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Mitigating gaps in Indonesia's social health insurance: Strategies for fulfilling the right to health for disabled persons

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Abstract: This study aims to identify gaps in Indonesia's national social health insurance scheme (Jaminan Kesehatan Nasional or JKN) in meeting the right to health for disabled persons in the country and to propose strategies to mitigate the gaps. This study employed descriptive qualitative methodologies. A questionnaire survey and structured interviews were undertaken from the period of October to December 2021, with a purposive sample of 317 disabled persons at their working age. Data collection also included on-site observations to sample of healthcare providers in six provinces and focused group discussions with key stakeholders. This study found that JKN is the primary source of hope for disabled persons. Nevertheless, approximately ten percent of disabled persons have been omitted from the scheme. Moreover, respondents of the survey expressed notably lower satisfaction level compared to the national average. Meanwhile, 25% of them also reported that JKN did not cover certain disability-specific benefits. The findings suggest that the national social health insurance scheme is not well prepared to offer disability-inclusive services. Thereby, policymakers should implement various interventions to improve the admission processes for disabled persons and to develop a system to identify disabled members based on their specific disabilities. Additionally, stipulating standards for disability-friendly minimum services for healthcare providers and incorporating the standards into the credentialing systems, providing regular training on disability-friendly services for healthcare personnel, also enhancing benefits coverage for disabled members in the Indonesian Case Base Groups (INA-CBGs) are the necessary strategies to mitigate the gaps.

Keywords: Convention on the Rights of Persons with Disabilities (CRPD); persons with disabilities; inclusive development; social health insurance; evidence-based policy; sustainable development goals

1. Introduction

Globally, persons with disabilities often face exclusion from development processes, resulting in lower levels of educational attainments, limited access to health services and employment opportunities, as well as decreased access to public facilities (Mellifont et al., 2023; International Labor Organization, 2017; United Nations, 2018; World Bank and WHO, 2011). To address this concern, Indonesia has shown some commitment to providing equal opportunities for persons with disabilities to have decent lives.

The country has ratified the United Nations Convention on the Rights of Persons with Disabilities (CRPD) (United Nations, 2007) since March 2007. Under law number 36 of 2009 concerning health and law number 8 of 2016 concerning persons with disabilities, the government has included provisions related to the right to health for persons with disabilities.

Article 12 of law number 8 of 2016 clearly outlines the right to health for persons

with disabilities. The right to health includes the right for persons with disabilities to obtain accessible information and communication in health services, obtain equal opportunities for access to resources in the health sector, obtain equality and opportunities for safe, quality, and affordable health services, obtain equality and opportunities to determine their own needs for health services, obtain health aids based on their individual specific needs, obtain quality drugs with low side effects, obtain protection from medical experiments, and obtain protection in health research and development that includes humans as subjects.

Furthermore, articles 61 to 74 of the law regulate the provision of health services for persons with disabilities. In particular, articles 61 to 62 mandate the government at all levels to ensure that health service facilities accept patients with disabilities, provide health services without discrimination, ensure the availability of health personnel who have the necessary competencies in providing healthcare services for persons with disabilities, and guarantee access to health services through the national social health insurance program (Program Jaminan Kesehatan Nasional, or hereinafter referred to as JKN).

The implementation of JKN is governed by law number 40 of 2004 concerning the national social insurance system and law number 24 of 2011 concerning social insurance administrators. In principle, as a social health insurance JKN applies mandatory contributory schemes for the whole Indonesian population, and the government must assist the disadvantaged groups.

The social health insurance administrator in Indonesia (Badan Penyelenggara Jaminan Sosial Kesehatan, hereinafter referred to as BPJS Kesehatan), as of the end of the year 2022, reported there were 248.77 million people covered by JKN, which is equivalent to 90.73% of the entire Indonesian population. While government regulation stipulates that persons with disabilities who cannot afford to contribute are covered as recipients of the government contribution assistance program (Penerima Bantuan Iuran, or PBI), the coverage of this group was not detailed in the figure.

Exertions on the fulfillment of the right to health for persons with disabilities in Indonesia were based on the fact that persons with disabilities often faced hardships in accessing public healthcare services. Multiple studies reported low accessibility to public healthcare services and facilities for this group (Adioetomo et al., 2014; Haryono et al., 2013; Indonesia Corruption Watch, 2021; Japan International Cooperation Agency, 2015; Syukria and Supriyanto, 2016).

A study by Haryono et al. (2013) in 2013 indicates provisions of curative healthcare services in various provinces, including in secondary healthcare facilities (referral hospitals and special clinics), were still limited. As a result, persons with disabilities and their families, particularly those who are impoverished and live far from health facilities, must bear significant transportation costs to go to referral hospitals.

Moreover, the study revealed that primary health facilities had not prioritized the promotion of disabled women's reproductive health. Even when health personnel tried to provide information about reproductive health to the group, their communication skills were often inadequate. A study by Syukria and Supriyanto (2016) in 2016 also revealed that the utilization of primary healthcare facilities by children with disabilities was low compared to other types of healthcare facilities.

The availability of healthcare facilities to meet the specific needs of persons with disabilities is crucial for enabling them to access healthcare services. On this matter, the government has established standards for the physical accessibility of public facilities in the Minister of Public Works regulation number 30 of 2006. The regulation includes standards for public facilities to have necessary facilities for the disabled.

However, healthcare facilities often lack disability-friendliness, which makes it difficult for persons with disabilities to self-access healthcare services (Haryono et al., 2013). Moreover, a survey in four secondary cities in Indonesia by the Indonesia Corruption Watch in 2019 identified various unmet standards in healthcare facilities. These include the absence of handrails, wheelchairs, braille-translated information, disabled toilets, and special counters for persons with disabilities. The study also found that the majority of healthcare personnel were considered incapable of handling the specific needs of persons with disabilities. To address these issues, Indonesia Corruption Watch (ICW) has suggested guidelines for minimum service standards to improve the quality of healthcare services for persons with disabilities.

Furthermore, the availability of healthcare facilities and personnel to provide medical rehabilitation services at both primary and secondary healthcare facilities remained limited. A study conducted by the Japan International Cooperation Agency (JICA) in 2021 revealed that the distribution of healthcare facilities in Indonesia with the capacity to provide medical rehabilitation services was uneven. The number of physical therapists providing basic medical rehabilitation services at primary healthcare facilities was only 652 personnel in comparison to the 9655 facilities available in the period of study.

Additionally, access to assistive devices for persons with disabilities is still lacking. According to the Survey on the Need for Social Assistance Programmes for People with Disabilities (SNSAP-PWD) in 2012, only 11% of individuals with severe hearing difficulties use hearing aids, while only 8.7% of individuals with vision problems use a white cane and 11.3% use glasses. The government's provision of assistive devices was relatively limited, and many persons with disabilities purchased them at their own expense. When these devices become damaged, the repair cost poses a challenge to them (Adioetomo et al., 2014).

In addition to those challenges, persons with disabilities often experience mistreatment. Research by Human Rights Watch in 2016 discovered that confinement, binding, and shackling of persons with mental disabilities were prevalent in Indonesia, and were carried out not only by their families but also by the rehabilitation centers. When mentally disabled persons are in rehabilitation centers, they are placed in overcrowded rooms, hindering their access to basic sanitation facilities and clean water, and also making them susceptible to the spread of diseases (Human Rights Watch, 2016).

The problems being elaborated on in this study are discussed in the social model of disability theory. This theory provides an important framework for understanding disability and for advocating for the rights of people with disabilities. The theory argues that disability is not caused by the individual's impairment, but by the way society is organized. For example, a person with a physical impairment may be considered disabled if they live in a society that is not accessible to wheelchair users. However, if they lived in a society that was fully accessible, they would not be

considered disabled (Barnes and Mercer, 1996; Humpage, 2007; Oliver, 1990; Shakespeare, 2013; Thomas, 2007).

Furthermore, it is noteworthy to add to this study a perspective from the human rights framework on disability-inclusive policy. According to this framework, persons with disabilities have the same human rights as everyone else. This means they have the right to life, liberty, security of person, education, work, and participation in all aspects of society (Jones, 2012; Stein and McMorrow, 2016; Wedgwood, 2017; World Bank, 2015). This framework has been used as a guide for the development of disability-inclusive policies in some countries.

It is essential for every person, and especially for those with disabilities, to have equal access to healthcare services to maintain their health and productivity. It is then crucial for the government to develop appropriate policies to mainstream the fulfillment of the right to health for persons with disabilities. Persons with disabilities have the constitutional right to get full access to national social health insurance.

Hence, the focus of the present study is to find evidence of gaps in the fulfillment of the right to health for persons with disabilities in Indonesia. Specifically, this study would like to conduct a policy output analysis on the outcomes of the country's social health insurance policy to fulfill the right to health for disabled persons (Peters, 2019). Furthermore, based on the findings, this study aims to propose strategies to mitigate the gaps.

2. Materials and methods

The current study employed descriptive qualitative approaches. The objective was to find empirical evidence on the accessibility of public healthcare systems for persons with disabilities in Indonesia. Based on the findings, the study aims to evaluate the fulfillment of the right to health for persons with disabilities as provided by the national social health insurance (JKN), assess the condition of existing health facilities in meeting disability-friendly standards, and find rooms for improvement in the accessibility of JKN for persons with disabilities. The study was conducted in 2021, that is five years after the enactment of law number 8 of 2016, which stipulates access to JKN services for persons with disabilities.

In this study, we took four steps. The first step, which took place from May to September 2021, involved study of literatures and a preliminary survey to prepare the research instruments and identify target respondents. The second step, which was delivered from October to December 2021, involved data collection through various techniques such as questionnaire survey, structured interviews with key respondents, field observations, and focused group discussions (FGD).

During the third step, from November to December 2021, we conducted two study meetings to gather all the data and do the analysis. In the final step, we compiled all the findings and analysis into a study report and disseminated it in a public seminar that was attended by key stakeholders and experts. We completed this step in December 2021.

To ensure the accuracy and validity of the data, we implemented a triangulation process. We employed the triangulation technique known as data triangulation. Data triangulation involves analyzing a research question or phenomenon using various

sources of data, from the questionnaire survey, interviews, field observations, FGDs, and document analysis, to find a more comprehensive understanding of the phenomenon. The use of multiple sources of data enables us to validate findings and minimize the risk of bias that may arise when a single method is used.

In the initial stage of the study, we realized that identifying the actual size of the disabled population in Indonesia is a challenging task. The source of data for their existence usually comes from surveys of persons with disabilities, which are conducted in targeted sectors such as special education schools or foundations that provide social services for persons with disabilities.

A study by the SMERU Institute in 2020 on persons with disabilities mapped their conditions based on the 2018 Susenas (Badan Pusat Statistik, 2018) and 2018 Riskesdas (Kementerian Kesehatan, 2018) surveys, which were conducted by the Central Statistics Agency and the Ministry of Health, respectively. The report found that the two surveys show significant discrepancies in the number of persons with disabilities, which may be attributed to the different sets of questions used to identify them (SMERU Research Institute, 2020).

Meanwhile, the Ministry of Social Affairs, which has compiled data since 2018 through the Disabled Information System, known as Sistem Informasi Penyandang Disabilitas (SIMPDA), revealed that there were only about 140,000 persons recorded with disabilities as of 2019. SIMPDA also recorded that the distribution of persons with disabilities throughout Indonesia was uneven, with the majority residing on the island of Java, where around 57% of the total number of people with disabilities can be found.

Given the background of the situation, most studies on persons with disabilities in Indonesia referred to a national survey from the Central Statistics Agency (Badan Pusat Statistik, 2018). The national social economic census in 2018 recorded several 31.2 million persons with disabilities, which was 12.29% of the total population in 2018. The most common types of disability were difficulty in seeing (36.09%), difficulty in hearing (14.11%), and difficulty in walking or climbing stairs (17.95%).

According to the survey, the number of persons with disabilities within the productive age group (15–64 years) was reported to be 19.8 million, which accounts for 11.12% of the total number of persons with disabilities. The elderly group over 65 years has the highest number of persons with disabilities, which accounted for 57.26%.

Moreover, persons with disabilities in Indonesia were not evenly distributed. The majority of them resided on the island of Java, accounting for 56.95% of the total number of people with disabilities. Meanwhile, the distribution of persons with disabilities across urban and rural areas was relatively balanced, although in the child and productive groups, the proportion of persons with disabilities in urban areas was slightly higher than in rural areas.

The target group of respondents in this study was the productive age group of workers and job seekers with various types of disabilities in rural and urban locations. Respondents were targeted using mixed approaches of quota and purposive samplings. Identification of respondents for the survey was based on the reference from the communities of persons with disabilities (Perkumpulan Penyandang Disabilitas Indonesia and Perkumpulan Penyandang Disabilitas Fisik Indonesia).

Based on the statistics record of the Central Statistics Agency, this study used Slovin's formula to determine the sample size of respondents for the questionnaire

survey. Data collection was carried out in six target provinces, including Jakarta Province, West Java Province, Central Java Province, East Java Province, Kepulauan Riau Province, and West Nusa Tenggara Province.

The six target provinces collectively represented 53.87% of the population of persons with disabilities in Indonesia and took into account representative provinces from both Java and outside of Java islands. The inclusion of respondents from islands outside of the Java is necessary to avoid biases related to disparities in socioeconomic development among provinces. Participants were drawn from urban and rural settings to reflect diverse perspectives within the country.

The questionnaire was distributed online across the six provinces during October–November 2021, resulting in 317 data inputs. In light of the COVID-19 pandemic, we conducted the survey entirely online using Google Forms. The survey granted disabled respondents the option to receive assistance from a companion in filling out the survey.

Given the situation of the pandemic, most interview activities were conducted via telephone. Only when the situation allowed, the interviews were conducted via in-person visits to the respondent’s residence. The interviews were specially conducted with disabled respondents who happened not to be covered by national social health insurance (JKN). The guidelines for respondents’ interviews are given in **Table 1**.

Table 1. Interview guidelines.

Objective	Aspects	Questions
Identification of accessibility problems for persons with disabilities to JKN services	A. Membership to JKN	a Is the respondent registered in the JKN program as a contribution assistance recipient?
		b If yes, what is the procedure followed by the JKN respondent to obtain his/her membership?
		c If not, did the respondent receive information about his membership in the JKN program?
	B. Delivery of JKN healthcare services	a Has the respondent ever obtained JKN health services?
		b If yes, did the healthcare facility provide disability-friendly services?
		c If yes, in general, is the respondent satisfied with JKN healthcare services?
		d If not, is there any obstacle for the respondent to use the JKN services?
	C. Coverage of JKN health benefits	a For respondents with past experience of using JKN services, did the health benefits of JKN meet all of his/her specific medical needs?
		b Does the respondent have specific medical needs that are not covered by JKN?

Data acquisitions were also executed using on-site observation in the six regions, consisting of 17 primary healthcare facilities, 20 secondary healthcare facilities, and 2 rehabilitation centers. For this observation, a list of available healthcare facilities and the rehabilitation centers was received from BPJS Kesehatan. We then further selected the sample of facilities based on their types and geographical proximities to the residing places of the disabled respondents in this survey. Further information regarding these healthcare facilities is provided in **Table 2**.

Table 2. List of number of healthcare facilities visited in each of the targeted province during the on-site observation.

Province	Number of primary healthcare facilities	Number of secondary healthcare facilities	Number of rehabilitation centers
Kepulauan Riau Province	1	2	-
Jakarta Province	2	2	-
West Java Barat Province	2	4	-
Central Java Province	2	4	2
East Java Province	7	5	-
West Nusa Tenggara Province	3	3	-
Total	17	20	2

The guidelines for JKN healthcare facilities’ on-site observation are provided in the following checklist, as presented in **Table 3**.

Table 3. Checklist for healthcare facilities observation.

Objective	Aspects	Findings
Identification of disability-friendly readiness for JKN healthcare facilities	A. Availability of standard operation procedure (SOP) for disability-friendly JKN services	Fill up the findings. When necessary, complete with evidence such as a document or picture.
	B. Availability of disability-friendly infrastructure of healthcare facilities	Fill up the findings. When necessary, complete with evidence such as a document or picture.
	C. Availability of trained health personnel for disability-friendly services	Fill up the findings. When necessary, complete with evidence such as a document or picture.

3. Results and discussion

All respondents involved in the study were people with disabilities at their productive age. The majority of respondents resided in the province of East Java, constituting 37% of the total respondents. Subsequent to this number were respondents from West Java Province, which accounted for 29%, followed by Jakarta Province, which accounted for 14% of the total respondents. Central Java Province and West Nusa Tenggara Province contributed 13% and 6% of the total respondents, respectively. The remaining respondents resided in Kepulauan Riau Province, representing 1% of the total respondents.

The majority of respondents were classified as having physical disabilities, accounting for 68% of the total respondents. Subsequently, individuals with sensory impairments constituted the second largest group at 26%, while respondents with multiple, intellectual, and mental disabilities comprised of 3%, 2%, and 1% of the respondents, respectively.

The majority of the respondents assumed their roles as heads of their respective households, accounting for 40% of the total. The second most prevalent category was that of respondents with the status of a family member or child, constituting 30%. The

remaining respondents were classified into the categories of housewives (19%), widows (4%), and widowers (1%). Additionally, a small percentage of respondents (6%) belong to other groups.

The majority of respondents, 48% of the total, were unemployed, while the remaining respondents belong to different occupational categories, such as private sector employees (31%), informal sector workers (17%), and civil servants (4%). In this regard, it is important to pay close attention to the unemployed respondents to ensure they are included as beneficiaries of government contribution assistance (PBI).

This distribution of respondents is in accordance with the national social economic census record in 2018 (Badan Pusat Statistik, 2018). The census recorded that persons with disabilities in Indonesia tend to have a lower level of welfare than those without disabilities, as evidenced by the higher poverty rate among those with disabilities. The proportion of persons with disabilities who live below the poverty line was around 14.97%, which is higher than the poverty rate of the general population.

Moreover, the census also recorded that the proportion of people with disabilities was greater in the lowest income quintile (poor) than in the highest income quintile (wealthy). This is largely due to the limited access to work opportunities for persons with disabilities, who have a higher tendency to be rejected for job vacancies (International Labor Organization, 2017).

Next, it is widely recognized that assistive devices play a significant role in enhancing the quality of life and productivity of persons with disabilities. The need for such devices, however, is contingent upon the specific medical condition of the individual. In response to the questionnaire, respondents of this study indicated that a majority of them (55%) were using assistive devices. Note that the relatively small percentage of assistive device users does not necessarily indicate a low demand for these devices. Rather, this data highlights the unfulfilled need for assistive devices, as some respondents may not have access to them.

3.1. Issues related to JKN membership for persons with disabilities

The questionnaire utilized in the survey requested all respondents to identify their current membership status in the JKN program. The results of the survey indicated that the majority of respondents, amounting to 43.6%, were active members who benefited from government contribution assistance (PBI), as illustrated in **Figure 1**. The remaining half of the respondents comprised of self-paid active members, totaling 31.2%, as well as active members who pay the contribution through the payroll system (workers), accounting for 14.8%, and non-active members, accounting for 10.4%.

The survey captured the presence of around ten percent of non-active disabled individuals. It is important to pay attention to this group, as it signifies problems related to access for persons with disabilities to the JKN services. Lack of awareness among government officers and the wider community about disability issues, particularly in remote and rural areas, might be a major reason behind this challenge. This situation is especially linked to broader societal issues, such as stigma, norms, and negative perceptions of persons with disabilities (SMERU Research Institute, 2020).

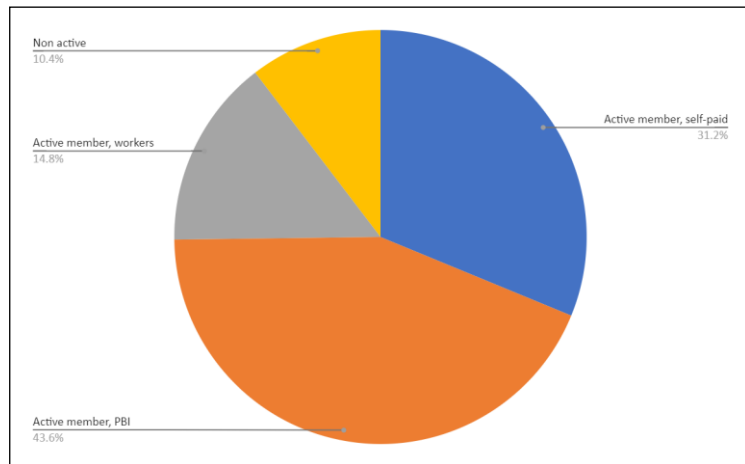


Figure 1. Membership status of the respondents in JKN.

In rural areas of Indonesia, the presence of persons with disabilities is often viewed as a source of shame or dishonor to the family. This results in their isolation from the entire society and later leads to a situation where their existence is excluded from the population database (Human Rights Watch, 2016; Sucahyo, 2016).

In a follow-up question, those non-active disabled individuals were requested to indicate their social status group. That is to further verify whether they meet the requirements for receiving government contribution assistance (PBI). **Figure 2** shows that the majority of them (51.6%) identified themselves as beneficiaries of other government assistance programs. It means they were eligible to receive PBI, but were not included.

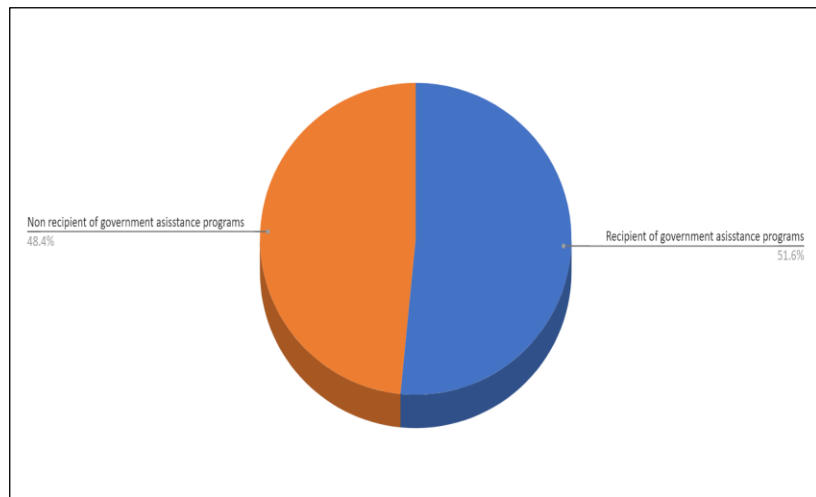


Figure 2. Social status of non-member respondents.

The aforementioned data indicates that a considerable proportion of persons with disabilities who stay unenrolled in the JKN scheme are part of a population that is susceptible to social vulnerabilities. This particular group is actually entitled to receive health insurance coverage as beneficiaries of contribution assistance (PBI). Despite this, in actuality, they are not registered to the JKN program.

To put it in context, the findings of the MAHKOTA survey in 2020 that examined the economic impact of the COVID-19 pandemic on persons with disabilities may

highlight some important points of view (Anggent et al., 2021). According to the survey, the majority of persons with disabilities work in the informal sectors, usually with low and unpredictable incomes, which leave them vulnerable to income shocks during crises. Approximately two-thirds of the survey respondents worked in the informal sectors as daily laborers, small traders, small farmers/fishermen, domestic workers, and handicraft makers. Respondents in the survey generally reported low incomes, with 58% earning approximately Indonesian Rupiah (IDR) 1 million or less per month. In terms of income type, 60% of working respondents reported earning irregular daily/weekly wages.

Further investigation into this issue was subsequently conducted via interviews. Based on the interviews, it was found that the primary cause of the membership issue was the omission of socially vulnerable persons with disabilities from the government assistance program (PBI). This is known as an exclusion error. This exclusion error for PBI beneficiaries might be due to the issuance of a government decree in January 2021 to deliver re-verification and re-validation processes for all recipients of the government contribution assistance program.

3.2. Delivery of disability-friendly JKN services

At first, it is important to verify the effective use of the JKN services for persons with disabilities. The survey in this study probed all respondents if they had ever utilized the JKN services which are provided by BPJS Kesehatan, and in case they did not utilizing the survey asked them the reasons behind their decision of not to utilize the services.

Results of the survey revealed that the majority of respondents abstained from using JKN services just because they were not registered as JKN members (43.4%), see **Figure 3**. In addition, several respondents expressed their willingness to access JKN services but were impeded by their lack of information about utilizing them (10.7%). This shows that among those who were not utilizing JKN services, 54.1% in total, necessitated the services but encountered barriers. Meanwhile, some respondents (38.7%) declared that they did not need JKN services as they did not encounter any health issues. Only a small number of respondents availed of other insurance programs (3.1%).

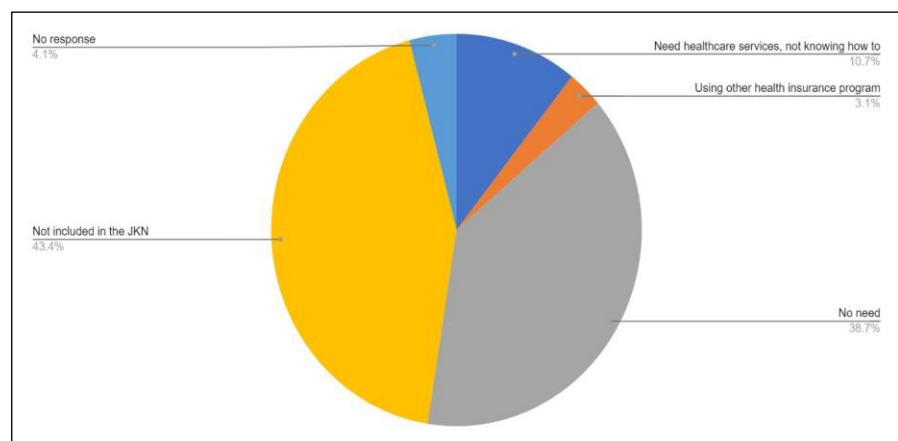


Figure 3. Effective use of the JKN services for persons with disabilities.

Next, respondents were asked to evaluate the delivery of JKN services based on their personal experience. The responses of the respondents are illustrated in **Figures 4–7**. According to **Figure 4**, 35.4% of the respondents reported encountering difficulties while attempting to access JKN services. Further investigation on this matter through interviews with the respondents revealed that the majority of the difficulties stem from a lack of information on how to utilize JKN services as well as the benefits of JKN. Difficulties related to utilizing the JKN services include lengthy procedures and administrative requirements.

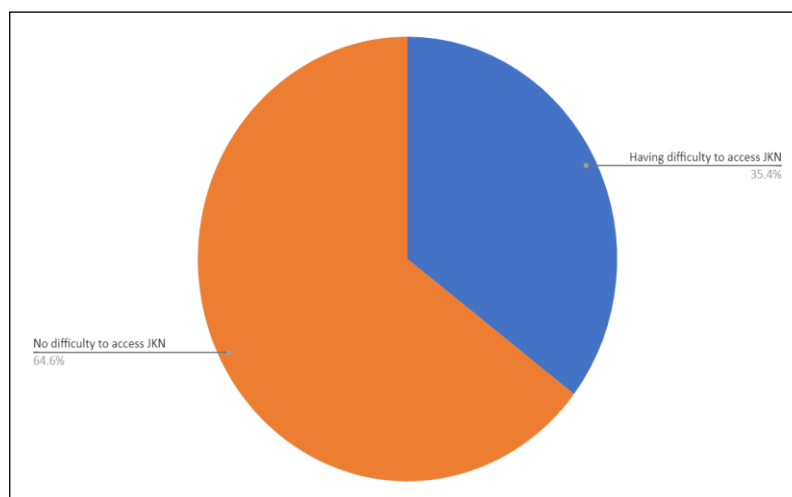


Figure 4. Access for participants with disabilities to JKN services.

Respondents of the survey were also asked to evaluate their extent of satisfaction with healthcare services delivered by JKN’s primary and secondary healthcare providers. **Figure 5** presents the results. It is revealed that 26.5% of respondents expressed being highly satisfied, and 33.1% stated that they were satisfied with the JKN services, whereas the remainder confirmed being neutral (26.0%), not satisfied (11.2%), and highly not satisfied (3.2%). The primary reasons underlying the dissatisfaction of the respondents were the lengthy administrative procedures for the referral process and the prolonged service waiting time.

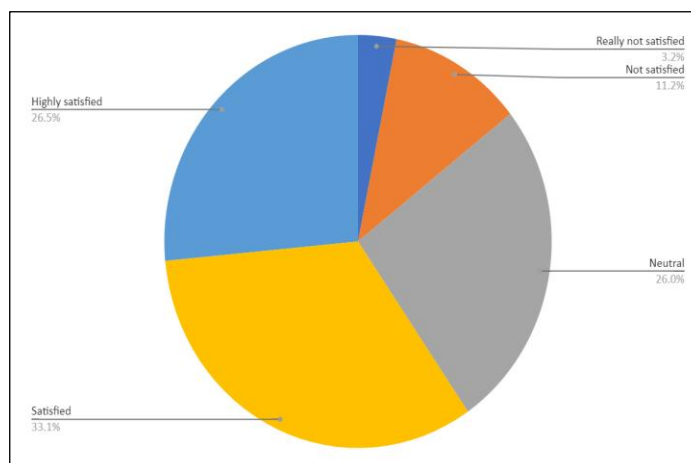


Figure 5. Level of satisfaction of disabled JKN members with JKN healthcare services.

Overall, the satisfaction level of the respondents was quite satisfactory, at 74%. However, though this study used a different approach to the survey when compared to the national satisfaction survey by BPJS Kesehatan in 2021, which reached the level of 87.6%, it is clear that the level of satisfaction of disabled JKN members was notably lower. A current investigation on the satisfaction level of BPJS Kesehatan is provided in the study of Faeni (2024).

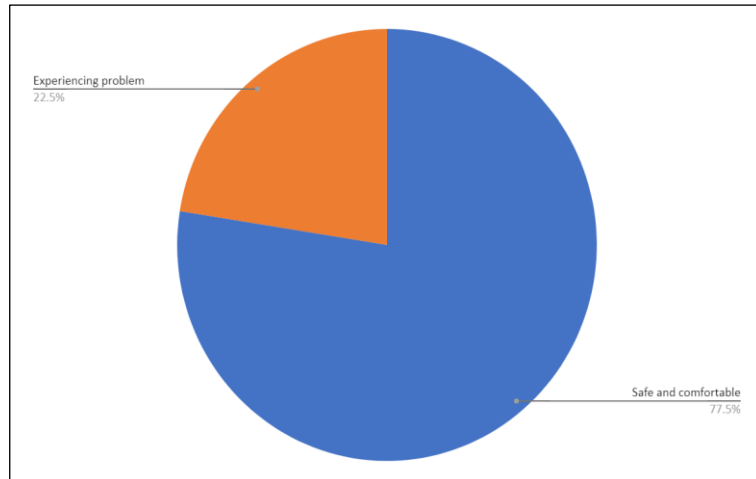


Figure 6. Level of safety and comfortability of JKN services.

Figure 6 displays the perceptions of disabled JKN members regarding the level of safety and comfortability of JKN healthcare providers. The majority of respondents in the survey confirmed that the overall healthcare services provided by JKN healthcare providers were safe and comfortable (77.5%). However, 22.5% of respondents experienced problems with JKN services. The main factor contributing to the problems was due to the lack of disability-friendly facilities at some JKN providers, such as inadequate physical access, unhygienic condition of restrooms, and inadequate physical access to the examination rooms. These circumstances pose significant obstacles for persons with disabilities, in accordance with the findings of Indonesia Corruption Watch’s survey in the year 2019 (Indonesia Corruption Watch, 2021).

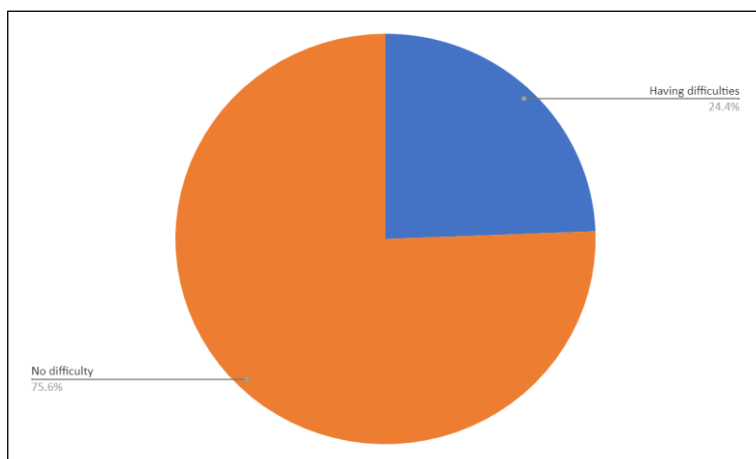


Figure 7. Level of affordability to JKN’s healthcare providers.

Figure 7 displays the findings of a study that investigated the affordability of JKN’s primary and secondary healthcare providers for patients with disabilities. The study revealed that the majority of respondents, specifically 75.6%, do not face any challenges in visiting these healthcare providers. However, 24.4% of the respondents reported experiencing difficulties. In general, the obstacle to accessing JKN healthcare providers was attributed to the considerable distance of the healthcare providers from their homes. The absence of public transportation, which is their primary mode of transportation, was another obstacle.

Based on field observations to the JKN’s primary and secondary healthcare providers in the six regions – results are summarized in **Table 4**, the findings of this study revealed that almost all of the healthcare providers do not have specific Standard Operating Procedures (SOPs) for disability-friendly JKN services. This is also found in the study of Indonesia Corruption Watch in 2019 (Indonesia Corruption Watch, 2021).

Table 4. Disability-friendly readiness of JKN healthcare providers in six regions.

Objective	Aspects	Findings
Identification of disability-friendly readiness for JKN healthcare facilities	A. Availability of standard operation procedure (SOP) for disability-friendly JKN services	Almost all of the visited primary and secondary healthcare providers did not have specific Standard Operating Procedures (SOPs) for disability-friendly JKN services. However, a few numbers of primary and secondary healthcare providers already have these SOPs, based on their own initiatives and innovations.
	B. Availability of disability-friendly infrastructure of JKN healthcare providers	Most of the visited primary and secondary healthcare providers have provided dedicated infrastructure aimed at patients with disabilities. However, the availability of these infrastructure facilities is not designed according to certain standards.
	C. Availability of trained health personnel for disability-friendly services	Very few primary and secondary healthcare providers, less than 8%, have provided trained health personnel with the necessary skills to communicate and deliver healthcare services for persons with disabilities.

Minutes from the FGDs of this study explain that this was considered normal since there are no technical guidelines from the Ministry of Health or related agencies (Anggent et al., 2021). Accreditation of healthcare facilities by the Ministry of Health also does not include indicators for assessing disability-friendly health facilities.

Despite this, a few healthcare providers have implemented some initiatives to provide disability-friendly services, such as the provisions of SOPs for disability-friendly healthcare services and dedicated physical infrastructure for disabled patients. Provisions of specific healthcare facilities for disabled patients by primary and secondary healthcare providers were basically voluntary and self-funded.

While central government-owned public hospitals are usually better equipped with infrastructure facilities that meet the minimum service standards for persons with disabilities, local government-owned and private hospitals have rather limited disability-friendly infrastructure. These latter hospitals, however, typically have a higher number of disabled patients, especially in their psychiatric clinics.

Next, we observed that some healthcare providers’ facilities were not entirely

disability-friendly, lacking handicapped stairs and disabled toilets. Moreover, it was rare for health personnel at both primary and secondary healthcare providers to have training and certification for disability-friendly healthcare services. Training and certification for sign language skills were also not delivered regularly.

Often, there were gaps of perception between primary and secondary healthcare providers in implementing the referral processes for patients with disabilities. As a result, the principle of service portability has not been effectively implemented due to inadequate information on the transfer procedures for patients and staff at primary healthcare providers.

Another important finding during the field observations was that the number of disabled patients visiting the healthcare providers had not been monitored by the JKN administration system. All JKN members are registered without being identified as disabled or non-disabled patients. As a result, healthcare personnel were unable to conduct monitoring, evaluation, and follow-up interventions needed for a continuing healthcare package for disabled patients.

This study also found important findings related to the provision of special healthcare services for persons with disabilities in two rehabilitation centers. The two rehabilitation centers, namely Kartini Rehabilitation Center and Prof. Dr. Soeharso Rehabilitation Center, are both operated with the support of the Ministry of Social Affairs. Kartini Rehabilitation Center is a mental health rehabilitation center in Temanggung Regency, Central Java Province. Prof. Dr. Soeharso Rehabilitation Center is a physical rehabilitation center in Surakarta City, Central Java Province. These rehabilitation centers are primarily focused on pre- and post-medical rehabilitation interventions.

Despite having certified personnel in special needs healthcare services, the provisions of health services in the two rehabilitation centers were not integrated into the JKN program. Therefore, disabled patients in the two centers cannot be facilitated by the JKN program. Staff and administrators at these two centers also had a lack of knowledge of the JKN systems and procedures, including membership, referral system, and benefit coverage for disabled patients.

3.3. Benefits coverage issues

Figure 8 illustrates that the majority of respondents reported that JKN benefits coverage had fulfilled their expectations (75%); however, a quarter of respondents believed that certain benefits remained unmet. Specifically, the provision of assistive devices posed a significant financial burden for recipients of government contributory assistance (PBI). For instance, benefits for patients with physical disabilities were found to be limited. Only a crutch was provided, precluding the use of other mobility aids like a walker or cane, despite the necessity of customized assistive devices to patients' individual needs. Moreover, the nominal amount of support for prostheses was deemed insufficient.

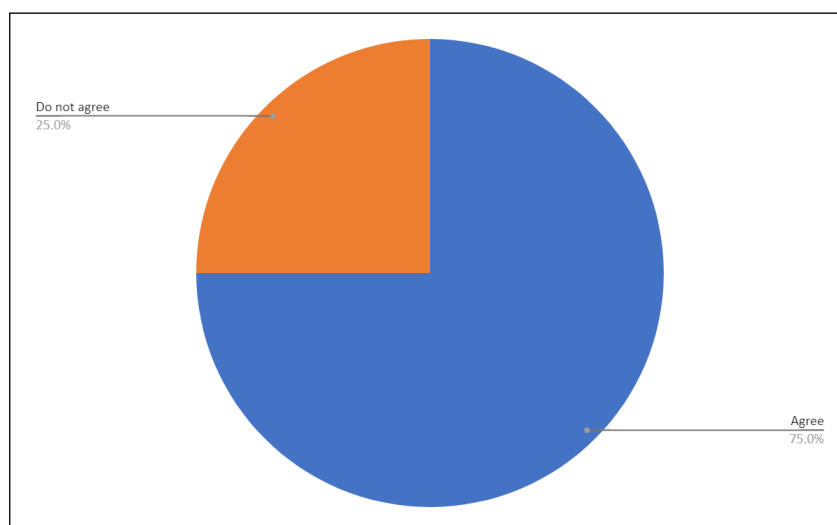


Figure 8. Coverage of JKN benefits for persons with disabilities.

3.4. Some initiatives toward disability-friendly healthcare services

The societal perspective on persons with disabilities is often framed in terms of their medical incapacity, portraying them as individuals who require constant assistance and are unable to receive an education or work assignment like other people. They are frequently referred to as a disadvantaged social group, necessitating the involvement of everyone in protecting their rights. Although government social assistance programs are often considered the foremost solution, they are not always the most effective means of accommodating persons with disabilities. In this regard, having equal access to public healthcare services is actually essential for persons with disabilities to maintain their personal health and productivity.

Policymakers often have little regard on the perspectives and specific needs of persons with disabilities, even though this is a requirement for implementing the Convention on the Rights of Persons with Disabilities (CRPD). Minutes of FGDs and the public seminar of this study highlight the urgency of doing transformation agenda of the JKN program (Anggent et al., 2021; Wibowo, 2022). In the wake of new public management, transformation agenda shall be addressed to the JKN program since it indicates the government's commitment to good governance (Carey and Matthews, 2017; Ferlie et al., 2005; Osborne and Gaebler, 1992; Piotrowska-Marczak and Kietlińska, 2001).

The following section provides some examples of initiatives toward disability-friendly healthcare services in the JKN's primary and secondary healthcare providers. A central government general hospital in Jakarta Province has demonstrated good practices in providing disability-friendly health facilities. The inclusion of the rights of persons with disabilities is evident in the hospital's special service policy, which places disabled patients separately in a special zone alongside the elderly and pregnant patients.

There are also SOPs at the hospital to designate patients with high risks or special needs, such as those who use wheelchairs, with a yellow ribbon for priority or special services in the special zone. Patients with disabilities who are unaccompanied by an escort are then assisted by security officers at the entrance and provided with a yellow

ribbon to get priority service.

All buildings in the general hospital area are accessible to persons with disabilities. Each floor of the hospital is equipped with special disabled bathrooms, and the medical rehabilitation unit has ramps, handrails, wheelchairs, and a spacious lift for wheelchair users. Health personnel at the hospital are also scheduled to attend gender-responsive training, which also incorporates disability-related topics.

The local government general hospital in Bandung City, West Java Province, has implemented a good practice of prioritizing patients with disabilities by providing them with separate queues, registration counters, and queue seats, as well as guiding blocks, and disability-friendly toilets. Moreover, there are standard operating procedures (SOPs) in place that regulate disability-friendly services, including those for disabled patients' registration and provision of drugs at the pharmacy.

In another case, a local government general hospital in Semarang City, Central Java Province, has exhibited other examples of good practices. The hospital has established disability-friendly services, which include, a designated parking area and special counters tailored to accommodate patients with Parkinson's disease.

A primary healthcare provider in Bandung City, West Java Province, demonstrates another good practice by providing disability-friendly services. They cooperate with special education schools to offer health check services for students directly at the schools and also implement disability-friendly service standards. These service standards include standardized procedures for staff-patient communications, flow of services, and medicine dispensing procedures, which are applied by all health personnel, security guards, and administrative officers.

The clinic also provides drug labels in braille to aid blind patients. Furthermore, since 2018, health personnel have undergone training on how to communicate with persons with disabilities, including how to use braille and sign language.

Next, a primary healthcare provider in Temanggung Regency, Central Java Province, has implemented a home care program for patients with mental disorders. A similar program was implemented by a primary healthcare provider in Tanjung Pinang, Kepulauan Riau Province. Interestingly, this innovative program was established as a result of feedback from town hall meetings at the sub-district level regarding the need for community services for people with mental disorders. This program has also allowed the primary healthcare provider to maintain a database of disabled patients in the four sub-districts it serves.

4. Conclusion

The current study highlights several primary findings. In general, the path to fulfilling the right to health for persons with disabilities in Indonesia is underway. Yet, in reality, five years after the enactment of law number 8 of 2016, persons with disabilities continue to face challenges when accessing public healthcare services. In this regard, the national social health insurance program (JKN) acts as the main hope for persons with disabilities concerning their rehabilitation and healthcare necessities. In general, this group belongs to socially vulnerable groups, necessitating access to the government's contributory assistance program (PBI).

There are gaps in the fulfillment of the right to health for persons with disabilities

in Indonesia. The accessibility of JKN services for disabled persons in the six provinces being studied is hindered by issues such as inadequate admission processes, inferior quality of healthcare services, and insufficient coverage of benefits.

Survey of this study revealed the presence of around ten percent of disabled persons being excluded from the JKN program. Moreover, disabled patients reported a lower level of satisfaction than the national average, indicating the unreadiness of JKN healthcare providers to deliver disability-friendly services. Yet, there have been several good practices toward disability-friendly services delivered by exemplary JKN healthcare providers. Meanwhile, a quarter of respondents testified that certain disability-specific benefits were uncovered by the JKN program.

To address the issues, policymakers must restructure the membership systems, improve the delivery of services by primary and secondary healthcare providers, and broaden the benefits coverage available to disabled groups. Certainly, there is a pressing need for strategic policies and cross-institutional coordination toward a disability-inclusive JKN program. This coordination should involve various stakeholders in Indonesia, such as the National Commission on Disabilities, the National Social Security Board, the Ministry of Social Affairs, the Ministry of Health, BPJS Kesehatan, regional governments, and civil society organizations.

Hence, the proposed transformation agenda aiming at improving public healthcare services for persons with disabilities in Indonesia includes policy interventions to ease the admission processes (data collection, verification-validation, and reactivation of membership) for persons with disabilities to the JKN program and to implement a tagging system for disabled JKN members based on their specific types of disability.

In addition, BPJS Kesehatan, as the administrator of the JKN Program, needs to stipulate technical guidelines for the disability-friendly minimum service standards of JKN healthcare providers, to include the disability-friendly minimum service standards in the credentialing systems of JKN healthcare providers, establish special primary healthcare providers for persons with disabilities in collaboration with the rehabilitation centers of the Ministry of Social Affairs, and conduct regular training on disability-friendly healthcare services for medical and administrative staffs. Last but not least, further evaluating and improving the benefits coverage for persons with disabilities (medicines, therapies, and assistive devices) as prescribed in the Indonesian Case Base Groups (INA-CBG's) are considered necessary.

Moreover, doing periodic measurements on the level of satisfaction of JKN disabled members and delivering campaigns on JKN's disability-inclusive initiatives through social media, mass media, and events, will be useful for promoting the health and well-being of persons with disabilities in Indonesia.

This study recognizes that the COVID-19 pandemic has presented notable challenges, as it may have influenced healthcare delivery and insurance utilization patterns for disabled people during the study period (2016–2021). While the core findings remain generally applicable, future research could investigate the pandemic's specific effects in greater detail.

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