

Impact of National Health Insurance Policy towards the Implementation of Health Promotion Program at Public Health Centers in Indonesia

Dampak Kebijakan Jaminan Kesehatan Nasional terhadap Implementasi Program Promosi Kesehatan pada Pusat Kesehatan Masyarakat di Indonesia

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Abstract

The National Health Insurance (NHI) Program was implemented in Indonesia on January 1st 2014. This program definitely brings some changes into managerial aspect in public health center (PHC). This study aimed to determine an impact of NHI policy in the implementation of health promotion programs at PHC in South Tangerang City, Indonesia. This study was conducted using qualitative method during February and March 2016. The impact of NHI is seen on policy, budget, equipment, human resource and implementation of health promotion program. With purposive sampling method, six policy makers, eight service providers and eight service users were selected for in-depth interview. 17 documents were analyzed. Observation was conducted at four selected PHC's. Data analysis used thematic content analysis. There was no difference of PHC's functions before and after NHI period. Budget expended for health promotion programs increased after NHI was implemented which could represent an opportunity for PHC to innovate, procure materials and implement better health promotion programs. Capitation budget which could be used for executing health promotion program and some recently implemented health promotion programs in the NHI era evidences that NHI policy has a positive impact on the implementation of health promotion programs at PHC.

Keywords: Health promotion program, national health insurance, public health center

Abstrak

Jaminan Kesehatan Nasional (JKN) telah diimplementasikan di Indonesia pada 1 Januari 2014. Hal tersebut membawa beberapa perubahan pada aspek manajerial pada pusat kesehatan masyarakat (puskesmas). Penelitian ini bertujuan untuk mengidentifikasi dampak dari kebijakan JKN terhadap implementasi program promosi kesehatan di puskesmas di Kota Tangerang Selatan, Indonesia. Penelitian menggunakan metode kualitatif. Data dikumpulkan pada Februari – Maret 2016. Dampak program dilihat dalam hal kebijakan, pendanaan, fasilitas, sumber daya manusia dan pelaksanaan program promosi kesehatan. Dengan menggunakan metode *purposive* sampling, enam pengambil kebijakan, delapan pemberi layanan dan delapan penerima layanan diambil sebagai informan dalam penelitian ini. Pada analisis dokumen, 17 dokumen telah dianalisis. Observasi dilakukan dengan melihat kegiatan yang dilakukan di empat puskesmas. Analisis data menggunakan analisis konten tematik. Tidak terdapat perbedaan dari fungsi puskesmas sebelum dan setelah adanya JKN. Dana yang digunakan untuk kegiatan promosi kesehatan telah mengalami peningkatan setelah implementasi kebijakan JKN dimana dana tersebut dapat digunakan untuk berinovasi, memberi peralatan dan melakukan promosi kesehatan dengan lebih baik. Dana kapitasi yang dapat digunakan untuk melaksanakan program promosi kesehatan dan beberapa kegiatan promosi kesehatan yang baru dilaksanakan pada saat era JKN menjadi bukti bahwa kebijakan JKN memiliki dampak positif terhadap pelaksanaan program promosi kesehatan di puskesmas.

Kata kunci: Program promosi kesehatan, jaminan kesehatan nasional, pusat kesehatan masyarakat

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Introduction

Indonesia has implemented the National Health Insurance program since January 2014. The National Health Insurance program in Indonesia has long been implemented, yet fragmentations still exist as well as managing institutions and provided services not yet being conducted integrately.¹ Based on the present literature, social insurance may improve people's ability to reach health services, so it may increase the use, improve the health status, and reduce out-of-pocket health costs.²⁻⁵

After the National Health Insurance program was implemented, primary healthcare services including public health centers had an important role in which public health center facilities have a gate keeper function. The function itself is depicted through the Health Social Insurance Agency, commonly known as *BPJS Kesehatan*, as the first-contact service, continuous service, comprehensive service which includes curative, promotive and preventive services and also coordination of services.⁶

After the implementation, changes also occurred in the management of health insurance budgets at public health centers within the issuance of new regulations related to implementation of capitation system. The change of budgeting pattern definitely affects programs conducted by public health centers. Another impact to primary healthcare services resulting from implementation of the National Health Insurance program is an increase of patient visits.

A study related to the use of capitation budget by primary care in Indonesia mentioned that the percentage of the budget use for promotive and preventive activities was only about 2.7%. Meanwhile, among individual practice doctors, it was found that 5.15% of capitation budget was used for promotive and preventive activities.⁷ A study conducted using qualitative methods on the effect of the National Health Insurance regulation toward the implementation of Population Based Programs at Public Health Centers in Sleman, Indonesia also mentioned that National Health Insurance regulation resulted in the flexibility of Population Based Programs becoming limited, so the implementation of those programs was not yet optimized.⁸

Considering an effect of National Health Insurance policy to health promotion program and also the circumstance whereas public health center in Indonesia still faces limited human resources, both from number and quality aspects as well as limited infrastructure used in implementation of public health center's programs, this study aimed to determine the impact of National Health Insurance policies on health promotion programs at public health centers and to find problems that occurred during the implementation.

Method

This study used cross-sectional design through quali-

tative approach. The study was conducted in South Tangerang City which is located in the Southern Jakarta. Data were collected within February – March 2016.

The population in this study was workers in the working area of South Tangerang City Health Office consisting of the Health Office staff, 25 Public Health Centers covering the public health center heads, healthcare service providers such as doctors, midwives, nurses and health promotion program officers and service users as well as people who participated at the health promotion program implementation.

Selection of informant samples in this study used purposive sampling method. Samples consisted of three different sources that were six policy makers consisting of two persons, namely staff at Health Office that were Head of Primary Health Care Division and Head of Health Promotion Division and four heads of Public Health Centers, eight service providers consisting of three doctors, one dentist and four health promotion program holders (two midwives and two public health graduates) and eight service users consisting of four patients or their relatives and four community health workers. Selection of informants was based on the length of working time, sex and public health center area (rural/urban).

System thinking concept was used as the conceptual framework in order to generate comprehensive analysis of this study. This study analyzed the impact of National Health Insurance in the input component including policy and commitment, funding, facility and equipment and human resources which related to implementation of health promotion program. Then, in the process component was the implementation of health promotion program at public health centers.

Instrument of study was divided into three parts including document analysis, observation and in-depth interview. Document analysis was conducted on regulations, annual reports, strategic plans and work plans, both issued by the Ministry of Health, South Tangerang City Health Office or other governmental bodies which related to the aim of the study. In this stage, 17 documents were analyzed including 9 legal products, 6 annual reports and 2 strategic documents. Observation was conducted on four Public Health Centers (2 rural, 2 urban). Observation was conducted on health promotion and health prevention activities process of services, space condition and work environment. The forms of in-depth interview were arranged based on a conceptual framework developed by the Ministry of Health in its technical guidance related to evaluation of health promotion program implementation at public health centers, with some adjustments. Data analysis used content analysis method. The interview transcript was then read carefully and given codes. Prior to study, general codes were determined including policies and commitment, funding, facilities

and equipments, human resource and implementation of health promotion.

Based on protocol number 2215-GOA with approval dated 2015/30-07 and 2016/06-42 issued by Ethic Committee of Faculty of Medicine, Dokuz Eylul University, no ethical problems were identified in this study.

Results

Policy and Commitment on Health Promotion Program

In accordance with guidance to National Health Insurance implementation, the benefits of National Health Insurance consist of medical and non-medical aspects. There were some services that could be used on primary healthcare services including health promotion and prevention services, diagnostic, recovery and health consulting, non-specific surgery, drug and health device, blood transfusion, laboratory service, inpatient service as well as administration service. Therefore, National Health Insurance contained not only various curative activities, but also health promotion and prevention programs.

Strategic documents issued by *BPJS Kesehatan* depict that public health centers as primary healthcare function as gate keepers in which one of the functions is to provide comprehensive services including promotive and preventive services.

Before National Health Insurance was implemented, South Tangerang City Government had implemented social insurance for all citizens in which the citizens of South Tangerang City could use public health center's services for free. Therefore, there was no change of public health center's functions after National Health Insurance was implemented in which public health center still concerned on promotive, preventive and curative services.

Based on interviews with policy makers, they considered that there was no difference found before and after National Health Insurance was implemented.

"If looking at the health insurance, [concerns of primary care] are still on curative [services] because medical treatment is written more than the health promotion [...]. If we see, there is also counseling service [in National Health Insurance scheme]" (South Tangerang, Health Office Staff).

However, some said that National Health Insurance policies also had focused on promotive and preventive services in which there were several policies related to National Health Insurance requiring public health center to perform health promotion.

"Programs are all similar, yet the addition is about fund concerns of National Health Insurance available for counseling and giving health information [Social Insurance Program]" (Head of Public Health

Center in Rural Area)

Based on the interview, public health centers also had to provide more curative services considering that there was a condition which encouraged public health centers to conduct curative and rehabilitative activities. The condition is the lack of secondary healthcare service facilities in South Tangerang, so it encouraged public health centers to provide inpatient services. Based on document analysis, 21 of 25 Public Health Centers in South Tangerang provided inpatient services.

According to service providers, functions of public health centers consisted of health promotion and prevention services as well as curative functions. For them, there was no significant increase of patient visits after National Health Insurance was implemented. From the perspective of service users, there was no difference in terms of public health center's functions before and after National Health Insurance was implemented.

"There is no difference (before and after National Health Insurance implemented), it concerns on curative [service] by any inpatient facility and promotive preventive [activities]" (Doctor of Public Health Center in Urban Area).

Funding for Health Promotion Program

Prior to National Health Insurance implementation, source of health promotion funding was from Health Operational Fund. Based on guidance for the use of Health Operational Fund issued by the Ministry of Health, 60% of funds from the Health Operational Fund was used by public health centers to reach Millennium Development Goals (MDGs) and 40% of such fund could be used for other services and management of public health centers.

After National Health Insurance was implemented, *BPJS Kesehatan* made pre-payment to public health center facilities based on capitation for the number of participants registered at the public health center facility. Capitation fund was used for payment of personnel reward and health service operation. Personnel rewards were paid with a minimum of 60% of total capitation received and was used for medical and non-medical workers that provided services at the public health center facility.

Distribution of personnel reward was determined by considering kinds of employment position or education and daily presence. Medical workers got 150 points, pharmacist and nursing profession got 100 points, bachelor in health sciences got 60 points, associate degree (Diploma 3) in health or non-health got 40 points, medical workers lower than associate degree got 25 points and non-medical workers lower than associate degree got 15 point. In term of daily presence assessment, workers being present every working day were given a score of 1

point per day and minus 1 point if arriving late or going home earlier up to seven hours.

Percentage for health service operation funding was addressed to fund drug, health equipments and first-used medical materials as well as other operational activities, such as individual health attempts including promotive, preventive, curative and rehabilitative activities, house visits in order of individual health attempts, operational for mobile public health center, printed material or office stationery. Therefore, after National Health Insurance was implemented, there was a change of fund amount received by public health center.

Policy makers said there was a change of funding source during the National Health Insurance era in which the fund source before was from Health Operational Fund, then now there is a capitation fund, so the budget is larger. They also said that the present fund is adequate to fund health promotion and prevention activities.

“In this era of National Health Insurance, health promotion activities are more optimum and maximum because of fund supports. These National Health Insurance policies feel so real [implemented]. We can use the fund for activities in the field, such as outdoor public health centers’ counseling including dangers of smoking, then people’s mental health. (Head of Public Health Center in Rural Area)

“30% of the capitation fund is for public health centers’ operation. From that [fund], we also use [the fund] for promotion, and giving information of National Health Insurance programs”. (Head of Public Health Center in Rural Area)

However, some also said that there was still confusion on the use of the capitation fund, so heads of Public Health Centers had to consult often to the Health Office within the use. Service providers stated that the fund used for health promotion and prevention was already adequate and increasing. They also said that the reward received was fair because it was divided in accordance with employment position or education levels. Incentive was also considered adequate.

“Calculation of [personnel rewards] on National Health Insurance is quite fair and appropriate with each education.” (Health Promotion Program Holder of Public Health Center in Urban Area)

Yet, there was still a complaint regarding the large difference in capitation fund received by each public health center in accordance with the number of persons registered at the public health center. Therefore, public health centers which had a larger number of patients had a larger share of the capitation fund than public health centers which had fewer patients.

“[The amount] is less. Service at every public health center is different. It’s better if it can be equalized.” (Doctor in Rural Area)

Public health workers also said that the existing fund for health promotion and prevention was considered adequate and that there was no difference before and after implementation of the National Health Insurance for health promotion prevention.

Facilities and Equipment on Health Promotion Program

Policy makers considered that health promotion facilities, such as projectors, laptops, posters, and banners at public health centers were adequate in terms of quantity and quality. Some also mentioned that by existing National Health Insurance funding, health promotion facilities increased such as speakers, posters and accommodation provided to patients during health promotion activities. However, some considered physical infrastructure was still inadequate, such as the lack of polyclinic rooms and the lower number of chairs in patient waiting room.

Service providers said that the present health promotion facilities were already adequate. They mentioned that the implementation of the National Health Insurance program contributed positively to health promotion facilities because the existing funds could be used to buy posters and other materials needed while performing health promotion.

“In National Health Insurance, we print leaflets on mother and child health, environmental health about health promotion, also print banners of promotive, preventive [activities] and backdrop for the events.” (Health Promotion Program Holder of Public Health Center in Urban Area)

“I feel it is already adequate as after National Health Insurance is implemented, there are additional funds. Counseling also increases. By the fund, we are very assisted for speakers and serving snacks.” (Health Promotion Program Holder of Public Health Center in Rural Area)

However, service providers also said that there were still less facilities, such as polyclinic room and chairs in waiting rooms. They stated that the funding received from the National Health Insurance could not be used to buy facilities such as chairs in waiting room.

“Seats in waiting rooms are inadequate because [the seats are] still made of wood, so [we have to] wait from the Health Office. National Health Insurance does not cover furniture purchase because National Health Insurance fund may only be used for health equipment, drugs, BMHP and promotive and preventive operational activities” (Health Promotion Program Holder of public health center in Urban Area)

Service users said that the present health promotion facilities were already adequate. Some considered them inadequate because there was no place for Integrated Health Care (Posyandu/the health care organized by

community), so people's houses had to be used for the integrated health care.

Human Resource on Health Promotion Program

In accordance with Health Ministry Regulation on implementation of health promotion, management of health promotion should be performed by coordinators who graduated from associate degree (Diploma 3) of health as well as interested and talented in the field of health promotion. If none met the requirements, there should be all other medical workers at public health center, such as doctors, nurses, midwives, sanitarians, etc.

Policy makers considered that human resources were already adequate in terms of quantity and quality, yet there were heads of Public Health Centers under rural criteria area who considered that the existing human resources were less in terms of quantity and quality.

Lack of workers was indicated by the lower number of doctors. In one public health center in a rural area, there were only three doctors where one doctor worked at morning shift, one doctor worked at afternoon shift and one doctor worked outside, therefore the number was considered inadequate. It was also mentioned that nowadays, the Health Office has been trying to meet human resources requirements by recruiting non-governmental workers.

"I think human resources are still not enough...ideal number for doctor is 6, which is 2 doctors for morning shift, and others can do health program outside public health center and evening shift." (Head of Public Health Center in Rural Area)

Service providers at public health centers in rural areas also said that there were still inadequacies in terms of both quantity and quality as shown by professional services handled by non-professionals, such as midwives who had to act as a nurse. Service receivers also mentioned that inpatient services added to the workload of medical workers. However, most medical workers in public health centers in urban areas said that the number and quality of human resources were already adequate.

Service users mentioned that the number and quality of human resources was already adequate. However, there were community health workers saying that the number of public health centers' human resources was still inadequate because there were Integrated Health Care which had not been visited by public health centers' staff frequently.

Implementation of Health Promotion Program

Policy makers said that there were some methods used in health promotion, such as providing leaflets, posters and health promotion inside and outside buildings such as visits to houses, schools, offices and people's empowerment both students and communities.

After National Health Insurance applied, some considered that there was additional method, such as availability of specialists or competent speakers in providing and counseling. There were also other programs performed, such as Chronic Disease Management Program (*Prolanis*) and health education regarding social insurance. Based on the *Prolanis* Implementation guidance document issued by *BPJS Kesehatan*, *Prolanis* aims to maintain the health for the National Health Insurance participants who suffered from chronic diseases to accomplish optimum life quality with effective and efficient costs of health services. Activities and Chronic Disease Management Program included medical consulting, home visits, reminders, club activities and monitoring of health status.

Informants mentioned problems during the implementation of promotion and disease prevention, such as the difficulty to change people's behavior because of some aspects, such as heterogeneous community condition, less awareness and the difficulty to reach male groups that worked during afternoons, so health promotion could reach housewives only.

"As National Health Insurance includes management of chronic diseases and health education, we invite 50 persons, we use competent speakers from outside. We do counseling on non-communicable diseases, policies in accordance with the fund we have." (Head of Public Health Center in Urban Area)

Service providers also said that health promotion and disease prevention were performed outside and inside buildings. Common activities included distribution of leaflets, installation of posters, and visits to houses, schools and work sites. Several informants said that there was a change after National Health Insurance was implemented in which there were additional funds that could be used for disseminating information regarding social health insurance and Chronic Disease Management Program activities. However, there were also informants who said that no change was found before and after National Health Insurance implemented. Problems of implementation of health promotion programs expressed by service providers were similar to problems mentioned before regarding the difficulty of changing people's behavior. Service providers considered that they already provided adequate health promotion, but the people were less aware of health as they had healthy lifestyle if they suffered from diseases.

"After National Health Insurance was implemented, we do more regularly direct counseling to neighborhood groups and hamlets. We also provide counseling on degenerative diseases. Now the target is larger." (Health Promotion Program Holder of Public Health Center in Urban Area)

Some service receivers knew less about existing health

promotion and disease prevention programs, but public health workers said that there were several methods of health promotion including making available posters, leaflets and health counseling. Problems mentioned by health promotion program participants were similar and included less awareness of health matters and the difficulty to reach wealthy people living in elite residences. They said no change was found before and after National Health Insurance was implemented.

Based on observations, there were poster and brochures related to health promotion at polyclinics, mother and child health rooms, contraception rooms, patient's waiting rooms, and drug room. Public health centers also performed the Chronic Disease Management Program in which the activities included gymnastics, medical checkups and drug provision. Several public health centers also used television as a health promotion media in the waiting room.

It is concluded that some health promotion programs such as providing leaflets, posters, house visits, school visits, work place visits and people's empowerment both students and communities have been implemented before and after National Health Insurance Policy has been implemented. However, there are some new health promotion programs which were implemented recently after the National Health Insurance program was implemented such as *Prolanis*, promoting National Health Insurance, more intense home visits and public counseling.

Besides this, informants have said that there was no change in implemented health promotion before and after the National Health Insurance program which may be due to insufficient regulation.

Actually, the guidance for primary health care to implement the *Prolanis* Program was launched by *BPJS Kesehatan*. Furthermore, the regulations that encourage primary health care to implement the *Prolanis* program also were executed through *BPJS Kesehatan*, Regulation Number 2 of 2015. Nevertheless, *BPJS Kesehatan* Regulation Number 3 of 2015 stated that primary health care compulsorily carry out that program on January 2017.

Precisely that regulation rules out the capitation norm and commitment based on the capitation system which aims to enhance efficiency and efficacy of the National Health Insurance program through quality control system and financing system in the primary health care. Therefore, in order to receive 100% capitation fund, primary health care should fulfill some indicators such as patient contact rate should be more than or equal to 150 per mile, non spesialistic case referral ratio which should be under 5% and *Prolanis* participant attendant should be more than or equal to 50% in one month. If public health centers did not meet those indicators, they would

receive capitation fund less than it should be. Otherwise, if public health centers exceeded those indicators, who would get a reward from *BPJS Kesehatan*. It is considered that regulation could be a supporting factor that encourages public health centers to conduct the *Prolanis* program and other health promotion programs.

Another factor was the lack of initiative from managers at public health centers to conduct additional health promotion programs. However, staff shortages could also be a reason for public health center being unable to implement additional health promotion programs.

Discussion

There are few studies regarding the impact of the National Health Insurance program on health promotion because the program is still being implemented. This study used a qualitative approach with three methods of data collection, in order to limit the bias of this study.

One of the limitations of this study is that it contains only the initial perspectives of service receivers and users because the program was implemented recently in early 2014. Therefore, further analysis is needed in the following year. Moreover, it also needs study by different approaches, such as quantitative to compare the efficacy of health promotion programs before and after implementation of the National Health Insurance program.

Policy on the use of capitation fund at National Health Insurance scheme that could be used for the implementation of health promotion and additional policies, such as *Prolanis* implementation and health counseling at public health center deemed had positive effects on implementation of health promotion.

In accordance with basic concepts stated by the Indonesian Government regarding the goals of the National Health Insurance program, comprehensive services include promotive, preventive, curative and rehabilitative services.¹ This is similar to the concept of National Health Insurance implemented in Turkey in which their Health Ministry added health promotion and disease prevention programs for the whole population, especially children and women.⁹

Universal Health Coverage can be well funded when the government performs fact-based health promotion program and employs health professionals. Effective health promotion and disease prevention reduces pressure on the health system and thus economy and directly improves a person's health as well as lengthening life expectancy.¹⁰

Considering the basic concept of public health centers as set out in the Health Minister's Regulation, public health centers deliver promotive and preventative actions as a primary healthcare facility. Provision of health promotion service is mandatory for public health centers.

At a global level, the first international conference re-

lated to primary health care as a device to increase health status was the Alma-Ata declaration conducted in 1978 in Kazakhstan.¹¹ In the declaration, basic health services were characterized as including solving health problems at a community level, and providing promotive, preventive, curative and rehabilitative services.¹²

A lack of number of health workers at public health centers in Indonesia was not only shown in this study. A study conducted in Gianyar District also showed that there was a lack of human resources such as physicians and nurses at public health centers.¹³ One of the challenges faced by public health centers in performing health promotion, especially public health centers with less human resources in South Tangerang, was inpatient service burden. The low number of bed at hospitals also occurred in several cities in Indonesia. Based on the existing data, public health centers providing inpatient services were 3,317 and those that did not provide inpatient services were 6,338. Thus, for every three public health centers, 1 public health center provides inpatient services. Ratio of beds at hospitals in Indonesia in 2014 was 1.12 per 1,000 population. At province level, there were 13 provinces with a ratio less than 1 per 1,000 population.¹⁴

The capitation fund portion granted to public health centers, which further was used for health promotion activities became one of the factors that had a positive effect on the implementation of health promotion activities at public health centers. The percentage of the capitation fund used for different public health center services varied from place to place.

In accordance with the regulation from the Health Minister of the Republic of Indonesia, the use of capitation funding received by public health center facilities is determined by Decision of Regional Head. The regulation only arranges that personnel rewards are at least 60% of capitation fund, so it possibly makes regulation in every region vary.

Based on the report by Center for Health Financing and Insurance of Health Ministry, there were differences in the use of capitation funds between regions. In this report, of 15 present provinces, 57 regions set the personnel reward at more than 60% and 83 regions set the reward at 60%.¹⁵

In one study, capitation funds received by public health centers were relatively adequate for the intended purpose, meanwhile capitation funds for private primary health clinics, individual-practice doctors and dentists were still inadequate, specifically for drug purchase and laboratory costs.⁷ Funding definitely became an important component in the success of health promotion implementation. Health Ministry in guidance to Health Promotion implementation listed funding as the strengthening factor in health promotion activities at public

health centers. A study at a public health center in Malang City, Indonesia mentioned that public health centers were not able to provide supporting media, such as video and reading materials for health promotion because of fund limitations.¹⁶

It was possible for public health centers to use capitation funds to provide supporting facilities in implementation of health promotion programs, such as transportation for people, competent speakers and meals for attendees. More adequate facilities in health promotion implementation definitely affected the success of the implementation.

Conclusion

Some regulations have been issued regarding National Health Insurance implementation considering the positive impact it could have on the implementation of health promotion programs at public health centers. Furthermore, the existence of additional funding sourced from the capitation fund in the National Health Insurance era can be used to procure materials and equipment for executing additional health promotion programs. Also health promotion programs which are newly implemented during the National Health Insurance era such as *Prolanis*, house visits and public counseling evidence the notion that National Health Insurance policy has a positive impact on the implementation of health promotion programs at public health centers.

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References

1. Kementerian Kesehatan Republik Indonesia. Buku pegangan sosialisasi jaminan kesehatan nasional. Jakarta: Kementerian Kesehatan Republik Indonesia; 2013.
2. Adam W, Magnus L, Gao J, Xu L, Qian J. Extending health insurance to the rural population: an impact evaluation of china's new cooperative medical scheme. *Journal of Health Economics*. 2009; 28 (1): 1-19.
3. Antonio JT, Jorge EP, John AV. The impact of subsidized health insurance for the poor: evaluating the Colombian experience using propensity score matching. *International Journal of Health Care Finance and Economics*. 2005; 5 (3): 211-39.
4. William HD, Kammi KS. Health insurance and child mortality in Costa Rica. *Social Science & Medicine Journal*. 2003; 57 (6): 975-86.
5. Aggrawal A. Impact evaluation of India's "Yeshasvini" community-based health insurance programme. *Health Economics Journal*. 2010; 19 (9): 5-35.
6. Badan Penyelenggara Jaminan Sosial Kesehatan. Gate keeper concept.

- Jakarta: Badan Penyelenggara Jaminan Sosial Kesehatan; 2014.
7. Wasis B, Lusi K. Pemanfaatan dana kapitasi oleh fasilitas kesehatan tingkat pertama (FKTP) dalam penyelenggaraan JKN. *Buletin Penelitian Kesehatan*. 2015; 18 (10): 437-45.
 8. Aminudin. Pengaruh regulasi jaminan kesehatan nasional terhadap pelaksanaan fungsi UKM di Puskesmas Ngaglik II Kabupaten Sleman [Tesis]. Yogyakarta: Universitas Gadjah Mada; 2015.
 9. Rifat A, Sabahatin A, Sarbani C, Safir S, Meltem A, Ipek G, *et al.* Universal health coverage in Turkey: enchancement of equity. *Health Policy Journal*. 2013; 382: 65-99.
 10. Gloria C, Joy de B. The imperative for health promotion in universal health coverage. *Global Health: Science and Practice*. 2014; 2 (1): 10-22.
 11. Karl T, Patricia E. An assessment of public health center in the Carribean pre and post Alma Ata Declaration and a way forward. *International Journal of Humanities and Social Science*. 2011; 1 (8): 1-10.
 12. Stephen G. Is the declaration of Alma Ata still relevant to public health center?. *British Medical Journal*. 2008; 336: 536-8.
 15. Indrayathi PA, Listyowati R, Nopiyani NMS, Ulandari LPS. Mutu pelayanan puskesmas perawatan yang berstatus badan layanan umum daerah. *Kesmas: Jurnal Kesehatan Masyarakat Nasional*. 2014; 9(2): 164-70.
 14. Kementerian Kesehatan Republik Indonesia. Profil kesehatan Indonesia tahun 2015. Jakarta: Kementerian Kesehatan Republik Indonesia. 2014.
 15. Pusat Pembiayaan dan Jaminan Kesehatan Kementerian Kesehatan Republik Indonesia. Resume laporan daerah dalam penyelenggaraan jaminan kesehatan nasional 2014. Jakarta: Kementerian Kesehatan Republik Indonesia. 2015.
 16. Indah PW, Soesilo Z, Riyanto. Implementasi kebijakan promosi kesehatan (studi pada pusat kesehatan masyarakat Dinoyo, Kecamatan Lonokwaru, Kota Malang). *Jurnal Administrasi Publik*. 2014; 2 (11): 1-10.