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Original Research Article

Policy Implementation Gaps in Indonesia's National Health Insurance Contribution Assistance Program: A Qualitative Study in Merauke

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Abstract: Achieving universal health coverage through the National Health Insurance (JKN) program depends not only on expanding enrollment but also on the quality of policy implementation at the local level. The Premium Assistance Program (PBI) is designed to ensure health protection for the poor and vulnerable, yet its implementation still faces various administrative and institutional challenges. This study aims to analyze gaps in the implementation of the PBI-JKN program in Kelapa Lima Village, Merauke District, using the four dimensions of implementation proposed by Edwards III: communication, resources, disposition, and bureaucratic structure. The study employed a qualitative descriptive approach with six institutionally-based informants selected through purposive sampling. Data were collected through in-depth interviews, observations, and documentation, and were subsequently analyzed through data organization, coding, the development of categories and themes, and triangulation. The results indicate that the PBI-JKN program is operational at the local level but has not yet been fully optimized. Gaps primarily arise in the speed and consistency of information, updating beneficiary data, technical capabilities, administrative completeness, limitations on authority, and interagency coordination. The disposition of implementers is relatively supportive; however, this commitment has not yet been fully able to overcome the system's limitations. Across all dimensions, data governance and interagency coordination are critical mechanisms that influence the accuracy of targeting and the responsiveness of services. This study concludes that strengthening the implementation of PBI-JKN requires data integration, improved technical capacity, clearer communication, and more responsive interagency coordination mechanisms.

Keywords: PBI-JKN, Policy Implementation, Implementation Gaps, Data Governance, Interagency Coordination, UHC.

1. INTRODUCTION

Achieving universal health coverage (UHC) is one of the main priorities of health system reform in Indonesia through the National Health Insurance (JKN) program. This program is designed to expand health protection for the public while reducing financial barriers to accessing health services (Pratiwi *et al*., 2021; Alkayyis, 2024). For poor and vulnerable groups, the government provides the Premium Assistance Recipient (PBI) scheme as a premium subsidy mechanism to expand health protection. However, increased enrollment coverage does not always equate to the achievement of effective and equitable health protection. Empirical evidence indicates that the benefits of the JKN are still influenced by the availability of services, utilization of health facilities, protection against out-of-pocket expenditures, and disparities among groups and regions (Maulana *et al*., 2022; Asante *et al*., 2023; Cheng *et al*., 2025).

These issues become increasingly important in the implementation of the PBI-JKN program because the program's effectiveness is determined not only by the availability of government subsidies but also by the accuracy of beneficiary identification, data quality, administrative mechanisms, public communication, and interagency coordination. Previous research indicates that socioeconomic, educational, and regional characteristics remain associated with JKN enrollment and utilization among the poor, while targeting mechanisms determine whether subsidies actually reach those most in need (Putri *et al*., 2023; Shah *et al*., 2025).

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In the context of Kelapa Lima Village, Merauke, the research findings indicate that the implementation of PBI-JKN is underway but still faces challenges regarding data updates, public understanding of PBI procedures, administrative completeness, interagency coordination, and the speed of service follow-up. These conditions reveal a gap between established policies and the quality of their implementation at the local level.

Various studies have examined JKN and PBI from the perspectives of financing, enrollment coverage, service utilization, and policy implementation. Dasopang *et al*., (2024) demonstrated that the implementation of JKN through BPJS still faces various policy challenges, while Indriani and Wahyuni (2025) found heterogeneity in the impact of JKN-PBI on household health expenditures. Lestari *et al*., (2025) show that the implementation of JKN-PBI at the regional level still faces issues related to coordination and public understanding, while Prasetyo *et al*., (2025) emphasize the importance of transforming the quality of services provided by BPJS Kesehatan. At the broader health system level, fragmentation in financing and institutional structures can also reduce the effectiveness, equity, and community-oriented nature of services (Gatome-Munyua *et al*., 2025; Pholpark *et al*., 2025). These findings align with the research by Susilo *et al*., (2025), which identifies organizational and financing challenges as key factors in achieving UHC in Indonesia.

Although previous research has provided important evidence regarding JKN coverage, financial protection, health service utilization, service quality, and the implementation of PBI, a deeper understanding is still needed of how these policies are translated into administrative and service practices at the local level. Much of the literature used in this study emphasizes outcomes at the national level, financial aspects, enrollment, or service utilization, while studies that simultaneously analyze communication, resources, implementers' dispositions, and bureaucratic structures to explain PBI-JKN implementation gaps at the local level remain limited in the reviewed literature. This need is particularly relevant in the context of Merauke because the research findings indicate that coordination and implementation structures are actually in place, but the quality of communication with the public, data updates, technical capabilities, and interagency coordination are not yet fully optimized. From a policy implementation perspective, this situation is significant because the success of a policy depends not only on its formal design but also on the implementing organization's ability to translate the policy into consistent actions on the ground (Edwards III, 1980; Hill & Hupe, 2022).

Based on these gaps, the novelty of this study lies in a qualitative analysis of the implementation gaps of the PBI-JKN at the local level in Merauke using Edwards III's four dimensions of policy implementation namely, communication, resources, disposition, and bureaucratic structure and linking these findings to issues of data updating, public communication, targeting accuracy, and interagency coordination. Unlike studies that primarily assess coverage, financing, or service utilization outcomes, this study focuses on the implementation process and institutional interactions that enable or hinder the policy from reaching its target groups. This approach is also relevant to the latest literature on health insurance targeting, institutional fragmentation, and organizational challenges in achieving UHC (Shah *et al*., 2025; Gatome- Munyua *et al*., 2025; Susilo *et al*., 2025). Furthermore, this study places the empirical findings analyzed based on Ministry of Social Affairs Regulation No. 21 of 2019 within the context of regulatory developments regarding the Premium Assistance Program (PBI) through Ministry of Social Affairs Regulation No. 3 of 2026, thereby providing policy relevance for strengthening the governance of the PBI-JKN program in the future.

Thus, this study aims to analyze implementation gaps in the National Health Insurance Premium Assistance Recipient Program in Merauke through the dimensions of communication, resources, implementers' dispositions, and bureaucratic structure, as well as to identify factors that hinder targeting accuracy, data updating, interagency coordination, and service responsiveness. A qualitative approach was used to gain a contextual understanding of how the PBI-JKN policy is implemented by government and health care actors at the local level. Thus, this study is expected to enrich the literature on health policy implementation by presenting empirical evidence from Merauke and providing practical implications for strengthening public communication, data governance quality, civil service capacity, and institutional coordination in the administration of the PBI-JKN program (Edwards III, 1980; Hill & Hupe, 2022; Susilo *et al*., 2025).

2. LITERATURE REVIEW

2.1 Policy Implementation and Implementation Gaps

Policy implementation is the process of translating policy decisions and objectives into operational actions by implementing organizations and actors. Edwards III (1980) explains that the success of implementation is influenced by four main dimensions: communication, resources, disposition, and bureaucratic structure. Communication relates to the transmission, clarity, and consistency of policy information; resources encompass human resource capacity, information, authority, and facilities that support implementation; disposition reflects the attitudes, commitment, and responsiveness of implementers; while bureaucratic structure relates to the division of tasks, procedures, authority, and coordination mechanisms. These four dimensions are interrelated, so that weaknesses in one dimension can affect the overall quality of implementation.

Policy implementation also does not proceed as a fully linear administrative process. Grindle (1980) emphasizes that the success of implementation is influenced by the interaction between policy content and the context of its implementation, while Hill and Hupe (2022) view implementation as a form of operational governance involving various actors, levels of government, and institutional relationships. From this perspective, the implementation gap can be understood as the discrepancy between policy intention and policy practice that is, when formal provisions are in place but their application has not yet fully produced the expected outcomes. This gap can arise due to inconsistent communication, limited resource capacity, weak support for implementers, or fragmentation in bureaucratic structures and coordination (Edwards III, 1980; Grindle, 1980; Hill & Hupe, 2022).

2.2 JKN-PBI, Universal Health Coverage, and Effective Coverage

The National Health Insurance (JKN) is Indonesia's primary instrument for expanding health protection toward universal health coverage (UHC), while the Premium Assistance Recipients (PBI) program serves to provide protection for the poor and groups unable to pay premiums on their own. However, the achievement of UHC cannot be assessed solely based on the number of people registered as participants. Pratiwi *et al*., (2021) demonstrate that UHC assessments must simultaneously consider insurance enrollment, health expenditures, and the availability of services. Maulana *et al*., (2022) also found that JKN coverage can reduce out-of-pocket expenditures for vulnerable groups, but the level of protection remains influenced by access to and the availability of health services. This highlights the importance of distinguishing between nominal insurance coverage and effective coverage.

The issue of equity further underscores the importance of effective coverage. Asante *et al*., (2023) show that the benefits and financial burdens of health care in Indonesia are distributed differently across socioeconomic groups. Putri *et al*., (2023) found that JKN enrollment among the poor is associated with factors such as education, socioeconomic status, and region of residence, while Cheng *et al*., (2025) demonstrated variations in the utilization of health services under the JKN system. Alkayyis (2024) also emphasizes the role of JKN as a key instrument for achieving UHC, but this success remains dependent on the quality of implementation. Thus, the success of the PBI-JKN program must be understood as the system's ability not only to enroll target groups but also to ensure that health protection is accessible and utilized effectively and equitably.

2.3 Targeting, Data Governance, and Inter-agency Coordination

Target accuracy is a critical element in subsidized health insurance programs because PBI is specifically directed at the poor and the financially disadvantaged. Inaccuracies in the identification process can result in exclusion errors when groups that meet the criteria do not receive subsidies or inclusion errors when assistance is received by individuals who do not meet or no longer meet the criteria. Shah *et al.,* (2025) demonstrate that strengthening health insurance targeting mechanisms can improve the accuracy of subsidy allocation to the groups most in need. From an implementation perspective, targeting accuracy is best understood as an outcome of the quality of the implementation process, particularly regarding the availability of information resources, policy communication, and bureaucratic coordination mechanisms.

The quality of targeting also depends on data governance and inter-organizational coordination. Accurate, up-to-date, and verifiable socioeconomic data are necessary to ensure that beneficiaries' status remains consistent with their actual conditions. At the same time, updating data requires the exchange of information among organizations with different authorities. Gatome-Munyua *et al*., (2025) demonstrate that the fragmentation of funding and service regulation can reduce equity and the community-oriented nature of services. Pholpark *et al*., (2025) also emphasize that institutional fragmentation poses a challenge to strengthening primary health care, including in Indonesia. These findings align with those of Sharma *et al*., (2024) regarding the importance of coordination among stakeholders, as well as Susilo *et al*., (2025), who indicate that organizational and financing challenges remain significant obstacles in the implementation of the National Health Insurance (JKN) toward Universal Health Coverage (UHC). Therefore, data governance and institutional coordination are crucial mechanisms that link policy to the accurate targeting of beneficiaries.

2.4 Theoretical Framework of the Study

This study employs Edwards III's (1980) policy implementation theory as the primary analytical framework, which encompasses communication, resources, dispositions, and bureaucratic structure. These four dimensions are used to assess how the PBI-JKN policy is translated at the local level. This perspective is reinforced by Grindle (1980) and Hill and Hupe (2022), who emphasize the importance of context, institutional capacity, and coordination among actors in the implementation process. The literature on universal health coverage, effective coverage, targeting, data governance, and interagency coordination is used to broaden the interpretation of these four dimensions. In this study, implementation gaps are analyzed across four domains: targeting accuracy, data governance, interagency coordination, and service responsiveness. These conceptual relationships are presented in Figure 1 as an analytical lens, not as a causal model.

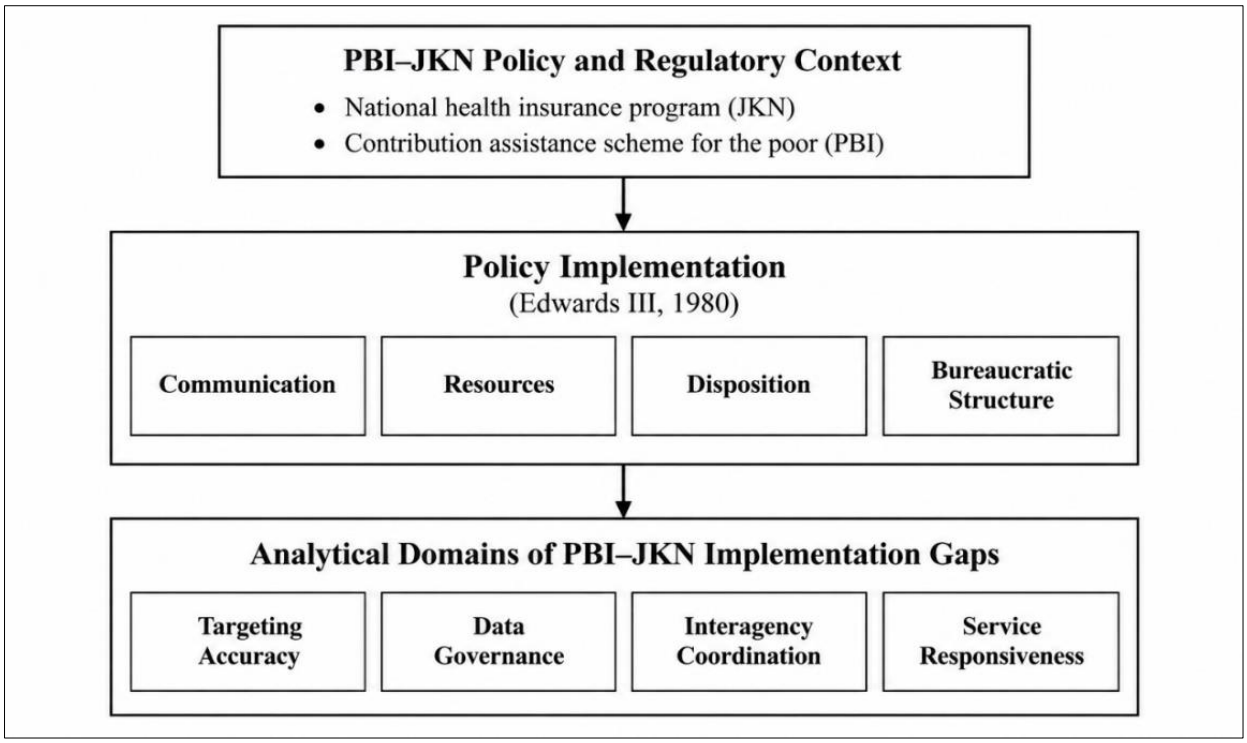

Figure 1: Conceptual Framework for Analyzing PBI-JKN Implementation Gaps
Source: Authors' conceptualization based on Edwards III (1980) and supporting literature.

3. METHOD

3.1 Research Design and Setting

This study employs a qualitative descriptive approach to understand the implementation of the National Health Insurance Premium Assistance Program (PBI-JKN) at the local level. The qualitative approach was chosen because it allows for the exploration of administrative practices, implementers' experiences, and institutional dynamics in the policy implementation process (Creswell & Poth, 2018). The study was conducted in Kelapa Lima Village, Merauke District, Merauke Regency, South Papua Province, which was purposively selected due to its implementation dynamics regarding the PBI-JKN program—specifically in terms of targeting accuracy, service delivery, and interagency coordination.

3.2 Informant Selection

Informants were selected using purposive sampling based on their involvement, authority, and knowledge regarding the implementation of the PBI-JKN at the local level. The selection focused on institutional actors directly involved in the administrative and service processes related to the program so that they could provide relevant information regarding policy implementation practices. Overall, the study involved six key informants, whose profiles are presented in Table 1.

3.3 Data Collection

Data were collected through observation, in-depth interviews, and documentation. Interviews were used to obtain information regarding the policy implementation process, while observation was used to understand the context of program implementation. Documentation supplemented the data through official documents, reports, policies, archives, and relevant administrative information. The use of multiple data collection techniques allowed for the comparison of information from various sources and supported the triangulation process.

Table 1: Profile of Key Institutional Informants

Code	Position	Institution / Administrative Level
I1	Acting Head of Merauke District	Merauke District
I2	Head of the Community and Urban Village Empowerment Section	Merauke District
I3	Head of Kelapa Lima Urban Village	Kelapa Lima Urban Village
I4	Head of the Community Empowerment Section	Kelapa Lima Urban Village
I5	Head of the Kelapa Lima Community Health Center	Kelapa Lima Community Health Center
I6	Coordinator of Management Cluster 1	Kelapa Lima Community Health Center
Total		**6 informants**

Source: Primary data, 2026.

3.4 Data Analysis and Reliability

Data analysis was conducted iteratively, following the qualitative analysis procedures outlined by Creswell and Poth (2018) and Miles *et al*., (2014). The analysis stages included organizing the data, conducting a comprehensive review of the data, coding, developing categories and themes, and presenting the findings narratively. Coding was guided by the four dimensions of implementation proposed by Edwards III—communication, resources, disposition, and bureaucratic structure—while allowing for the inductive emergence of codes and categories from the data. The resulting categories were then used to identify patterns of implementation gaps, including issues of target accuracy and interagency coordination.

The validity of the findings was strengthened through triangulation of sources, data, and methods. The analysis was conducted iteratively until new information no longer resulted in substantive changes to the established categories and themes. The principles of credibility, transferability, dependability, and confirmability were applied to support the quality of the research interpretation.

4. RESULTS

4.1 Overview of PBI-JKN Implementation

The implementation of the PBI-JKN program in Kelapa Lima Village involves the district government, the village government, health care facilities, and other agencies with authority over participant management. At the local level, the village plays a role in disseminating information, conducting initial data collection, gathering documents, and proposing data changes, while the Community Health Center (Puskesmas) is responsible for health services and verifying participant status. Administrative data show that PBI-JKN participants are distributed across seven RTs in Kelapa Lima Subdistrict. This distribution provides context regarding the program's coverage at the local level and serves as a basis for understanding the dynamics of PBI-JKN implementation in the study area. Details of participant distribution are presented in Table 2.

Table 2: Distribution of PBI-JKN Participants by RT in the Kelapa Lima Subdistrict

Neighborhood Unit	Number of Participants	Percentage
RT 01	50	10%
RT 02	75	15%
RT 03	60	12%
RT 04	80	16%
RT 05	100	20%
RT 06	70	14%
RT 07	65	13%
Total	**500**	**100%**

Source: Kelapa Lima Subdistrict Monograph Data, 2026.

Interviews with six informants indicated that, in general, the PBI-JKN mechanism is functioning. However, its implementation is not yet fully optimal. Recurring issues identified in the interviews include delays in data updates, uneven public understanding of procedures, limited authority at the kelurahan and Puskesmas levels, and time-consuming interagency coordination. Conversely, implementers' attitudes toward the program are relatively positive and supportive of service delivery to the community. A summary of findings based on the four dimensions of implementation is presented in Table 3.

Table 3: Summary of Findings on PBI-JKN Implementation

Dimension	Key Findings	Identified Gaps
Communication	Inter-agency coordination and information sharing have been carried out	Information has not always been timely, consistent, and understood by the public
Resources	Personnel, data, health workers, facilities, and information systems are available	Data updates, technical capabilities, and administrative completeness still need to be strengthened
Disposition	Implementers demonstrate responsibility and responsiveness	Accuracy, consistency of information, and response speed still need to be improved
Bureaucratic structure	The division of tasks and authority is relatively clear	Problem-solving can be slowed down because it involves multiple levels and agencies

Source: Research findings, 2026.

4.2 Communication: Coordination Is Taking Place, but Information Is Not Yet Fully Effective

Interview results indicate that communication has taken place both vertically and horizontally among districts, sub-districts, health facilities, and relevant agencies. The information shared includes the registration of potential beneficiaries, nominations, data updates, enrollment status, and the resolution of administrative issues. At the district level, communication mechanisms are considered to be in

place, but the speed of information dissemination and data updates remains a challenge. Informant I1 stated:

> *"There are still limitations, particularly regarding the speed of information dissemination and data updates."* (I1, interview, 2026)

The perspective from the urban village level reveals slightly different issues. Obstacles lie not only in inter-institutional communication flows but also in the public's understanding of the PBI-JKN procedures. Some residents are not yet fully aware of the data update mechanisms, while changes in social or family circumstances are not always promptly reported to the urban village office. Informant I3 explained:

> *"There are still members of the community who are not very proactive in reporting changes in their family circumstances."* (I3, interview, 2026)

This situation can result in beneficiary data that does not fully reflect the community's current circumstances. Subdistrict informants also emphasized the need for simpler and more intensive information dissemination so that the requirements and mechanisms for updating data can be better understood.

From the perspective of health services, community health centers (Puskesmas) face communication challenges primarily related to enrollment status. Staff provide information and guide the public when administrative issues arise, but further resolution must be handled in collaboration with the authorities responsible for data management. Informants from the Puskesmas also noted that there are still members of the public who do not fully understand their enrollment status or the steps to take when data changes occur.

Thus, the communication problem does not stem from a lack of inter-institutional relationships. Rather, gaps arise in the speed of information delivery, the consistency of information, public understanding, and follow-up on data changes. Differences in experiences across districts, urban villages, and community health centers indicate that the quality of communication depends heavily on an institution's position within the implementation chain.

4.3 Resources: Available, but Data and Technical Capacity Remain Challenges

Research findings indicate that the implementation of PBI-JKN has been supported by various resources, including government officials, population data, administrative facilities, health workers, administrative staff, and the enrollment information system. At the district and sub-district levels, human resources are needed to receive information from the public, conduct data collection, assist with administrative processes, and submit proposals for data changes.

Nevertheless, data quality remains a major issue. Changes in the economic, social, and administrative conditions of the community require periodic updates. Informant I2 emphasized:

> *"Regular updates are necessary to ensure that PBI recipients truly reflect the actual conditions of the community."* (I2, interview, 2026)

At the urban village level, resource issues are also related to the completeness of community documents and the technical capabilities of staff. Officials have assisted the community with data collection and document gathering, but not all residents have the same level of administrative readiness. Additionally, informants noted that technical capabilities for data updates still need to be strengthened so that services can be delivered more quickly and accurately.

At the community health center (Puskesmas) level, service resources are relatively available in the form of health workers, administrative staff, service facilities, and an information system that can be used to verify participant status. However, the availability of these resources does not automatically mean that all enrollment issues can be resolved at health facilities. Informant I5 stated:

> *"Community health centers do not have the authority to determine PBI recipients."* (I5, interview, 2026)

When enrollment data does not match current conditions, community health centers must coordinate with the sub-district office or the relevant authority. This situation indicates that resource constraints are not only related to the number of personnel or facilities but also to data accuracy, technical capacity, administrative completeness, and institutional authority.

4.4 Disposition: Implementers' Commitment Relatively Supports Implementation

Unlike communication and resources, the disposition dimension shows a relatively stronger condition. Informants described that district officials, sub-district health centers ( ), and Puskesmas staff strive to carry out their duties within their authority, assist the community, provide information, and deliver services without discriminating against recipients based on their background.

At the kelurahan level, officials strive to assist the community with administrative processes and provide guidance when enrollment issues arise. At health facilities, the commitment to service is reflected in efforts to provide care professionally and in accordance with procedures. Informant I5 stated:

> *"Services must be provided professionally and without discrimination."* (I5, interview, 2026)

Although the attitudes of service providers are generally positive, informants still identified a need to

improve accuracy, discipline, and response speed. This relates primarily to handling reports of data changes and ensuring the consistency of information provided to the public. Informant I6 noted:

> *"There is still a need to improve coordination and consistency in providing information."* (I6, interview, 2026)

Thus, the attitudes of implementers are not a dominant barrier to the implementation of the PBI-JKN. Implementers demonstrate a commitment to the program's objectives, but the impact of these positive attitudes remains dependent on the available data systems, technical capacity, and coordination.

4.5 Bureaucratic Structure: Clear Division of Labor, but Multi-Level Coordination

The bureaucratic structure in the implementation of PBI-JKN has demonstrated a relatively clear division of tasks. Districts carry out coordination and guidance functions, sub-districts handle administrative relations with the community, while community health centers (Puskesmas) provide health services to participants. Informants generally understand their respective positions and authorities in the implementation process.

However, this division of authority also creates inter-institutional dependencies. Sub-districts lack the authority to resolve all issues related to changes in participant status, while community health centers (Puskesmas) cannot establish or modify PBI participant data. Consequently, certain issues must be referred to other agencies with further authority. Informant I2 explained:

> *"Administrative processes involving multiple levels take time if coordination is not carried out promptly."* (I2, interview, 2026)

From the subdistrict's perspective, processes that cannot be resolved at the local level must be referred to other parties. This situation can prolong the resolution of issues if communication and follow-up do not occur promptly. At health facilities, a similar pattern is observed when patients encounter enrollment status issues. Community health centers can provide information and guidance, but administrative resolution remains dependent on the authorized agency.

These findings indicate that the problem with the bureaucratic structure lies not primarily in unclear functions, but rather in the fragmentation of authority and the need for interagency coordination. A structure involving multiple administrative levels is effective when information exchange and follow-up mechanisms occur quickly; conversely, delays in coordination can prolong the resolution of enrollment issues.

4.6 Implementation Gaps in the PBI-JKN

An analysis across the four dimensions reveals four main areas of implementation gaps. First, targeting accuracy relates to the system's ability to maintain alignment between the actual conditions of the population and the status of PBI recipients. Changes in family circumstances that are not immediately reported, as well as incomplete administrative documents, can result in recipient data that does not fully reflect the most current situation. Second, data governance is a cross-dimensional issue because data updates depend not only on the availability of information but also on communication with the public and interagency coordination. Thus, data issues are not merely technical but also institutional in nature.

Third, interagency coordination represents a significant gap because implementation responsibilities are spread across several organizations. The sub-district office serves as the primary point of contact for the community, while the community health center (Puskesmas) provides health services; however, neither has full authority to make changes to beneficiary data. This situation means that the speed at which issues are resolved depends heavily on the quality of coordination with the relevant authorities. Fourth, service responsiveness relates to the system's ability to promptly address enrollment issues and provide easily understandable information. Although officials tend to demonstrate a responsive attitude, the effectiveness of their responses can still be limited by outdated data, restricted authority, and the need for cross-organizational coordination.

Overall, the PBI-JKN has been operating at the local level and is supported by available staff and implementation structures; however, gaps still exist in data updates, procedural understanding, administrative completeness, and interagency coordination. Thus, the main issue does not lie in a lack of implementation, but rather in the quality of the implementation process particularly in integrating data, communication, authority, and coordination so that beneficiaries' problems can be addressed more accurately and responsively.

5. DISCUSSION

5.1 Communication and Information Gaps

The findings indicate that communication issues in the implementation of PBI-JKN do not stem from a lack of communication channels, but rather from the quality of information dissemination particularly regarding speed, consistency, and public understanding. This implies that formal interagency coordination does not automatically result in effective policy communication at the beneficiary level. From the perspective of Edwards III (1980), implementation requires the transmission, clarity, and consistency of information so that policies can be understood and implemented uniformly. Because PBI-JKN information

passes through several institutional levels, misalignment or delays at any one stage can affect the administrative follow-up process.

This finding is consistent with Dasopang *et al*., (2024), who demonstrated that JKN implementation still faces various operational and coordination challenges, as well as Lestari *et al*., (2025), who highlighted challenges in implementing PBI-JKN at the local level. Hill and Hupe (2022) also explain that the implementation of policies involving many actors is prone to differences in interpretation and information flow within the operational governance process. These conditions help explain why information regarding procedures for data changes and enrollment status is not always understood uniformly. Consequently, improving communication requires not only increasing the frequency of outreach but also simplifying information, ensuring consistency of messages across agencies, and clarifying follow-up procedures for the public.

5.2 Resources and Data Governance

In terms of resources, the main issue is not merely the availability of personnel, facilities, or information systems, but the system's ability to ensure that beneficiary data remains accurate and aligned with the actual conditions of the community. These findings indicate that data is a strategic resource in the implementation of the PBI-JKN. When data is not updated in a timely manner, the accuracy of targeting and the smoothness of administrative processes can be disrupted even if personnel and service facilities are available. Thus, resources in program implementation are not merely material in nature but also encompass the quality of information, technical capabilities, and institutional authority.

This interpretation aligns with Shah *et al*., (2025), who highlight the importance of targeting mechanisms in improving the accuracy of health insurance subsidies, as well as Susilo *et al*., (2025), who emphasize organizational challenges in administering the JKN. Data issues in this study can be understood as the result of interactions between changes in the community's socioeconomic conditions, administrative capacity, document completeness, and the distribution of authority among organizations. Therefore, the implications extend beyond the need for routine database updates to include enhancing the technical capacity of civil servants, implementing more responsive verification procedures, and establishing more coordinated data-update mechanisms.

5.3 Disposition as a Supporting but Insufficient Condition

The disposition of implementers is the aspect that is relatively most supportive of PBI-JKN implementation. Officials demonstrate a commitment to helping the public, carrying out their duties according to procedures, and providing services in a nondiscriminatory manner. The key implication of this finding is that implementation barriers do not primarily stem from resistance or a lack of willingness on the part of implementers. However, a positive attitude does not always result in optimal service delivery if implementers are still faced with outdated data, limited authority, and coordination procedures involving multiple agencies.

These findings are consistent with Edwards III (1980), who identifies disposition as one of the key conditions for implementation, though not a standalone factor. Grindle (1980) also emphasizes that implementers' behavior always operates within specific institutional and administrative contexts. This study shows that the commitment of new implementers can only translate into effective service delivery if it is supported by adequate information, authority, and coordination mechanisms. The implication is that improving the quality of implementation requires more than just strengthening motivation or service orientation; it must be accompanied by improvements to the work system that enable civil servants to respond to enrollment issues quickly, accurately, and consistently.

5.4 Bureaucratic Structure and Interagency Coordination

The findings indicate that the division of tasks among organizations is relatively clear, but the resolution of enrollment issues often depends on interagency coordination. This implies institutional interdependence in the PBI-JKN implementation process. While the division of authority is necessary to maintain accountability, when authority is dispersed across multiple organizational levels, the speed of problem resolution is heavily determined by the quality of coordination and the clarity of follow-up procedures.

These findings align with those of Susilo *et al*., (2025), who identified organizational challenges in the implementation of JKN. Within the broader literature, Gatome-Munyua *et al*., (2025) and Pholpark *et al*., (2025) demonstrate that institutional and funding fragmentation can hinder the integration of health services. While this literature does not directly address the bureaucratic structure of the PBI at the kelurahan level ( ), it provides the context that the separation of authority can increase the need for cross-organizational coordination. Therefore, policy implications need not involve changes to formal structures but rather the strengthening of coordination channels, case escalation mechanisms, and more integrated information exchange among agencies.

5.5 Cross-Cutting Implementation Gaps and Policy Implications

Overall, this study shows that PBI-JKN implementation gaps arise from the interplay between targeting accuracy, data governance, interagency coordination, and service responsiveness. These four aspects are not new dimensions beyond Edwards III but

are empirical manifestations of the interaction between communication, resources, dispositions, and bureaucratic structure. Among these four, data governance and interagency coordination appear as cross-dimensional mechanisms because data quality depends on communication with the public, civil service capacity, the diligence of implementers, and interorganizational working relationships. Thus, the existence of policies, civil service personnel, and formal structures is not always sufficient to ensure responsive implementation if the relationships among these elements are not well integrated.

This finding aligns with the UHC literature, which emphasizes that the success of a health insurance system is determined not only by the number of enrollees but also by the system's ability to effectively provide protection and access (Pratiwi *et al*., 2021; Maulana *et al*., 2022; Asante *et al*., 2023; Cheng *et al*., 2025). Therefore, the success of the PBI-JKN should not be assessed solely based on enrollment coverage but also on the system's ability to ensure the accuracy of beneficiary identification, update data in a responsive manner, and resolve administrative issues efficiently. In the context of the evolving PBI policy, including the issuance of Ministry of Social Affairs Regulation No. 3 of 2026, the findings of this study are relevant for strengthening the governance of implementation at the local level, particularly through data integration, interagency coordination, and improved administrative responsiveness.

6. CONCLUSION

This study shows that the implementation of PBI-JKN in Kelapa Lima Subdistrict has proceeded with the support of communication, resources, implementers' disposition, and bureaucratic structure, but has not yet been fully optimal. Implementation gaps are primarily related to data updates, understanding of procedures, administrative completeness, limitations on authority, and interagency coordination. Implementer disposition is relatively the most supportive aspect, while data governance and interagency coordination emerge as key mechanisms influencing the quality of implementation. The contribution of this study lies in the use of the Edwards III framework to explain that the success of the PBI-JKN program is determined not only by the existence of regulations and administrative personnel but also by the system's ability to integrate information, data, authority, and administrative follow-up. Consequently, efforts to strengthen the program should focus on more responsive data updating and verification, enhancing the technical capacity of officials, simplifying information for the public, and establishing clearer mechanisms for interagency coordination.

This study is limited to one local region and six institutional informants; therefore, the findings primarily represent the perspectives of program implementers and do not directly reflect the experiences of PBI beneficiaries. Furthermore, the qualitative design is not intended to produce statistical generalizations. Future research could involve beneficiaries, expand the study locations to include several regions with different characteristics, and use comparative, longitudinal, or mixed-methods designs to further examine how the quality of data governance and interagency coordination affect the accuracy of targeting and the effectiveness of PBI-JKN implementation.

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