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Evaluation of the Garut Regency National Health Insurance Program

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Abstract

The purpose of this study was to evaluate the National Health Insurance Program at the Garut Regency level. This study uses a mixed-method with a perception survey approach conducted on the quality of the National Health Insurance program in the Garut district. The sources of data in this study are primary data and secondary data. The data collection technique used is the questionnaire method with a data collection range of January-February 2021 with the questionnaire method and in-depth interviews. The unit of analysis in this study is the service provided to patients at the First Level Health Facility in Garut district. Determination of the sample using purposive random sampling method with criteria as patients who receive tiered referral services. Based on the results of research and analysis, it can be seen that: 1) The evaluation of the National Health Insurance program at the Garut Regency level is considered quite good with an index value of 3.05 (Enough), and the service model achievement indicator obtains an index value of Enough; 2) Based on the results of interviews with respondents, it shows that there are several health service problems, including the lack of understanding of the participants of the Health Social Security Administering Body on the service procedures applied, the socialization of the program has not been thoroughly carried out to the community; and 3) The service quality of the Health Social Security Administering Body in Garut district is considered quite good.

Keywords
evaluation; national health insurance; program

I. Introduction

Health is one of the human rights. The guarantee of health aspects is the government's obligation to its citizens, especially to citizens who lack access to quality health services due to the influence of economic incapacity (Faulina et al., 2017). The National Health Insurance Program, which was launched by the government on January 1, 2014, to improve the community's welfare in the health sector, is like having two sides of a coin. On the one hand, it makes it easy for the district to feel health insurance, but on the other hand, it provides a burden because the existing health insurance is not offered for free; there is a price paid to get health services (Utami & Mutiarin, 2017). Equitable distribution of every citizen, such as Law Number 36 of 2009 concerning Health, emphasizes that health development is carried out based on the principles of benefit, balance, protection, respect for rights and obligations, justice, humanity, gender and non-discrimination (Akbar, 2020).

In 2000, for the first time, the word "health" was included in the 1945 Constitution in article 28H, which was the result of an amendment in 2000 "...every citizen has the right to health services." This, of course, is a guarantee of health rights for all

Indonesian people following the Declaration of Human Rights by the United Nations in 1947 (Martin et al., 2018). Service is an invisible activity (cannot be touched) that occurs due to interactions between consumers and employees or other things provided by service providers that are intended to solve consumer or customer problems (Sudrajat, 2020).

At the beginning of 2014, the operation of the Health Social Security Administering Body implemented legal health insurance in Indonesia. Health insurance is a fundamental form of social protection for all citizens to obtain their basic rights and needs (Kim et al., 2018). The Social Security Administration for Health is a transformation of Askes Ltd. (Limited Company). The consequences of this include: 1) The Ministry of Health no longer provides health insurance programs for the community; 2) The Ministry of Defense, the Indonesian National Armed Forces, and the Indonesian National Police are no longer providing health programs for their members, except for operational purposes; 3) PT. Jamsostek no longer runs a health social security program. With this change, participants of the previously held health insurance program were transferred to health insurance participants managed by the Health Social Security Administering Body (Karim et al., 2018). Mu'rifah in Hasibuan et al (2019) stated about personal health, namely that someone will try to maintain andincrease their own level of health in order to achieve peace of life and have the best workforce.

Today's development has included empowerment as one that is prioritized in building a nation. This situation is interpreted as the existence of power or autonomy given by the government to the community in order to be able and independent in determining goodness for themselves, or in other words that there is openness from the government to accommodate various kinds of initiatives from groups that are considered to experience powerlessness or vulnerability (Adiwijaya et al, (2018).

There are several benefits from using the Health Social Security Administering Body, including 1) Health insurance participants receive health insurance which includes primary, secondary and tertiary facilities, both owned by the government and the private sector in collaboration with the Social Security Administering Agency; 2) Ensure medical health from service administration, examination, treatment and consultation of a person's medical to non-medical such as accommodation and ambulance; 3) Non-specialistic media actions, both operative and non-operative, then blood transfusion services according to medical needs; 4) Health insurance benefits are individual health services, including promotive, preventive, curative and rehabilitative services. Promotional and preventive services include providing services, individual health counselling, primary immunization, family planning and diagnostic screening, first-level laboratory and first-level inpatient services according to disease complaints, and 5) Guaranteeing health services for five family members, including contributors (Ardita, 2020).

The fact is that in Presidential Decree No. 23/2013 concerning National Health Insurance, several articles are discriminatory, do not respect the health rights of the people, especially the poor, and do not consider the current situation and condition of health care facilities in Indonesia. Almost 4 (four) years of implementing the National Health Insurance program. As the sole organizer, the Social Security Administration is sought to accommodate the systematic implementation of the National Health Insurance program to fulfil the law's mandate. However, it is undeniable that various weaknesses still occur in its operations. Of course, the young age of the Social Security Administering Body cannot be used as an excuse considering that the Health Social Security Administering Body is a transformation from a business entity that was previously also engaged in health insurance (Wulandari et al., 2020).

The increase in fees charged to the public has also become a polemic of its own, following Presidential Regulation Number 19 of 2016 concerning the Second Amendment to Presidential Regulation Number 12 of 2013 concerning Health Insurance. So that starting April 1, 2016, the contribution of the National Health Insurance participants for both the wage-earning workers and the non-wage worker participants has increased. The increase is reasonable to reduce the payment claims deficit, besides the hope to improve the quality of service (Dahlan et al., 2017).

For example, in Garut Regency, poor patients still do not want to use the Community Health Insurance card for fear of being rejected by the hospital. The reasons for refusal are usually like the bed is complete, medical equipment is not available, there is no doctor or medicine for what the patient needs. Based on data obtained from the Social Security Administration of Garut Regency, from a total of 989 respondents, 47.3% still complained about poor service. Meanwhile, complaints about the benefits of doctors, nurses, other hospital staff, down payment complaints, and hospital refusal complaints were submitted respectively by 18.2%, 18.7%, 10.2% and 13.6% of poor patients.

The impact is that health services are disrupted. There are many cases where health facilities cannot provide good services due to the lack of supporting infrastructure for services (Arundel, 2017). The demand for health services increases every year (Nugraheni & Hartono, 2017). It is typical for long queues of patients who want to get health services.

This certainly has an impact on people's perceptions of health services in the National Health Insurance system. The emergence of negative perceptions from the public dramatically affects the National Health Insurance system (Tobari et al., 2019). Hopes to improve the health care system can be hampered due to poor health services received to the community (Retnaningsih, 2018). However, the rules in the tiered referral system have long been applied. However, much remains to be done. Therefore, it is essential to continuously evaluate the tiered referral system's implementation in many locations in the Garut district so that the quality of health services can be constantly improved.

II. Research Methods

This study uses a mixed-method with a perception survey approach conducted on the quality of the National Health Insurance program in the Garut district. The sources of data in this study are primary data and secondary data. Preliminary data were obtained from questionnaires and interviews with research respondents (Suebvises, 2018). At the same time, the secondary data was obtained from the literature study results and compared with previous research. The data collection technique used is the questionnaire method with a data collection range of January-February 2021 with the questionnaire method and in-depth interviews. The unit of analysis in this study is the service provided to patients at the First Level Health Facility in Garut district. Determination of the sample using purposive random sampling method with criteria as patients who receive tiered referral services. Quantitative analysis was used on the results of the questionnaires distributed to the respondents. At the same time, qualitative research was used on the results of in-depth interviews. The qualitative analysis section measures the level of patient satisfaction with implementing a tiered referral system in First Level Health Facilities.

III. Results and Discussion

3.1. Description of Research Respondents

During the January-February 2021 period, the team managed to get 70 patients receiving referral services at two First Level Health Facilities. The group felt several obstacles in collecting questionnaire data, including respondents' delay in filling out the questionnaire. The research respondent profile is presented in the following table:

Table 1. Research respondent profile

Variable	Category	Amount	Percentage
Age Group	Teenager	9	12.86
	Mature	15	21.43
	Pre Elderly	29	41.43
	Elderly	17	24.23
Gender	Male	47	61.14
	Female	23	32.86
Type of disease	Infectious	16	22.85
	Non-Infectious	54	77.15
Reason for Referral	Need for further diagnosis (non-Lab)	18	25.71
	Supporting Examination (Lab)	7	10
	Patient Request	14	20
	Hospital Control Request	21	30
	Other	10	14.29

Source: processed data

Based on the survey results above, patients who received tiered referrals were dominated by pre-elderly patients (41.43%) and elderly patients (24.23%). Meanwhile, based on gender, men dominate the percentage at 61.14%, and women at 32.86%. Based on the type of disease suffered by the patient, it was still dominated by non-communicable conditions at 77.15%. Meanwhile, the reasons for referral of most patients were overwhelmed by requests for control by the hospital by 30%.

Table 2. Audit Results Completeness and accuracy in the implementation of a tiered referral system in First Level Health Facilities

Variable	Indicator	Audit Results (%)
Reference Letter Completeness	Patient identity	100
	Hospital Name	100
	Information on the types of services required by patients at the Referral Hospital	93.2
	Diagnosis	97.5
	Reason for Referral	53.6
	Reference Date	93.1
	Instructions for reaching Referral Health Facilities	72.5
	Anamnesis	58.1
	Physical examination	52.6
	The Therapy given	31.3
Reference Accuracy	Compatibility with tiered referral system	100

Source: processed data

To analyze the quality of tiered referral services in First Level Health Facilities, this study conducted an audit of the completeness and accuracy in its implementation. The accuracy of referrals is measured by the compatibility between the referrals given to patients and the tiered referral system procedures regulated by BPJS Kesehatan (Table 2). As a result, the accuracy rate reaches 100%. All patients are referred from the First Level Health Facility to type C and type D hospitals. None of them goes directly to type B and types A hospitals.

However, in the completeness of the referral letter, there are still many patients who are referred incompletely filled with reference information by the service officer. Of the ten indicators that must be filled in, only two hands are filled in completely, namely the patient's identity and the name of the hospital or referral health facility. However, many of the other eight indicators were not filled in.

The indicator that is not filled in the most is the therapy health workers have given at the First Level Health Facility. In the results of the survey, only 31.3% of the total respondents were filled in. The physical examination results that should have been filled in also only had 53.6% filled in. The same thing happened in the indicator of referral reasons.

Many referral service officers also do not fill in the anamnesis indicator; the level of content only reaches 58.1%. Instructions on how to get referral health facilities were only filled with 72.5%. Important information, such as information on the type of service required by the patient at the referral health facility, diagnosis results, and date of referral, is only filled in between 92%-98.5%.

Table 3. The results of the questionnaire on the level of patient satisfaction with the service of the Tiered Referral System in First Level Health Facilities

Variable	Category	Low Level of Patient Satisfaction (%)		
		Low	Medium	High
Age Group	Teenager	92	2	0
	Mature	51.5	28.5	20
	Pre Elderly	15.8	33.2	51
	Elderly	32.3	39	28.7
Gender	Male	37.3	36.7	26
	Female	39.4	33.4	37.2
Type of disease	Infectious	16.3	42.9	40.8
	Non-Infectious	36.2	37.7	26.1
Reason for Referral	Need for further diagnosis (non-Lab)	37.9	36.8	25.3
	Supporting Examination (Lab)	0	57	43
	Patient Request	36.9	40.9	22.2
	Hospital Control Request	39.7	25	35.3
	Other	17.3	29.6	55.1

Source: processed data

Service quality is also measured by analyzing patient satisfaction with referral services provided by First Level Health Facilities. As a result, 34.9% of patients had a low level of satisfaction, 33.3% moderate, and 31.7% high. Based on the age group variable, all patients in the adolescent age group had a low level of satisfaction (92%), only 2% of the population had a moderate level of satisfaction. In the adult age group, the level of low satisfaction reached 51.5%. Meanwhile, in the elderly age group, the level of low satisfaction reached 32.3%. Only pre-elderly have a high level of satisfaction, reaching 51%.

Based on gender, men have a low satisfaction level of 37.3%. Only 26% have a high level of satisfaction. In contrast to men, more women have a high level of satisfaction with referral services, 37.2%. Only 39.4% have a low level of satisfaction.

Based on the type of disease, patients with infectious diseases had a high level of satisfaction as much as 40.8%, moderate happiness as much as 42.9%, and low joy as much as 16.3%. Meanwhile, patients with non-communicable diseases had a high level of satisfaction of 26.1%, moderate happiness as much as 37.7%, and low satisfaction as much as 36.2%.

Based on the reasons for referral, patients with a high level of satisfaction that reaches 50% and above are patients with supporting examinations (laboratory) and others. Meanwhile, for patients with referral reasons for further diagnosis (non-laboratory), the level of satisfaction was 37.9% low, 36.8% moderate, and 25.3% high. For referrals at patients' request, the level of low satisfaction is 36.9%, reasonable is 40.9%, and high is 22.2%. Meanwhile, for patients who requested hospital control, the level of satisfaction was 39.7% low, 25% moderate, and 35.3% high.

The increase in access to health services since the National Health Insurance has not been accompanied by an improvement in the service system, especially in referral services. The application of a tiered referral system aims to control the quality of services to be more optimal. However, the implementation is still not as expected. In a tiered referral system, the role of First Level Health Facilities is very vital. First Level Health Facilities are the first health facilities to provide services before being referred in stages. As a result, the number of patients has increased. Increased services did not match this increase at the First Level Health Facilities because the infrastructure was limited.

In addition, many health workers complain about infrastructure constraints in First Level Health Facilities. Many patients to get referral services to have to wait a long time. They have a severe illness. This is what causes low patient satisfaction with referral services based on many surveys (Szczepaniuk et al., 2020). Based on the service quality audit, the accuracy in the implementation of referrals as measured by the suitability of referrals given to patients with tiered referral service system procedures has been carried out according to the rules. This can be done because of the online system in the referral procedure that is already in effect for all First Level Health Facilities. The First Level Health Facility cannot issue referrals that are not following the system.

However, the quality audit of the completeness of the referral letter is still problematic. Although all of the reference letters were filled in, many were not filled in. This results in incomplete data and information received at Advanced Health Facilities. Health workers at Advanced Health Facilities need this data and knowledge to make appropriate and accurate medical action. The most crucial data, such as the results of the diagnosis, physical examination, anamnesis, and therapy that have been given, are information that should be included in the referral letter. However, it is the data and information that are mostly not filled in. The absence of such data causes health workers at Advanced Health Facilities not to get accurate information to take action on patients.

It must be admitted, the implementation of the tiered referral system has not run optimally. In terms of administrative procedures, this system is already sound. However, its performance is still problematic. Therefore, improvements need to be made in First Level Health Facilities. The high level of patient visits in First Level Health Facilities must be balanced with advances in human resources and service infrastructure (Busse et al., 2017). The government needs to improve human resources and infrastructure in First Level Health Facilities. These improvements are not only in quantity but also in quality. So that the service can be better and the level of community satisfaction is high.

Socialization needs to be continued to strengthen public knowledge of the tiered referral service system. The socialization can be done in First Level Health Facilities or through brochures and advertisements. What is done in the First Level Health Facility where this research is located needs to be done elsewhere.

3.2. The Service Model of the Garut Regency Health Social Security Administering Body

To analyze the respondent's assessment of the service model of the Health Social Security Administering Body, the previous researchers had made measurements with an indexing model based on the dimensions of the variables. After that, the researcher has determined the total score for the service model variable of the Health Social Security Administering Body at the First Level Health Facility of Garut Regency. The dimensions of the service model variables are public understanding of service procedures and fulfilment of service models. The results of the calculation of the service model of the Health Social Security Administering Body in Garut Regency are presented in the following table:

Table 4. Service model variable assessment

Service Model Dimension Items	SD	D	N	A	SA	Indeks	Interpretation
Service Procedure	6	23	42	29	5	3.05	Enough
Service Model Impact	7	21	35	31	11	3.19	Enough
Total	14	43	75	58	15		Enough
Service Index						3.09	Enough

Source: processed data

The service procedure is one of the most critical indicators in evaluating the service model of the Health Social Security Organizing Agency program in Garut Regency. Based on the table above, it can be seen that the index value for the service procedure was found to be included in the excellent category. The problem found by researchers in the service procedure is that people are often confused with the services provided at First Level Health Facilities.

The Health Social Security Administering Body is still experiencing problems in serving because not all people who use the Health Social Security Administering Body understand the applied treatment flow. However, the Health Social Security Administering Body continues to provide services according to the laid procedures. It is still facilitating its objectives so that National Health Insurance participants know the steps to take when receiving treatment.

In the service procedure of the Health Social Security Administering Body in Garut district using a tiered referral pattern, or the level of health facilities, namely National Health Insurance participants who wish to seek treatment must go through first-level health facilities except for emergency patients who can choose the closest health facility (de Moor et al. 2018). If the First Level Health Facility cannot do so, it will be referred to an advanced level health facility.

Following the existing procedures, the first-level facility service procedure at the Health Facility has been running well, following the targets achieved. The process for the service program of the Social Security Health Insurance Program in Garut Regency can be said to be well fulfilled. However, in the service model that runs, some people still do not fully understand because of the lack of socialization. Although the socialization is still

ongoing, the feedback from the socialization has not yet felt its overall impact on the community (Zhao et al., 2018).

The hospital admits that until now, socialization is still being carried out by going directly to the community, or through media such as pamphlets attached to health centres and hospitals, or on the internet, which is published now from the official website of the Garut Regency Health Social Security Organizing Agency. So, based on the analysis above, it can be said that the public's assessment of the service procedure is said to be sufficient with an assessment index of 3.05. The problem found is the lack of understanding of the community with service procedures and the socialization program of the Health and Social Security Organizing Agency that has not reached the target to provide knowledge to the public. Respondents' assessment of service quality variables is presented in the following table:

Table 5. The level of respondents' assessment of the service quality variable

Service Facilities	SD	D	N	A	SA	Index	Interpretation
Facility Availability	2	20	40	37	6	3.26	Enough
Completeness of Facilities	4	21	39	32	9	3.22	Enough
Service Executor	4	16	33	47	5	3.34	Enough
Service Implementing Effectiveness	4	30	27	29	15	3.22	Enough
Implementing Cooperation	2	14	33	47	9	3.48	Good
Courtesy in Service	2	12	30	50	11	3.57	Good
Communication and Information	3	10	47	24	21	3.51	Good
Service Quality Index							Enough

Source: processed data

Based on the data above, it can be seen that the service quality of the Health Social Security Administering Body in Garut Regency can be seen from several indicators, including:

a. Availability and Completeness of Health Facilities

In the Availability of Service Facilities indicator, there are two assessments: the availability of health facilities and the completeness of health facilities; what is meant by availability are facilities available to participants of the Health Social Security Administering Body at First Level Health Facilities. The community's assessment of the availability of facilities is 3.26, which can be categorized as sufficient. Meanwhile, completeness of facilities is complete facilities and infrastructure that support treatment for participants of the Health and Social Security Administering Body. According to the community's assessment, the completeness of health facilities is categorized as adequate, which scores 3.22.

The availability of these facilities includes medical equipment, administration, and the availability of drugs in hospitals and health centres. Some problems indicate that the community considers the First Level Health Facilities in Garut Regency to lack the availability of health facilities. Participants cannot distinguish between categories of health facilities applied by the Health Social Security Administering Body. The Health Social Security Administration Agency system uses three types of health facilities, according to the SJSN Law number 40 of 2004, to develop an effective and efficient system. What can be served at the lower type of health facilities may not go directly to the Advanced Health

Facilities. Thus, if there are patients who cannot be treated at the hospital because some health facilities and infrastructure are not available, then the patient will be referred to an advanced level of health facility. Health facilities are sufficient and following health service standards (Tobari et al., 2019). The First Level Health Facilities have also provided supporting facilities that offer comfort in service, especially for the Health Social Security Administering Body participants.

Health facilities or medical equipment are also available and following the standards specified in the First Level Health Facility. However, the First Level Health Facility does not provide medical equipment for certain diseases, so participants who cannot be treated at the First Level Health Facility will be referred to an advanced health facility with facilities for treating conditions that cannot be treated at the First Level Health Facility.

b. Reliability

Reliability is one indicator that refers to officers and skills/responsiveness in providing services. In the reliability indicator, there are two assessment models: an assessment of the implementation by officers and the ability of officers to serve. The evaluation of the performance of duties and obligations in providing services gets an index value of 3.33 and 3.38 on the skills of officers in delivering services.

The problems found by the author are related to the issues of implementing services that are not following the specified schedule. According to one patient, sometimes First Level Health Facilities do not receive assistance before the treatment schedule is completed (Zhao et al., 2018). This problem is one of the factors that cause the assessment of the participants of the National Health Insurance to be categorized as sufficient.

c. Responsiveness

Responsiveness is an indicator that explains the effectiveness of the Health Social Security Administering Body at First Level Health Facilities. Participants in the National Health Insurance assess the effectiveness of the services provided by the Health Social Security Administering Body officers at 3.22. This shows that the efficacy is categorized as moderate.

The problem found by researchers is that patients complain of long queues at the administration. One of the problems in health workers is the shortage of officers in the service. Administrative matters sometimes serve as medical officers concurrently serving administration so that health services are disrupted. Service personnel are sufficient because there is cooperation from the BLUD (Regional Public Service Agency), which provides officers at First Level Health Facilities in Garut Regency. The problem of shortages experienced is in the personnel who take care of the Health Social Security Administering Body.

d.Empathy

The empathy indicator is an assessment of the participants of the National Health Insurance on the politeness and communication (completeness of supporting tools) provided by the service officer. The empathy indicator obtained an index of 3.57 on refinement in service, while on contact and information, an index of 3.51 so that both assessments were included in the excellent category.

Health workers have provided services to National Health Insurance participants according to the Health Social Security Administering Body standards. Service support tools have also been fulfilled to improve service quality, such as speakers, monitors, and room tags. So health workers have met the service quality standard, namely empathy

(Hadiyati et al., 2017). So overall, the highest level of community assessment is on the empathy indicator, especially on politeness in service, while the smallest value is on the tangible and responsiveness indicator. The total index calculation on the service quality variable is 3.37, which is included in the excellent category.

IV. Conclusion

Based on the results of research and analysis, it can be seen that: 1) The evaluation of the National Health Insurance program at the Garut Regency level is considered quite good with an index value of 3.05 (Enough), and the service model achievement indicator obtains an index value of Enough; 2) Based on the results of interviews with respondents, it shows that there are several health service problems, including the lack of understanding of the participants of the Health Social Security Administering Body on the service procedures applied, the socialization of the program has not been thoroughly carried out to the community; and 3) The service quality of the Health Social Security Administering Body in Garut district is considered quite good.

References

Adiwijaya, S., et al. (2018). Empowerment Pattern for Thalasemi Patients in Dr. Soetomo Hospital Surabaya (Study of the Association of Parents with Thalassemia Indonesia, Surabaya). Budapest International Research and Critics Institute-Journal (BIRCI-Journal), P. 289-298.

Akbar, M. I. (2020). Studi Implementasi Program Jaminan Kesehatan Nasional Di Kabupaten Muna. Jurnal Kesehatan Masyarakat Celebes, 1(03), 21-27.

Ardita, M. (2020). Tanggung Jawab Negara Terhadap Jaminan Kesehatan Dalam Perspektif Hak Asasi Manusia. Jurnal HAM, 11(2), 319-33.

Arundel, A. (2017). Rethinking the effect of risk aversion on the benefits of service innovations in public administration agencies. Research Policy, 46(5), 900-910.

Busse, R., Blümel, M., Knieps, F., & Bärnighausen, T. (2017). Germany's statutory health insurance is a health system shaped by 135 years of solidarity, self-governance, and competition. The Lancet, 390(10097), 882-897.

Dahlan, M., Setyopranoto, I., & Trisnantoro, L. (2017). Evaluasi Implementasi Program Jaminan Kesehatan Nasional terhadap Pasien Stroke di RSUP Dr. Sardjito. Jurnal Kebijakan Kesehatan Indonesia: JKKI, 6(2), 73-82.

de Moor, J. S., Cohen, R. A., Shapiro, J. A., Nadel, M. R., Sabatino, S. A., Yabroff, K. R., ... & Klabunde, C. N. (2018). Colorectal cancer screening in the United States: trends from 2008 to 2015 and variation by health insurance coverage. Preventive medicine, 112, 199-206.

Faulina, A. C., Khoiri, A., & Herawati, Y. T. (2017). Kajian Pelaksanaan Sistem Rujukan Berjenjang dalam Program Jaminan Kesehatan Nasional (JKN) di UPT. Pelayanan Kesehatan Universitas Jember. IKESMA, 12(2).

Firdaus, K. K., & Wondabio, L. S. (2019). Analisis Iuran dan Beban Kesehatan dalam Rangka Evaluasi Program Jaminan Kesehatan. Jurnal ASET (Akuntansi Riset), 11(1), 147-158.

Hadiyati, I., Sekarwana, N., Sunjaya, D. K., & Setiawati, E. P. (2017). Konsep Kualitas Pelayanan Kesehatan berdasar atas Ekspektasi Peserta Jaminan Kesehatan Nasional. Majalah Kedokteran Bandung, 49(2), 102-109.

Hasibuan, S. W., et al. (2019). The Effect of Health and Religious Beliefs on Consumer Consciousness of Using Halal Cosmetics. Budapest International Research and Critics Institute-Journal (BIRCI-Journal) Volume 2, No 3, Page: 239-249.

Karim, M. I. T., Moenta, A. P., & Riza, M. (2018). Implementasi Kebijakan Pemerintah Daerah di Bidang Kesehatan Masyarakat Melalui Jaminan Kesehatan Nasional. Amanna gappa, 53-63.

Kim, D., Yang, P. S., Jang, E., Yu, H. T., Kim, T. H., Uhm, J. S., ... & Lip, G. Y. (2018). 10-year nationwide trends of the incidence, prevalence, and adverse outcomes of non-valvular atrial fibrillation national health insurance data covering the entire Korean population. American heart journal, 202, 20-26.

Martin, D., Miller, A. P., Quesnel-Vallée, A., Caron, N. R., Vissandjée, B., & Marchildon, G. P. (2018). Canada's universal health-care system: achieving its potential. The Lancet, 391(10131), 1718-1735.

Nugraheni, W. P., & Hartono, R. K. (2017). Analisis Pola Layanan Kesehatan Rawat Jalan pada Tahun Pertama Implementasi Program Jaminan Kesehatan Nasional (JKN). Media Penelitian dan Pengembangan Kesehatan, 27(1), 9-16.

Retnaningsih, H. (2018). Prinsip PortabilitasDalam Program Jaminan Kesehatan Nasional (Studi Di Kota Jambi Provinsi Jambi Dan Kota Banjarmasin Provinsi Kalimantan Selatan). Jurnal Masalah-Masalah Sosial, 9(2), 153-72.

Sudrajat, T. (2020). Perlindungan Hukum dan Pemenuhan Hak Pekerja pada Program Jaminan Kesehatan Nasional. Pandecta Research Law Journal, 15(1), 83-92.

Suebvises, P. (2018). Social capital, citizen participation in public administration, and public sector performance in Thailand. World Development, 109, 236-248.

Szczepaniuk, E. K., Szczepaniuk, H., Rokicki, T., & Klepacki, B. (2020). Information security assessment in public administration. Computers & Security, 90, 101709.

Tobari, A., Muhsin, B., & Widodo, R. (2019). Implementasi Kebijakan Program Jaminan Kesehatan Masyarakat Di Puskesmas Batu Desa Pesanggrahan Kecamatan Batu. Respon Publik, 13(5), 48-52.

Utami, A. N. F., & Mutiarin, D. (2017). Evaluasi Program Jaminan Kesehatan Nasional Pada Fasilitas Kesehatan Tingkat I Kabupaten Sleman Tahun 2016. Journal of Governance and Public Policy, 4(1), 39-70.

Wulandari, A., Syah, N. A., & Ernawati, T. (2020). Faktor-Faktor yang Mempengaruhi Kepatuhan Peserta Mandiri Dalam Pembayaran Iuran Program Jaminan Kesehatan Nasional di Kota Solok. Jurnal Kesehatan Andalas, 9(1), 7-17.

Zhao, G., Okoro, C. A., Li, J., & Town, M. (2018). Health insurance status and clinical cancer screenings among US adults. American journal of preventive medicine, 54(1), e11-e19.