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From Welfare to Biopolitics: State Power and Universal Health Coverage Implementation in East Java Province

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Abstract
Indonesia's National Health Insurance (JKN) is the main policy vehicle for reaching Universal Health Coverage (UHC). It is meant to widen access to care, protect households from health costs, and raise service quality. In East Java Province, however, the programme still runs unevenly: enrolment, access to services, and financing capacity differ markedly from one district to another. This article examines JKN implementation in East Java through Michel Foucault's notion of biopolitics, which treats health as one of the means by which a state knows, sorts, and manages its population. The study is a qualitative literature review of journal articles, books, regulations, and research reports, analysed descriptively and critically. Three problems stand out: gaps in enrolment, low public awareness, and limited financing. Seen through a biopolitical lens, JKN is more than a health protection scheme. Registration, beneficiary classification, and rules on who may use which services are also ways of governing people, and where administrative capacity and resources vary across regions, these same mechanisms produce unequal protection. Policy therefore needs to fit local conditions, strengthen financial protection, simplify administration, and improve service quality. The article offers a critical reading of how health governance, power, and unequal access are bound together in East Java's path toward UHC.

Keywords*: Biopolitics, East Java Province, National Health Insurance, Universal Health Coverage*

Abstrak
Jaminan Kesehatan Nasional (JKN) adalah instrumen utama Indonesia untuk mencapai *Universal Health Coverage* (UHC). Program ini dirancang untuk memperluas akses layanan kesehatan, melindungi rumah tangga dari beban biaya berobat, dan meningkatkan mutu pelayanan. Di Provinsi Jawa Timur, pelaksanaannya masih timpang: cakupan kepesertaan, akses layanan, dan kemampuan pembiayaan berbeda cukup jauh antardaerah. Artikel ini mengkaji implementasi JKN di Jawa Timur dengan perspektif biopolitik Michel Foucault, yang memandang kesehatan sebagai salah satu cara negara mengenali, memilah, dan mengelola penduduknya. Penelitian ini merupakan kajian pustaka kualitatif atas artikel jurnal, buku, regulasi, dan laporan penelitian, yang dianalisis secara deskriptif-kritis. Tiga persoalan menonjol: kesenjangan kepesertaan, rendahnya pemahaman masyarakat, dan keterbatasan pembiayaan. Dari sudut pandang biopolitik, JKN bukan sekadar skema perlindungan kesehatan. Pendataan, penggolongan peserta, dan aturan tentang siapa berhak atas layanan apa juga merupakan cara mengatur penduduk. Ketika kapasitas administrasi dan sumber daya tiap daerah berbeda, mekanisme yang sama justru melahirkan perlindungan yang tidak setara. Karena itu, kebijakan perlu disesuaikan dengan kondisi lokal, memperkuat perlindungan finansial, menyederhanakan administrasi, dan memperbaiki mutu layanan. Artikel ini menawarkan pembacaan kritis atas keterkaitan tata kelola kesehatan, kekuasaan, dan ketimpangan akses dalam perjalanan Jawa Timur menuju UHC.

Kata Kunci*: Biopolitik, Jaminan Kesehatan Nasional, Jaminan Kesehatan Universal, Provinsi Jawa Timur*

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Introduction

BPJS Kesehatan, the Health Social Security Administrator, was established under Law Number 24 of 2011. Its operation was later detailed in Minister of Health Regulation Number 28 of 2014 on the guidelines for implementing the National Health Insurance (JKN) programme, which formally began on January 1, 2014. From the outset, the programme's enrolment rules created a hurdle. Prospective participants must hold a National ID Card (KTP) and a Family Card (Kementerian Kesehatan RI, 2014; Republik Indonesia, 2011). Anyone who cannot produce both documents cannot complete registration.

Administrative requirements are only part of the problem. JKN also struggles with uneven coverage and with the accuracy of its targeting. Government-subsidised contributions under the *Penerima Bantuan Iuran* (PBI) scheme do not always reach the right people: some households that can afford to pay are listed as subsidised, while some poor households are left out. Errors of this kind, whether of inclusion or exclusion, erode the sense that the system is fair and weaken public trust in it. They usually trace back to outdated socioeconomic data, weak verification, and poor coordination among the agencies that identify beneficiaries. Fixing them requires better data, clear eligibility criteria, and a working mechanism for updating household conditions (Alkayyis, 2024).

JKN was designed to deliver Universal Health Coverage (UHC), that is, access for everyone to comprehensive, good-quality health services without financial hardship. UHC covers promotive, preventive, curative, and rehabilitative services, and the Indonesian government has invested heavily in moving toward it.

At the global level, the World Health Organization's Thirteenth General Programme of Work (GPW13) for 2019–2023 set out the "Triple Billion" targets: one billion more people benefiting from universal health coverage, one billion more better protected from health emergencies, and one billion more enjoying better health and well-being by 2023 (World Health Organization, 2019). Within this framework, universal health coverage means that people can obtain the quality services they need without being pushed into financial difficulty (World Health Organization, 2020). Indonesia's own efforts to improve health services have been aligned with national development goals and with WHO's work plans (Sobeang, 2022).

Even so, a larger insured population has not translated automatically into equitable access. National data show that insurance coverage on its own does not guarantee that people can actually use services; where facilities are scarce and funding is thin, the benefits of being insured shrink, especially in underserved regions (Pratiwi et al., 2021). UHC in Indonesia also raises governance questions about how a national insurance scheme fits with health services that are the responsibility of local governments (Saputro & Fathiyah, 2022). One such question concerns the link between JKN and the Minimum Service Standards (*Standar Pelayanan Minimal*, SPM) for health, which define the basic services every regional government must provide. Minister of Health Regulation No. 6 of 2024 sets the technical rules for meeting those standards (Kementerian Kesehatan RI, 2024). Reaching UHC thus depends on more than enrolment figures. It also depends on regional financing, clear institutional responsibilities, and coordination between national insurance and local service delivery.

Local governments carry much of this burden. Besides providing facilities and health workers, they are expected to register their residents in the programme. The original target was for every Indonesian resident to be a JKN participant by January 1, 2019 (Hergianasari & Hadiwijoyo, 2021).

WHO identifies two core elements of UHC: equitable access to quality care for everyone, and protection from financial risk when people use health services. From these follow three objectives. The first is equity, so that people receive care according to need rather than ability to pay. The second is quality, so that services actually improve health over time. The third is financial protection, so that paying for care does not destabilise a household's finances.

Indonesia has come a long way on enrolment. According to the National Social Security Council (DJSN, 2025), JKN covered 98.7% of the population, or about 281.6 million people, as of August 31, 2025. Active membership, however, stood at only 79.8% of

the population, a reminder that being registered and being covered are not the same thing.

The East Java provincial government has worked to raise participation in *BPJS Kesehatan* through regular public outreach and simpler registration and payment procedures. In their evaluation of JKN in Bantul Regency, Suprianto and Mutiarin (2017) rated the BPJS financing model as good. The government also cancelled a planned premium increase for Class III participants and chose instead to focus on improving primary and referral services.

These efforts have had limited effect. Between 2017 and 2020, non-PBI participation in East Java grew by only 3.83%, 3.69%, and 0.83% in successive years. Growth that slow calls for closer attention from policymakers.

Banyuwangi Regency illustrates the problem. Its health development has lagged behind cities such as Madiun and Mojokerto, which had already achieved UHC for their residents. Banyuwangi began its own programme in 2005, the Banyuwangi Poor Community Health Service Guarantee (JPKMB), as an early step toward UHC. The programme rested on Banyuwangi Regent Instruction No. 2 of 2005, which abolished fees for basic services at community health centres (*puskesmas*) and their networks. In practice, JPKMB worked much like a Regional Health Insurance scheme (Jamkesda).

Its weakness was scope. JPKMB paid only for basic outpatient care at *puskesmas*; it did not cover inpatient care there or treatment in hospitals. Hospitalisation is precisely where costs become catastrophic for poor households. For Banyuwangi to reach its UHC targets, its strategy has to anticipate how conditions are likely to change.

Strategic plans can also fail when they assume the future will unfold in a straight line. Conditions shift for many reasons, and health programmes need plans that can adjust to what happens on the ground (Litawati, 2016).

This article examines what regional governments in East Java have done to advance UHC through JKN. Instead of evaluating national policy as a whole or tracking national enrolment, it looks at regional problems and responses concerning coverage, administrative inclusion, financing capacity, and access to care. It also brings in Michel Foucault's concept of biopolitics to ask how registration, beneficiary classification, administrative requirements, and the allocation of health resources shape who ends up protected. This allows the analysis to go beyond a standard implementation assessment and to consider how governing population health can open the door to inclusion while also producing new inequalities. The article's contribution lies in linking regional variation in JKN implementation in East Java to a biopolitical reading of health governance.

The purpose of this article is to identify the strategies used in implementing the National Health Insurance programme as part of the effort to realise UHC in East Java Province.

Method

This study is a literature review. It draws on peer-reviewed journals, academic books, and research articles relevant to the topic. A review of this kind makes it possible to trace how a field has developed, to see which theories and methods dominate, and to locate gaps between theory and empirical findings.

The literature examined concerns national health insurance strategies as an instrument for implementing UHC in East Java. All data are secondary: previously published research findings and related academic material, compiled and analysed to answer the research questions. Sources include books, journal articles, research reports, and other publications on universal health coverage.

Data were collected through documentation and reviewed in three stages: (1) identifying and gathering relevant literature from journals, articles, and books; (2) evaluating the selected sources critically; and (3) synthesising findings that bear on the theoretical framework and the research questions. The material was analysed descriptively, with findings from different sources brought together and read in the context of UHC implementation in East Java.

Results and Discussion

National Health Insurance (Universal Health Coverage)

By the end of 2025, JKN membership administered by *BPJS Kesehatan* was projected to reach about 283.1 million people, or 98.75%

of the population. The target for *active* participants was around 229 million. Roughly 23 million participants, however, had unpaid contributions, which were scheduled to be written off by the end of 2025. In March 2025 there were about 222.7 million active participants, consisting of Contribution Assistance Recipients (*Penerima Bantuan Iuran*, PBI) and non-PBI members such as self-employed people, workers, and business entities. The programme's stated goal, commonly described as UHC, was comprehensive national coverage by 2025. Membership in *BPJS Kesehatan* is therefore compulsory for both formal and informal workers.

This study focuses on urban areas in East Java, particularly Surabaya. The city is a useful case for looking at UHC among informal workers and at whether people stay insured over time. Surabaya is also a city where residents often deal with urban problems through social and cultural arrangements rather than through purely administrative channels (Sa'ir et al., 2020). According to *BPJS Kesehatan* Surabaya, JKN enrolment reached 99.08% of the city's population as of June 1, 2025. Yet only 81.98% of residents held active membership, and some 500,000 registered participants were classified as inactive (Dimensi News, 2025). High enrolment, in other words, does not mean that people remain active members and can use services when they need them.

This gap matters most for informal workers, including those registered as *Pekerja Bukan Penerima Upah* (PBPU), or non-wage earners. Formal-sector employees usually have their contributions handled through their employers. PBPU participants have to pay their own, unless a subsidy or a local government scheme covers them. For people with irregular incomes, keeping membership active can be difficult, which makes their participation an important indicator of whether UHC in Surabaya can be sustained.

Indonesia first aimed to reach UHC by 2019 by increasing participation in the National Social Security System (*Sistem Jaminan Sosial Nasional*, SJSN). This made *BPJS Kesehatan* the main agency responsible for expanding enrolment in the National Health Insurance and Indonesia Health Card (JKN-KIS) programme across regions. Earlier studies confirm that participation rates vary widely between regions.

Laturrakhmi et al. (2020) identified Tulungagung Regency as one of the areas with relatively low participation in JKN-KIS. In Boro Village, misinformation about health and limited health literacy made many residents reluctant to enrol, especially among those not eligible for subsidies. Affordability alone, then, does not explain low participation; poor information and misconceptions about the programme also shape people's decisions. In a separate news report, Sujarwoko (2017) described an initiative by *BPJS Kesehatan* Tulungagung to work with local businesses, including hotels, a café, and a massage service, to offer discounts to JKN participants. The aim was to make membership more attractive. The report, however, only describes the partnership and its intentions; it does not show that enrolment rose as a result.

Strategies for Implementing the Universal Health Coverage Programme

Litawati (2016) examined the prospects for UHC in Banyuwangi Regency. Her study found three favourable conditions: a local government committed to expanding health insurance, a large share of residents already covered by central government schemes, and health resources spread fairly evenly across the regency. The regency had run several programmes, including the Banyuwangi Community Health Service Guarantee (*Jaminan Pelayanan Kesehatan Masyarakat Banyuwangi*, JPKMB), Regional Health Insurance (Jamkesda), the Minimum Service Standards (*Standar Pelayanan Minimal*, SPM), and JKN.

To reach UHC, the Banyuwangi government drew up several strategic scenarios. These included raising the quality of health services, improving coordination among stakeholders, and developing health workers' skills. Funds previously spent on JPKMB were to be redirected to pay JKN contributions for low-income residents not yet registered with *BPJS Kesehatan*, and registration requirements for self-employed participants were to be simplified.

In Tulungagung, Laturrakhmi et al. (2020) linked low public awareness to the regency's position among the areas with the lowest JKN-KIS participation. Outreach had been thin, and many people did not understand how to enrol.

The regency government responded by stepping up information campaigns and countering the misinformation that had made residents hesitant. It continues to urge people to register so that the community can benefit from JKN-KIS and the regency can reach UHC.

Data from *BPJS Kesehatan* Malang show that JKN coverage in Malang City had reached 94.39% by November 2020, placing the city among those in East Java that had met UHC targets. Compliance is another matter. Self-employed participants in particular often struggle to pay contributions every month, and many fall into arrears even as enrolment rises. The government cannot rely on premiums alone to finance care; it needs to strengthen its fiscal capacity if coverage is to be sustainable and fair (Simbareja & Dewiyani, 2020).

Discussion of Research Findings

JKN is about more than adding people to an insurance list. It also shows how the state arranges, classifies, and manages the health of its population. Higher enrolment is a step toward UHC, but registration does not by itself mean that a person is an active member, can obtain adequate care, or is protected from financial hardship. WHO and the World Bank argue that UHC should be judged by how many people can use essential services and by how well they are shielded from financial harm (WHO & World Bank, 2023).

Foucault's concept of biopolitics offers a useful way to think about this. Biopolitics refers to the ways in which the health and well-being of a population become objects of government (Foucault, 1978, 2010; Gudmand-Høyer & Hjorth, 2009). In JKN, registering people, sorting beneficiaries, setting contribution levels, and deciding where health funds go are all ways in which the state administers health protection. These steps are necessary to run the programme. They can, however, produce unequal outcomes when rules and financing arrangements ignore the very different social and economic circumstances of the people they govern.

The gap between registered and active members shows the limits of coverage on paper. A person can remain on the JKN list while their membership has lapsed, and lapsed members cannot use the services they are nominally entitled to. Non-wage earners are especially exposed, because their incomes rise and fall and regular payment is hard to keep up. From a biopolitical standpoint, governing well requires more than a headcount. It requires knowing why memberships lapse and how economic vulnerability alters a person's chances of being protected.

JKN divides the population into subsidised and non-subsidised participants so that the state can plan its budget and allocate resources. Whether this division is fair depends on accurate beneficiary data and straightforward registration. Faulty socioeconomic data can exclude households that should receive subsidies or include those that should not, although the scale of these errors still needs to be established empirically. How such classifications play out also depends on local power relations. In East Java, formal state authority operates alongside religious and cultural sources of authority, and these shape how policies are received and carried out locally (Sair et al., 2025).

As coverage has expanded over the past decade, Indonesians have also become more aware of the barriers to quality care. Citizens who are dissatisfied with services or with their contribution obligations can turn to the courts, including through judicial review of the regulations governing JKN. In 2019, Presidential Regulation No. 75 of 2019 amended Presidential Regulation No. 82 of 2018 on Health Insurance, including its provisions on contribution rates. After Supreme Court Decision No. 7 P/HUM/2020, the government issued Presidential Regulation No. 64 of 2020, which amended the framework again and adjusted the contribution arrangements. These changes were intended to keep the programme financially viable while paying attention to fairness in financing and the continuity of services (Republik Indonesia, 2020).

The COVID-19 pandemic in 2020 made the case for solidarity and shared responsibility in protecting public health even more plainly, and these are the principles on which UHC rests.

The use of health services, finally, depends on many factors, from personal characteristics and psychological conditions to social determinants. Dever (1984) points to sociocultural factors, organisational structures, community characteristics, and provider-related factors. Enrolment and service use under JKN

therefore need careful handling, particularly in segmenting the population accurately so that budgets, contributions, and the state's responsibility for subsidised participants are managed properly. The aim of the programme remains comprehensive UHC: every citizen, including those who fall outside both the PBI and non-PBI categories, should be registered and able to use essential health services.

Policy Implications

The findings suggest several ways to strengthen UHC implementation and health governance at the subnational level.

Local governments should use enrolment strategies that fit their own socioeconomic conditions. Districts with high poverty rates need broader subsidies and active identification of eligible beneficiaries, supported by poverty and health data systems that are linked to each other.

Coordination between central, provincial, and district governments also needs work. Clear roles, together with performance-based monitoring and evaluation, would make each level more accountable and narrow the gaps between regions.

Community involvement should become a regular part of UHC governance rather than an occasional add-on. Community leaders, religious organisations, cooperatives, and local employers can help raise awareness, build trust, and improve compliance among informal workers, who have long been the hardest group to enrol.

Financing is the fourth area. Contribution schemes for non-salaried workers should be more flexible, and fiscal transfers to regions with low revenue should be strengthened. Without such measures, people will continue to drop out for financial reasons, and the long-term viability of JKN will be at risk.

Evaluation, lastly, should look beyond enrolment targets. Indicators of equity, service use, and financial protection would tie UHC more closely to the performance of the health system as a whole, so that success is measured by real access and better health rather than by coverage rates alone.

Conclusion

Read through the lens of biopolitics, UHC in East Java is not simply a technical health policy. It is also a way for the state to govern the lives, health, and productivity of its population. The uneven distribution of enrolment across districts reflects uneven forms of biopolitical intervention. Urban residents and formal workers are drawn into state-sponsored protection far more effectively than marginalised, rural, and informal-sector populations.

Poverty, irregular income, and difficult administrative access act as biopolitical filters that decide who becomes "governable" within JKN. Enrolment becomes a matter of regulated inclusion and exclusion: those who cannot meet contribution requirements are pushed to the edges of state care. Participation in health insurance thus works as a disciplinary instrument, tying citizenship, responsibility, and access to care to economic capacity and bureaucratic compliance.

Differences in local government performance show that this power is exercised unevenly. Districts with stronger finances and better administrative coordination can mobilise data integration, enforcement of enrolment, and incentives for participation, and they expand coverage as a result. Where governance is weaker, the state is less able to regulate and protect life, and health inequities persist.

UHC in East Java, in short, operates as a biopolitical regime in which health policy serves both as welfare provision and as population control. Unless deliberate corrective steps are taken, the current model is likely to reproduce structural inequality by favouring those who are administratively visible and economically compliant, instead of protecting health as a social right for everyone.

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