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Public Policy Evaluation of Free Health Social Security: Social Equity, Governance, and Access in Maluku Province

Fajar Pelu[1], Mohammad Arsyad Rahawarin[2], Hengki Virgo Rihcardo Pattimukay[3]
Department of Public Administration, Faculty of Social and Political Sciences, Pattimura University, Ambon, Indonesia

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ABSTRACT

Purpose of the study: This study evaluates the implementation of the free public health insurance program managed by the Maluku Provincial Health Office, focusing on policy performance, social equity, governance capacity, and access for low-income and vulnerable communities in an archipelagic setting.

Methodology: This study employed a descriptive qualitative approach with a public policy evaluation design. Data were collected through observation, in-depth semi-structured interviews, and document analysis. Informants were selected purposively from health officials, program administrators, and beneficiary communities. Data were analyzed through data reduction, thematic categorization, data display, conclusion drawing, and source triangulation.

Main Findings: The program reduces financial barriers and improves formal access to health services for disadvantaged groups. Administrative performance is relatively effective, particularly through same-day activation and interagency verification mechanisms. However, fiscal limitations, uneven health infrastructure, data governance problems, weak information dissemination, and geographic fragmentation across islands continue to limit substantive equity.

Novelty/Originality of this study: This study provides a theory-based evaluation of provincial-level health insurance implementation using William N. Dunn's policy evaluation framework. It explicitly links effectiveness, efficiency, adequacy, equity, responsiveness, and accuracy to welfare state theory, social protection, distributive justice, decentralized governance, and spatial access in an archipelagic region.

Corresponding Author:
Fajar Pelu,
Department of Public Administration, Faculty of Social and Political Sciences, Pattimura University, Ir. M. Putuhena Street, Poka Campus, Ambon, Maluku, Postal Code 97233, Indonesia
Email: pelufajar02@gmail.com

1. INTRODUCTION

Health is a condition of physical, mental, and social well-being and is not limited to the absence of disease. Because health affects citizens' ability to participate in social and economic life, access to health services should be understood as a basic social right rather than merely an individual responsibility [1]. In Indonesia, the right to health is constitutionally recognized, and the state is responsible for providing health service facilities and public service facilities. This obligation is further strengthened through the Health Law, which positions health services as part of public welfare and national development [2], [3].

The National Social Security System and the Social Security Administering Body for Health provide the institutional foundation for national health insurance. Under these regulations, health insurance is implemented through social insurance principles, contribution assistance, risk pooling, and government support for poor and vulnerable groups [4]-[7]. Universal health coverage emphasizes access to needed health services without financial

hardship. International studies show that health financing reforms, prepaid pooling, and subsidized insurance can improve service utilization and financial protection, but they also warn that coverage expansion does not automatically eliminate inequity when infrastructure, purchasing, and local governance remain weak [8]-[13].

Indonesia's National Health Insurance has become one of the largest social health insurance programs in the world. Prior studies show that National Health Insurance and earlier subsidized insurance schemes have increased utilization and strengthened financial protection, yet implementation continues to face political, fiscal, administrative, and regional disparities [14]-[18]. The research gap addressed in this study is the limited attention given by previous scholars to provincial implementation of free health insurance in archipelagic and geographically fragmented regions. Specifically, the studies of Tangcharoensathien et al. [12], Agustina et al. [14], Pisani et al. [15], Sparrow et al. [16], Erlangga et al. [17], Pinto et al. [18], Hsiao and Shaw [19], and Berman [20] provide important evidence on health financing, national insurance expansion, reform design, and financial protection, but they do not sufficiently explain how provincial governments translate free health insurance into substantive access in island regions where transportation, health workforce distribution, and administrative data systems are uneven.

This gap is also connected to policy implementation and evaluation theory. Dunn's public policy evaluation framework emphasizes effectiveness, efficiency, adequacy, equity, responsiveness, and accuracy as evaluative criteria for assessing whether public programs solve public problems [21]. Program evaluation scholars further argue that policy performance must be judged not only by outputs but also by outcomes, utilization, institutional feasibility, and the match between policy instruments and citizens' needs [22]-[24].

Implementation studies also show that formal policy design can diverge from practice because of bureaucratic discretion, resource constraints, interorganizational coordination, and local capacity [25], [26]. These concerns are particularly relevant for Maluku Province, where dispersed islands, high transportation costs, unequal health facilities, and limited administrative reach shape the experience of program beneficiaries.

The theoretical basis of this study combines welfare state theory, social protection, and distributive justice. Welfare state theory views publicly funded health insurance as a redistributive institution that protects citizens from social risks [27], [28]. Distributive justice and capability-based perspectives emphasize that equal rights must be supported by real opportunities to access services [29]-[31]. Social protection theory further highlights the role of public programs in reducing vulnerability and preventing households from falling into poverty after health shocks [32], [33].

Access is also multidimensional. It includes availability, affordability, accessibility, accommodation, acceptability, and the empowerment of citizens to use available services [34]-[37]. In decentralized systems, local decision space, fiscal capacity, and administrative coordination affect whether national policy objectives can be achieved at the subnational level [38]-[41]. Therefore, this study aims to evaluate the implementation of the free Health Social Security policy in Maluku Province by examining its effectiveness, efficiency, adequacy, equity, responsiveness, and accuracy, with particular attention to social justice and access in an archipelagic context.

2. RESEARCH METHOD

2.1. Research Design and Approach

This study employed a descriptive qualitative research design with a public policy evaluation approach. Qualitative inquiry was selected because the study examines implementation processes, institutional practices, beneficiary experiences, and contextual barriers that cannot be fully captured through numerical indicators alone [42]-[45]. The evaluation approach was guided by Dunn's criteria of effectiveness, efficiency, adequacy, equity, responsiveness, and accuracy [21]. These criteria were used as sensitizing concepts for developing interview questions, observation points, document review categories, and thematic analysis.

2.2. Research Location and Time

The research was conducted at the Maluku Provincial Health Office, located on Jl. Dewi Sartika, Karang Panjang, Ambon City, Maluku Province. The location was purposively selected because the institution has formal authority in administering, supervising, coordinating, and evaluating the free Health Social Security program at the provincial level. The research was implemented after the proposal had been presented and approved. Field activities covered observation, interviews, document collection, data verification, and analytical interpretation.

2.3. Research Subjects and Informants

The research subjects consisted of policymakers, program administrators, and community beneficiaries who were directly involved in or affected by the implementation of the free Health Social Security program. Informants were selected using purposive sampling to ensure relevance and information richness. They included the Head of the Referral Health Services Section as the main informant, the Manager of the National Health Insurance Program as the key technical informant, and three community members who had accessed free health

insurance services as beneficiary informants. This composition enabled triangulation between administrative perspectives and citizen experiences, as recommended in qualitative health research reporting standards [46]-[49].

2.4. Data Sources and Data Collection Instruments

This study used primary and secondary data. Primary data were obtained through field observations and in-depth semi-structured interviews. Secondary data were collected from official documents, regional regulations, program guidelines, budget information, reports, books, scientific articles, and relevant legislation. The instruments were designed around the evaluation criteria and were used to maintain consistency across data sources.

Table 1. Research instrument grid

No.	Data source	Instrument	Indicator focus	Function/output
1	Program officials and administrators	Semi-structured interview guide and audio recorder	Effectiveness, efficiency, accuracy, coordination, fiscal constraints	Verbal data on implementation process and institutional constraints
2	Beneficiary communities	Semi-structured interview guide	Adequacy, equity, responsiveness, access barriers, perceived benefits	Citizen experience and service access information
3	Field setting and service environment	Observation sheet and field notes	Service flow, administrative practice, information availability, facility context	Contextual evidence to verify interview data
4	Policy and administrative documents	Documentation checklist	Legal basis, budget information, beneficiary data, program reports	Secondary data for triangulation and policy context
5	Cross-source verification	Triangulation matrix	Consistency between interviews, observation, and documents	Credibility check and thematic validation

2.5. Data Analysis Techniques

Data analysis followed qualitative procedures consisting of data reduction, coding, categorization, data display, conclusion drawing, and verification [43], [47]. Interview transcripts, observation notes, and documents were coded according to the six evaluation indicators and cross-cutting themes such as social justice, fiscal capacity, intergovernmental coordination, spatial access, and data accuracy. Credibility was strengthened through source triangulation, method triangulation, and consistency checks between administrative information and beneficiary narratives [46], [48], [49].

2.6. Research Procedures

The research procedures were carried out systematically. The study began with problem identification and formulation of research objectives, followed by a literature review, construction of the theoretical framework, preparation and validation of instruments, field data collection, data organization, coding, interpretation, verification, conclusion formulation, and preparation of the revised manuscript. The procedure is summarized in Figure 1.

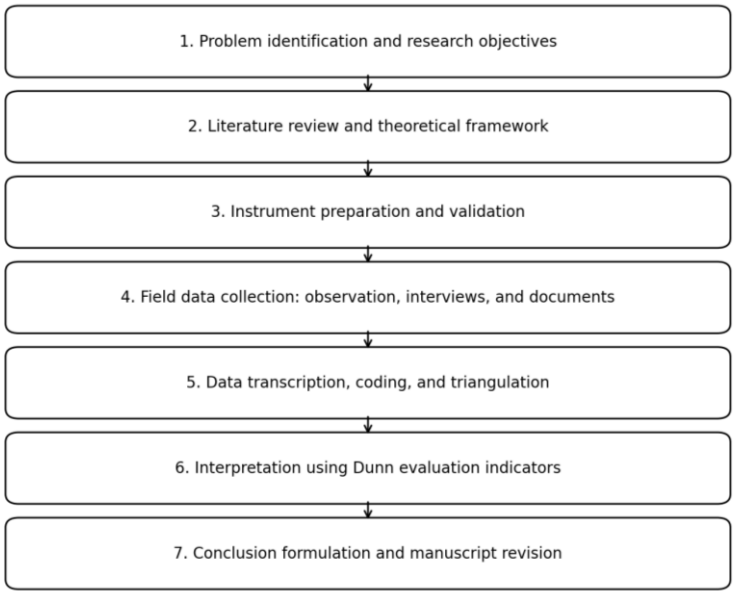

Figure 1. Research Procedure Flowchart

3. RESULTS AND DISCUSSION

This section evaluates the implementation of the free Health Social Security policy managed by the Maluku Provincial Health Office. The analysis applies Dunn's policy evaluation criteria and connects the empirical findings with theories of welfare state responsibility, social protection, distributive justice, decentralization, and spatial access [21]-[24], [27]-[41]. The discussion also considers Indonesia's Universal health coverage and National Health Insurance context, where formal coverage has expanded substantially but regional disparities remain a major policy challenge [14]-[18].

3.1. Effectiveness

Effectiveness refers to the extent to which policy objectives are achieved [21], [22]. The primary objective of the free Health Social Security policy in Maluku Province is to expand access to health services for low-income and vulnerable communities. The findings show that the policy has been effective in reducing direct financial barriers because eligible beneficiaries do not have to pay monthly contributions or bear direct service costs at the point of care.

This achievement is consistent with the logic of Universal health coverage, which emphasizes financial protection and service access [8]-[13]. For poor households, the elimination of contribution payments reduces the risk of catastrophic health expenditure and strengthens social protection against illness-related poverty [32], [33]. The same-day activation mechanism through Universal health coverage Priority also increases practical effectiveness because beneficiaries who require urgent treatment can activate membership quickly.

However, effectiveness should not be measured only by formal coverage. Access literature emphasizes that real access depends on the fit between citizens and health systems, including geographic accessibility, facility availability, affordability of indirect costs, and acceptability of services [34]-[37]. In Maluku, formal inclusion is stronger than substantive access because beneficiaries in remote islands still face transportation barriers, limited health facilities, shortages of health personnel, and uneven referral capacity. Therefore, the program is effective in expanding formal coverage, but its effect on actual service utilization remains spatially uneven.

3.2. Efficiency

Efficiency concerns the relationship between resources used and results achieved [21], [24]. Administratively, the program shows moderate efficiency. Health Office staff understand verification procedures, participant registration, referral coordination, and communication with Social Security Administering Body for Health. Coordination between the Health Office, hospitals, and program administrators reduces administrative delays, especially in Ambon City.

Nevertheless, fiscal and geographic conditions reduce overall efficiency. Decentralization studies show that local governments operate within different decision spaces, resource bases, and institutional capacities [38]-[41]. In an archipelagic province, service delivery costs are higher because of sea transportation, dispersed settlements, and uneven health infrastructure. As a result, equal program standards require greater resources than in compact mainland regions.

For low-income citizens in remote islands, inefficiency is experienced as longer travel time, additional transportation expenses, delayed referral, and dependence on limited facilities. This shows that administrative efficiency at the provincial office level does not automatically translate into beneficiary-level efficiency. Efficiency improvements must therefore include fiscal equalization, logistics planning, inter-island referral support, and integration of provincial health data systems.

3.3. Adequacy

Adequacy assesses whether the policy response is sufficient to solve the problem faced by the target group [21], [22]. The findings indicate that the policy is financially adequate for reducing direct contribution burdens. Beneficiaries can access primary and referral services without monthly premiums, which is important for households with unstable income and limited savings.

However, adequacy also depends on whether the benefits are sufficient in relation to citizens' real needs. International evidence shows that health insurance improves utilization and financial protection when it is supported by available services, responsive providers, and functioning referral systems [10]-[13]. In Maluku, adequacy is weakened by uneven availability of hospitals, specialist doctors, medicine, emergency transport, and diagnostic equipment in remote areas.

From a distributive justice perspective, formal equality of coverage is not enough when citizens face unequal starting points [29]-[31]. Poor households in remote islands experience double vulnerability: economic poverty and geographic isolation. Therefore, the policy is adequate as a financing instrument, but it remains incomplete as an access instrument unless accompanied by health infrastructure development, stronger referral transport, and targeted investment in underserved islands.

3.4. Equity

Equity refers to fairness in the distribution of policy benefits and burdens [21], [22]. The policy promotes vertical equity because public resources are directed toward poor and vulnerable groups through contribution assistance. This is consistent with welfare state and social protection theory, which justify redistribution toward citizens who face higher social risk [27], [28], [32], [33].

In urban centers such as Ambon City, equity is relatively more visible because beneficiaries have better physical access to health centers, hospitals, administrative offices, and information channels. In these locations, the program enables poor households to access services that would otherwise be financially difficult.

However, horizontal inequity remains a serious problem. Citizens with equal entitlement experience unequal practical access because of territorial disadvantage. Spatial access theory explains that service proximity, transportation time, and provider distribution shape the real opportunity to use care [34]-[37]. In Maluku, remote island communities face higher indirect costs, fewer health workers, and weaker referral options. As a result, the policy reduces financial inequality but has not fully overcome spatial inequality. True equity requires territorially sensitive budgeting, mobile services, inter-island referral subsidies, and stronger coordination between provincial and district governments.

3.5. Responsiveness

Responsiveness refers to the extent to which policy implementation responds to citizens' needs, expectations, and complaints [21], [23]. The findings show that beneficiaries appreciate free contributions, simplified access, and same-day activation, particularly when urgent care is required. These elements strengthen public trust because citizens perceive that the state is present in protecting basic health rights.

Nevertheless, responsiveness is uneven. Some beneficiaries reported long waiting times, medicine limitations, inconsistent service quality, and insufficient information dissemination. Access studies remind that responsiveness is not only about affordability but also about accommodation, acceptability, and the ability of service systems to adapt to users' constraints [34], [37].

Information gaps are especially important in remote islands where internet connectivity, outreach activities, and administrative support are limited. When eligible residents do not understand registration procedures, activation requirements, or referral rules, they cannot fully exercise their social rights. This condition creates informational injustice. Improving responsiveness requires regular socialization, complaint-handling mechanisms, digital and non-digital communication channels, and community-based assistance through village and health center networks.

3.6. Accuracy

Accuracy concerns whether the policy is properly targeted and implemented according to its intended objectives [21], [22]. The program demonstrates relatively strong targeting because eligibility is verified through administrative instruments such as the Certificate of Inability to Pay, civil registration data, and coordination with relevant government agencies. These mechanisms are intended to ensure that public subsidies reach poor and vulnerable residents.

However, data governance remains a challenge. Duplicate identification numbers, incomplete civil documents, migration, and delayed updating of beneficiary data can produce inclusion and exclusion errors. These problems are common in social protection systems when administrative capacity and data interoperability are uneven [32], [33]. In archipelagic regions, data updating is more difficult because administrative offices and communities are separated by distance and transportation barriers.

Targeting accuracy has direct social justice implications. If eligible residents are excluded because of data problems, they may be unable to access health services despite being poor. Conversely, leakage to non-eligible groups can reduce fiscal space for those most in need. Strengthening accuracy requires integrated data between the Health Office, population administration, social affairs agencies, Social Security Administering Body for Health, and local governments, as well as periodic verification in remote communities.

3.7. Theoretical Synthesis: Welfare State, Social Protection, and Distributive Justice

The findings show that the free Health Social Security policy is a redistributive instrument of the welfare state. It reflects the state's responsibility to protect citizens from health-related social risks and to guarantee minimum social protection [27], [28], [32], [33]. In practical terms, the policy reduces direct financial barriers and strengthens citizens' sense of entitlement to basic health services.

However, distributive justice requires more than formal membership. Rawlsian justice, capability theory, and health justice perspectives emphasize that institutions must reduce structural disadvantages and provide real opportunities for citizens to achieve well-being [29]-[31]. In Maluku, geographic fragmentation, health workforce shortages, limited facilities, transportation costs, and uneven information access restrict the capability of remote communities to use their formal entitlements.

The findings also confirm that decentralized governance matters. Decentralization can improve accountability and local adaptation, but it can also produce uneven outcomes when fiscal capacity, infrastructure, and administrative competence vary across regions [38]-[41]. Thus, the Maluku case demonstrates a tension between national universal policy standards and archipelagic implementation realities. Effective social protection in island provinces requires adaptive financing, territorial equity, and stronger intergovernmental coordination.

3.8. Support from Previous Research

The results are consistent with international studies showing that health insurance expansion can increase utilization and financial protection but does not automatically guarantee equity if service supply, purchasing, and local implementation remain weak [10]-[13]. Evidence from Indonesia also shows that National Health Insurance has expanded coverage and utilization, yet disparities in geography, fiscal capacity, provider distribution, and administrative readiness continue to affect outcomes [14]-[18].

This study extends those findings by focusing on provincial implementation in Maluku. Unlike national-level studies, this research shows how archipelagic geography transforms financial protection into a problem of territorial access. The findings therefore address the gap left by previous studies that emphasized national policy expansion, political development, financial protection, and general reform design but did not sufficiently analyze how poor communities in remote island contexts experience the policy in practice [12], [14]-[20].

The results are also supported by access and decentralization literature. The multidimensional access framework explains why formal insurance does not always become service utilization [34]-[37], while decentralization studies explain why provincial and district capacities shape policy performance [38]-[41]. National health profile data further indicate that distribution of facilities and health workers remains an important concern for health system equity in Indonesia [50].

3.9. Research Impact and Limitations

Academically, this study contributes to public policy evaluation by integrating Dunn's evaluation indicators with welfare state theory, social protection, distributive justice, access theory, and decentralization literature. This integration offers a more comprehensive way to evaluate health insurance policies in geographically fragmented regions.

Practically, the findings suggest that improving the program requires more than maintaining insurance coverage. Policy improvements should include fiscal support for archipelagic service delivery, strengthened referral transport, better medicine and workforce distribution, regular beneficiary data updating, offline and online socialization, and complaint-handling mechanisms that are accessible to remote communities.

This study has limitations. First, the qualitative design provides contextual depth but does not allow statistical generalization across all districts and islands in Maluku. Second, the number of community informants is limited. Third, the study focuses on administrative performance and access rather than long-term health outcomes or poverty reduction. Future studies should use mixed-method designs, larger beneficiary samples, and comparative analysis between archipelagic and mainland provinces.

4. CONCLUSION

Based on Dunn's policy evaluation indicators, the free Health Social Security policy implemented by the Maluku Provincial Health Office has generally contributed positively to the expansion of formal health service access for low-income and vulnerable communities. The policy is effective in reducing direct financial barriers and responsive to urgent health needs through same-day activation. It is administratively efficient in urban settings and relatively accurate in targeting poor beneficiaries through verification mechanisms. Nevertheless, the policy has not fully achieved substantive equity. Fiscal limitations, geographic fragmentation, uneven health infrastructure, shortages of health personnel, transportation barriers, limited information dissemination, and data governance problems continue to restrict access for remote island communities. Therefore, formal coverage must be complemented by territorially sensitive implementation, fiscal equalization, inter-island referral support, integrated beneficiary data, and stronger coordination between provincial, district, and national institutions. For future research, mixed-method and comparative studies are recommended to measure the long-term social and economic impacts of free health insurance on poverty reduction, health inequality, and service utilization. Further studies should also examine digital governance, state capacity, intergovernmental coordination, and community-based outreach as strategies for improving social justice in decentralized and archipelagic health systems.

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