of the first-level health facilities in Bone Regency has a responsibility in the implementation.

The findings indicate that the implementation of BPJS health services at UPTD Puskesmas Ajangale, Bone Regency, has not yet been fully optimal due to several structural and technical constraints, including limited human resources, insufficient facilities and infrastructure, administrative inefficiencies, and communication barriers in service delivery (Edwards III, 1980).

The implementation of the National Health Insurance Program (JKN) aims to realize equitable and quality access to health services for all segments of society (Republic of Indonesia, 2011; BPJS Kesehatan, 2024). The implementation of BPJS police requires effective coordination between health workers, adequate resources and efficient administrative systems.

Puskesmas Ajangale is one of the first-level health facilities in Bone Regency which is the initial referral for BPJS participants from 8 villages and 2 sub-districts in Ajangale District, Bone Regency.

According to Edwards George C. there are 4 factors that support the implementation of the BPJS Health policy, namely:

Communication

Successful policy implementation requires that implementors clearly understand what actions must be taken in carrying out the policy (Edwards III, 1980). What are the goals and objectives of the policy must be transmitted to the target group so as to reduce implementation distortions. In the implementation of the BPJS Health policy at the Ajangale Health Center, it highlights how information related to the BPJS Health policy is conveyed to implementers (puskesmas officers) and policy targets (BPJS participants) and the extent to which policy messages are understood and carried out consistently. This focus includes the form of socialization, clarity of information regarding procedures, services and the effectiveness of the delivery of technical directions from the center to the regions.

Forms of Socialization

Socialization of BPJS Health policies is an important part of the communication process in the implementation of health services at the first facility level. The implementation at UPTD Puskesmas Ajangale found that various forms of socialization have been carried out to BPJS recipients through Internal Socialization Meetings, direct delivery during services, information on bulletin boards and the use of social media such as WhatsApp Village Groups. However, the form of socialization has not been evenly distributed and has not fully reached the community as a whole, especially people living in rural areas and remote hamlets.

Communication in the context of policy implementation does not only concern the delivery of information but also the clarity of messages, consistency between orders and implementation and a complete understanding of the implementers and the Ajangale District community as policy targets. Internal communication at UPTD Puskesmas Ajangale in implementing the BPJS Health policy has been carried out in the form of routine meetings and informal coordination between staff and the head of the puskesmas with medical personnel. Internal communication carried out at the Ajangale Health Center is going well, communication between staff takes place well and smoothly so that it can accelerate service activities.

External communication is also carried out to reach the community or BPJS participants but has not run optimally. This can be seen from the lack of socialization of service procedures, rights and obligations of BPJS participants and the lack of information media available at the puskesmas. External communication that is carried out is still not running optimally, there are still misunderstandings between puskesmas employees and patients in the delivery of information, but from the UPTD Puskesmas Ajangale trying to make efforts through the delivery of information on announcement boards and banners listed based on the information needs needed so that it can be conveyed to all patients and guests visiting UPTD Puskesmas Ajangale.

Information Clarity

One of the main obstacles in the implementation of BPJS policy at UPTD Puskesmas Ajangale is the lack of clarity of information received by BPJS participants and

implementing officers. Although technical guidelines from the Central Government and BPJS are available, in practice the delivery of information is not always easy to understand, either because the format is too technical, using uncommunicative language or because of the lack of debriefing to health workers. Most BPJS participants at the UPTD Puskesmas Ajangale in rural areas admit that they do not fully understand the procedures for using BPJS, including their rights and obligations, the referral system and the claim mechanism. Information that should be the basis for service decision-making is often only known in passing when they are already at the place of service without a full understanding.

This factor is caused by inconsistent and incomplete information received by the community and health workers. The community often receives incomplete information, changes between officers and is not delivered systematically. This arises because of the lack of standard written guidelines, lack of training and changes in rules and systems from the Central BPJS without direct socialization to the community.

This inconsistency in information reflects weak communication vertically (from the center to implementers) and horizontally (between service units at puskesmas). The lack of standardization of information delivery also affects the quality of service and makes people reluctant to ask further questions for fear of getting different answers.

This lack of clarity of information indicates weak two-way communication between policymakers and implementers in the field, as well as a lack of community-friendly educational media. This impedes a full and consistent understanding of policy implementation, as explained in the George C. Edwards III theory, which states that ambiguous or poorly communicated information can lead to distortions in policy implementation (Edwards III, 1980). Communication in policy implementation must run consistently, clearly and can be understood by all implementers and beneficiaries. If the information is ambiguous or changing, the policy objectives will not be achieved effectively. In addition, according to Grindle (1980.), this factor is also related to the context of implementation, especially in areas with low levels of information literacy. If information is not packaged appropriately, then even good policies will not be understood and accepted by the target group.

Effectiveness of delivery

The effectiveness of the delivery of technical directions from the Central Government and from BPJS Health to implementers at the puskesmas level is an important aspect in ensuring the success of policy implementation. At UPTD Puskesmas Ajangale, the effectiveness of delivering technical directions is still a real obstacle. Directives received by health workers are often one-sided, not accompanied directly and only sent in the form of circulars or digital files through WhatsApp groups without room for clarification and technical discussion. This situation causes some officers to interpret the new procedures themselves and in some cases, implementation has become non-uniform. This not only impacts on service effectiveness, but also on legal certainty, transparency of procedures and satisfaction of BPJS participants. According to George C. Edwards III, failure to convey directives clearly and consistently can lead to distortions in implementation. Policies that do not consider the local context and the technical capacity of implementers may result in low implementation effectiveness in the field (Edwards III, 1980).

Resources

The resource focus serves to evaluate the adequacy and quality of resources used in policy implementation including medical personnel (doctors, nurses, administrative

officers), availability of medicines and medical devices, physical infrastructure and operational budget support.

1) Medical personnel

One of the main challenges in implementing BPJS-based health services at UPTD Puskesmas Ajangale is the limited number of medical personnel available compared to the high number of patient visits every day. On average, this puskesmas serves more than 4,000 patients per month, the majority of whom are BPJS Health participants, especially from the Contribution Assistance Recipient (PBI) category.

The limited availability of health workers leads to a high workload per individual, which ultimately impacts the quality of care. Many patients have to wait hours for service, especially on market days or when immunization and outpatient services are congested. Officers are also required to complete administrative work, data entry in the BPJS system (P-Care), while providing clinical services.

In the perspective of From the George C. Edwards III perspective, resources are a key component in policy implementation. Without adequate human resources, both in terms of quantity and competence, public services will not operate optimally. This condition also reflects weak planning in the distribution of health workers, particularly in rural areas (Edwards III, 1980; Widodo, 2011).

Meanwhile, according to Grindle (1980), the success of implementation is also largely determined by the readiness of implementing agencies in terms of organizational capacity. Too high a workload not only reduces the quality of services, but also reduces the motivation and mental health of implementers in the field.

2) Availability of medicines and medical devices

The availability of medicines and medical devices is an essential part of health services, especially in social security systems such as BPJS Kesehatan. However, the results showed that at the UPTD Puskesmas Ajangale, the availability of medicines and medical devices is still not stable, and even tends to often experience vacancies, especially towards the end of the month or during a surge in patient visits.

Medicines that are covered by BPJS often run out before the next procurement time, and re-procurement is often delayed due to administrative processes and budget constraints. The drugs that often run out are drugs for diabetes and hypertension. This forces patients to buy drugs outside the puskesmas, which is certainly an additional burden, especially for participants from the Contribution Assistance Recipient (PBI) category. Drug procurement at Ajangale Health Center is often hampered by a slow distribution process, dependence on BPJS stocks and BPJS formulary restrictions which result in not all the drugs needed being available at the health center. Likewise, medical equipment is often damaged or limited in number such as blood pressure measuring instruments, glometers and limited laboratory test kits.

This shows the gap between the ideal BPJS policy and the reality on the ground. Although BPJS guarantees treatment and services, limitations in the procurement and distribution of drugs and medical devices hamper the service process. According to the theory of George C. Edwards III theory, one of the factors that greatly affects the success of policy implementation is the availability of sufficient resources, including drugs and medical devices. Merilee S. Grindle also

emphasizes that the capacity of the physical resource availability system at the implementing level plays an important role in policy success. Without adequate resource support, policies will be difficult to implement effectively.

In the George C. Edwards III theory, the success of policy implementation is largely determined by the adequacy of resources, including medical logistics. A good policy will not produce optimal results if it is not supported by adequate facilities and infrastructure in the field (Edwards III, 1980). In addition, according to Grindle (1980), the availability of resources also reflects the quality of institutional support and the operational capacity of policy implementers. The condition at UPTD Puskesmas Ajangale shows a gap between the idealism of BPJS policy and the operational reality in the field, where participants who should have access to free medicines still incur additional costs because stocks are not available.

3) Physical infrastructure

Adequate physical infrastructure conditions determine the quality of health services, especially in the implementation of BPJS policies that demand fast, decent, and inclusive services. Based on the results of observations and interviews, UPTD Puskesmas Ajangale still faces limitations in physical facilities and infrastructure, such as narrow patient waiting rooms, lack of ventilation, limited inpatient facilities, and uneven medical equipment in all service units.

The lack of facilities is also evident in supporting equipment, such as bathrooms, breastfeeding rooms, and parking areas that are not well organized. According to the puskesmas minimum service standards, such infrastructure is essential to support inclusive and dignified BPJS services. This affects patient comfort, but also has the potential to reduce service quality and patient safety.

From the perspective of George C. Edwards III, the availability of infrastructure is part of the resources that strongly influence the effectiveness of policy implementation. Without adequate physical facilities, policy implementation may be disrupted even when the implementers have a high level of commitment (Edwards III, 1980). Grindle (1980) also states that organizational readiness, including the aspect of physical resources, is part of the "content of implementation" which determines policy outcomes.

4) Operational budget support

The availability of medicines and medical devices is an essential part of health services, especially in social security systems such as BPJS Health. However, the results showed that at the UPTD Puskesmas Ajangale, the availability of medicines and medical devices is still not stable, and even tends to experience frequent vacancies, especially towards the end of the month or during a surge in patient visits.

Puskesmas receive Health Operational Assistance (BOK) funds amounting to ±Rp 100,000,000 per year, which are devoted to promotive and preventive activities. However, while this may seem sufficient on paper, in practice it is not sufficient to cover all service needs, especially in the event of a surge in patient visits or sudden needs.

The current budget system at UPTD Puskesmas Ajangale is still not responsive to the needs of the field. Although there are funds available, the management system is very rigid and procedural. This makes it difficult for officers when facing emergency situations or needs that cannot be predicted in advance. In the George C. Edwards III theory, one of the important factors in policy

implementation is the availability of resources, including financial resources. Without sufficient and flexible budget support, policy implementation will be difficult to carry out effectively (Edwards III, 1980). In line with this, Grindle (1980) emphasizes that implementation will be successful if institutional support and resources are tailored to the needs and capacity of lower-level implementers.

Disposition

Disposition refers to the character and characteristics of the implementer. If the implementer has a positive disposition, the policy will be implemented properly in accordance with the intentions of the policy maker. However, when implementers have different attitudes or perspectives from policy makers, the policy implementation process tends to become ineffective (Edwards III, 1980).

1) Variations in attitudes and behaviors

According to the George C. Edwards III theory, implementer disposition refers to the attitudes, commitments, and perceptions of policy implementers toward the policies being implemented (Edwards III, 1980). In the context of BPJS Health services at UPTD Puskesmas Ajangale, the disposition of the officers still varies, both in terms of attitude, empathy, and treatment of BPJS participants, especially those from underprivileged groups. The results showed a professional and friendly attitude, but some others seemed impatient, uncommunicative, or even discriminatory towards BPJS participants. This was especially evident when the puskesmas was under heavy traffic, where staff fatigue affected the way they served patients.

The findings at UPTD Puskesmas Ajangale indicate that not all policy implementers have consistent dispositions in providing equitable services. Differences in perceptions of patient status (BPJS vs general) and high work pressure are factors that influence officer treatment. This also shows that the lack of understanding and internalization of public service values is a challenge in implementing BPJS policy. If the implementer does not have the appropriate value orientation, the big goal of public service policy, namely justice and equal access to services, will not be achieved.

According to the George C. Edwards III theory, the attitudes and tendencies of policy implementers are crucial factors that can strengthen or weaken policy implementation. If implementers do not have commitment or a positive perception of the program, policy implementation tends to be carried out only half-heartedly and becomes ineffective (Edwards III, 1980). This is also in accordance with the views of Grindle (1980), that the success of implementation is influenced by the motivation, personal interests, and orientation of the implementers.

2) High commitment but constrained by the system

Health workers at UPTD Puskesmas Ajangale show high commitment in serving the community, including BPJS Health participants. They continue to carry out their duties despite facing various obstacles in the field, ranging from heavy workloads, limited infrastructure, to policies that often change. However, this commitment is often not in line with the available system support, both in terms of internal management, coordination with BPJS Health, and policy support from local governments.

Health workers feel that many of their efforts are hampered by the unintegrated service system, the slow referral process, limited access to

participant data, and technical problems such as network disruptions when inputting data into the P-Care application. The implementation of BPJS administration at UPTD Puskesmas Ajangale has a complicated, slow and inflexible claims administration. Health service claims that are the right of BPJS participants for drugs, referrals, and follow-up examinations are often hampered by long bureaucratic flows, rigid verification systems, and limited digital access (P-Care and V-Claim applications). As a result, services to participants are inefficient and require long waiting times.

According to the George C. Edwards III theory, a bureaucratic structure that is too rigid and convoluted will hinder effective policy implementation. Long administrative procedures can slow down services and reduce the satisfaction of policy beneficiaries (Edwards III, 1980). Meanwhile, Grindle (1980) emphasizes that the implementation process must be adaptive to local capacity and must not sacrifice speed and accessibility of services. According to Edwards III's theory, the disposition of implementers is strongly influenced by perceptions of system effectiveness and organizational support. Commitment alone is not sufficient without an adaptive, consistent system that facilitates policy implementation (Edwards III, 1980). Grindle (1980) also emphasizes that policy implementation is not only determined by actors, but also by the institutional structure and context that surrounds it.

3) Attitude alignment with policy objectives still needs to be strengthened

The alignment between the attitudes of officers and the main objectives of the policy in this case is fair, equitable, and non-discriminatory health services for all BPJS participants. Based on the findings in the field, although most health workers have commitment and good intentions in providing services, there is still a misalignment between the attitudes of individual implementers and the basic principles of BPJS policy, such as the principles of universal service, service without class distinction, and equal treatment for PBI and non-PBI participants.

In the George C. Edwards III theory, one of the factors determining successful implementation is the compatibility between the implementer's disposition and the substance and spirit of the policy. If implementers do not fully understand or accept the policy objectives, a gap may arise between policy expectations and the reality of service delivery (Edwards III, 1980). Grindle (1980) also states that the value orientation and preferences of implementers can be key variables in hindering or accelerating policy success.

Bureaucratic Structure

According to the George C. Edwards III theory, the organizational structure responsible for policy implementation significantly influences the effectiveness of policy implementation (Edwards III, 1980). The bureaucratic structure supports or hinders the smooth implementation of BPJS policies at UPTD Puskesmas Ajangale. Evaluation of aspects such as standard operating procedures (SOPs), internal coordination systems, referral mechanisms and claims administration shows challenges that have a direct impact on the smooth running of services.

1) SOPs are available but implementation is not consistent

According to the George C. Edwards III theory, an effective bureaucratic structure is characterized by clear and organized work mechanisms through Standard Operating Procedures (SOPs), which guide implementers in carrying out policies consistently (Edwards III, 1980). At UPTD Puskesmas Ajangale, all service units

have SOPs, both related to the flow of BPJS patients, referrals, medical records, and data input into the BPJS Health system (P-Care). However, field findings show that although SOPs are available, their implementation has not been consistent in all units and in every service condition. SOPs are seen when the puskesmas is under heavy traffic, where staff tend to ignore some procedures due to work pressure. There are also differences in application between officers that result in inconsistencies in patient experience, as well as the emergence of unfair perceptions among BPJS participants.

The existence of SOPs is not enough if it is not accompanied by supervision, routine coaching and discipline enforcement. Inconsistent implementation of SOPs risks reducing public trust in services and causing uneven services. In the implementation of this SOP, there are technical and administrative obstacles that cause the process to run inefficiently, slowly and often confusing. The main problem lies in the limited capacity of the digital system (P-Care and online referral), the limited number of referral hospitals that have to wait for approval from the system. On the other hand, in emergencies, the strict referral procedures become an obstacle to service delivery.

This finding shows that the referral system, which is supposed to facilitate access to follow-up services, is actually an additional burden for implementers and patients, mainly due to technological barriers and limited procedural flexibility. In the context of public services, this shows weak system integration between levels of health facilities.

According to the George C. Edwards III theory, an effective bureaucratic structure is characterized by clear coordination mechanisms and structured workflows that support policy implementation at the technical and operational levels (Edwards III, 1980). Meanwhile, according to Grindle (1980), the implementation system must consider local realities, including institutional capacity and geographical constraints that are very relevant to the conditions of puskesmas in rural areas such as Ajangale participants.

In the George C. Edwards III theory, a good bureaucratic structure requires clarity and consistency in procedures. If Standard Operating Procedures (SOPs) are not implemented uniformly, the bureaucracy becomes ineffective and policy objectives become difficult to achieve (Edwards III, 1980). Grindle (1980) also emphasized that successful implementation is not only influenced by the availability of procedural documents, but also by the capacity and commitment of implementers in carrying them out in a disciplined manner.

2) Internal coordination channels are still ineffective

Internal coordination is an important part of the bureaucratic structure that functions to unify understanding, synchronize actions between units, and ensure that policy implementation is carried out uniformly and in a directed manner (Edwards III, 1980; Widodo, 2011). At UPTD Puskesmas Ajangale, internal coordination channels between implementers and between service units are available, such as through monthly staff meetings, internal communication groups, and morning briefings. However, the results showed that the coordination has not run optimally, both in terms of frequency, substance of discussion, and follow-up. Ineffective coordination has resulted in miscommunication between officers, as well as unsynchronized information related to changes in BPJS service procedures. In addition, some implementing units felt that they were not involved in decision-making or socialization of the new policy, as well as differences in service delivery

between units, which caused confusion among participants. In addition, some implementing units felt that they were not involved in decision-making or socialization of new policies.

Based on the George C. Edwards III theory, the ideal bureaucratic structure is one that ensures effective two-way communication and coordination. Poor coordination can create inconsistencies in policy implementation and reduce implementation effectiveness (Edwards III, 1980). Grindle (1980) also emphasizes that successful implementation depends on institutional integration and internal cohesion of implementers at all levels.

3) The referral system is less effective and causes obstacles

The tiered referral system is one of the main pillars in the implementation of the National Health Insurance (JKN) policy by BPJS Kesehatan. This system is designed to ensure that patients receive the right services at facilities that match the level of medical need. However, at UPTD Puskesmas Ajangale, the referral system is considered less flexible and causes a number of obstacles, especially when facing emergency conditions, limited facilities, or delays in access. digital referral system (SPM/PCare). Based on the results of the study, health workers often experience difficulties when they have to refer BPJS patients in urgent conditions due to limited referral quotas at destination hospitals, network disruptions, or complicated administrative procedures. As a result, patients often have to wait longer or even be referred to places far from their domicile, which certainly adds to the burden and reduces the effectiveness of services.

The referral system, which is supposed to be a solution, is actually a source of service delays. This shows the rigidity of bureaucratic procedures, the lack of technological flexibility of the referral system and the low capacity for coordination across facilities. According to the George C. Edwards III theory, a bureaucratic structure that is excessively rigid and unresponsive to field conditions may obstruct effective and efficient policy implementation (Edwards III, 1980). Grindle (1980) also emphasized that a system that is not adaptive to the local context will fail to respond effectively to the needs of the community.

4) The claims administration process is slow and bureaucratic

One of the obstacles often complained about by BPJS participants at UPTD Puskesmas Ajangale is the slow, complicated, and bureaucratic administrative process. Although the puskesmas has standard service procedures, in practice, administrative management still takes a long time, involves many stages, and requires many documents that are often not understood by patients.

These problems are exacerbated by the lack of administrative personnel, suboptimal technological devices, and reliance on manual systems or double input, such as filling out paper forms as well as inputting them into P-Care. This condition not only slows down services, but also generates complaints from the public because it is considered complicated and not patient-friendly. The administrative structure that is too rigid and inefficient is one of the obstacles in the implementation of BPJS policy. This is contrary to the spirit of the JKN policy, which should facilitate access to health services for the entire community. According to the theory

George C. Edwards III explains that an overly lengthy and inefficient bureaucratic structure can hinder the implementation of public policies effectively (Edwards III, 1980). Meanwhile, according to Grindle (1980), implementation will

be hampered if the administrative system does not consider the conditions and capacity of service recipients at the lower levels.

Based on the results of the research and discussion regarding the implementation of the BPJS Health policy at the UPTD Puskesmas Ajangale, Bone Regency, it can be concluded that the implementation of BPJS-based health services has been running, but not yet optimal. Policy implementation still encounters various obstacles related to communication, resources, implementer disposition, and bureaucratic structure, as analyzed through the George C. Edwards III theoretical approach (Edwards III, 1980).

First, from the communication aspect, information regarding the rights and obligations of BPJS participants and service procedures has not been conveyed thoroughly to the community. Socialization is still minimal, thus causing ignorance of participants in accessing services appropriately.

Second, in terms of resources, Ajangale Health Center experiences a shortage of medical personnel, limited medicines, and inadequate infrastructure. The high workload is not proportional with the number of implementing personnel, thus reducing the efficiency and quality of service.

Third, the disposition of the implementers has not been fully consistent. Although there are officers who have high commitment, there are still unfriendly and unresponsive attitudes from some service implementers. This has the potential to reduce participants' trust in the health service system.

Fourth, in terms of bureaucratic structure, BPJS service procedures are still perceived as slow and complicated, especially in the referral and claim processes. The lack of utilization of information technology and the unintegrated administrative system worsen the effectiveness of the service bureaucracy. Thus, it can be concluded that the successful implementation of the BPJS Health policy at the puskesmas level is not only determined by the applicable regulations, but is strongly influenced by technical readiness, human resources, and adaptation of the local bureaucracy to the dynamics in the field.

CONCLUSION AND SUGGESTION

Based on the results of the research and discussion regarding the implementation of the BPJS Health policy at UPTD Puskesmas Ajangale, Bone Regency, it can be concluded that the implementation of BPJS-based health services has been running, but not optimal. The policy implementation still faces various obstacles in the aspects of communication, resources, executor disposition, and bureaucratic structure, as described through the George C. Edwards III theory approach.

First, from the communication aspect, information regarding the rights and obligations of BPJS participants and service procedures has not been conveyed thoroughly to the community. Socialization is still minimal, thus causing ignorance of participants in accessing services appropriately. Second, in terms of resources, Ajangale Health Center experiences a shortage of medical personnel, limited medicines, and inadequate infrastructure. The high workload is not proportional to the number of implementers, thus reducing the efficiency and quality of service. Third, the disposition of implementers is not fully consistent. Although there are officers who have high commitment, there are still unfriendly and unresponsive attitudes from some service implementers. This has the potential to reduce participants' trust in the health service system. Fourth, in terms of bureaucratic structure, BPJS service procedures are still perceived as slow and complicated, especially in the referral and claim processes. The

lack of utilization of information technology and the unintegrated administrative system worsen the effectiveness of the service bureaucracy.

Thus, it can be concluded that the successful implementation of BPJS Kesehatan policy at the puskesmas level is not only determined by the applicable regulations, but is strongly influenced by technical readiness, human resources, and adaptation of the local bureaucracy to the dynamics in the field.

For UPTS Puskesmas Ajangale, it is necessary to increase the number and competence of health workers, improve the availability of medicines and medical equipment, and enhance supporting service facilities to optimize BPJS health services. In addition, strengthening communication and socialization regarding BPJS procedures and participant rights is essential to improve public understanding and service effectiveness. For the Government and BPJS Kesehatan, it is recommended to simplify administrative procedures, improve the referral system, and strengthen digital-based service systems to support faster, more efficient, and more transparent health services. Furthermore, periodic monitoring and evaluation should be conducted to ensure that BPJS policies are implemented effectively at the primary health care level. For future researchers, it is recommended to conduct broader studies involving more health centers or hospitals in different regions, as well as to use quantitative or mixed-method approaches to obtain more comprehensive findings regarding the implementation of BPJS health services in Indonesia.

For future research, it is recommended to conduct studies with a broader scope by involving more health centers or hospitals in different regions to obtain more comprehensive findings regarding BPJS health service implementation. Future researchers are also encouraged to use quantitative or mixed-method approaches to compare service quality, patient satisfaction, and policy effectiveness in various health institutions.

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