



Evaluation of the Implementation of the Healthy Special Authority Card Program (KO Sehat) Health Services at BLUD RSUD Nabire

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ABSTRACT

This qualitative case study examines the implementation of the Special Autonomy Health Card (KO SEHAT) program at BLUD RSUD Nabire in Central Papua Province, Indonesia. The research investigates the program's effectiveness in improving healthcare access for Indigenous Papuans, identifying implementation challenges, and analyzing its impact on healthcare service quality. Utilizing a purposive sampling approach, the study gathered data through in-depth interviews with 12 key informants, including hospital management, healthcare professionals, patients, and local health officials. The findings reveal that while the KO SEHAT program has significantly enhanced healthcare accessibility for Indigenous Papuans, several critical challenges persist. These include insufficient program socialization, administrative barriers, limited funding, and communication gaps between healthcare providers and beneficiaries. The study highlights the program's positive contributions to healthcare equity, while also identifying key areas for improvement in implementation and service delivery.

INTRODUCTION

Healthcare accessibility remains a persistent challenge in developing countries, particularly in remote and marginalized regions with complex socio-geographical landscapes (Crisp et al., 2018). In Indonesia, the Province of Papua exemplifies these challenges, characterized by significant healthcare disparities that disproportionately affect Indigenous populations. Historical systemic inequities, compounded by challenging geographical terrain and limited infrastructure, have consistently hindered equitable healthcare access for Indigenous Papuans (Renwarin et al., 2020).

The implementation of targeted healthcare interventions has emerged as a critical strategy to address these deep-rooted disparities. The Special Autonomy Health Card (KO SEHAT) program represents a pioneering policy initiative designed to bridge healthcare gaps and provide specialized medical access for Indigenous Papuans. Grounded in the principles of social justice and healthcare equity, this program aims to rectify historical marginalization through a localized, context-specific approach to healthcare delivery (Moniaga & Sahetapy, 2022).

Contextualizing the program's significance requires understanding the unique healthcare landscape of Papua. The region faces multifaceted challenges, including geographical isolation, limited healthcare infrastructure, cultural diversity, and socioeconomic constraints that systematically impede healthcare access (Julianty et al., 2021). Indigenous populations in Papua have historically experienced lower health outcomes, reduced medical service utilization, and significant barriers to comprehensive healthcare services (Wahyuni et al., 2019).

The KO SEHAT program emerges as a strategic response to these complex challenges. Implemented by the Central Papua Provincial Government, the initiative seeks to transcend traditional healthcare delivery models by providing targeted support for Indigenous Papuans. Unlike broader national health insurance schemes, KO SEHAT offers a localized approach that recognizes the unique contextual requirements of the region's Indigenous communities.

The program's theoretical foundation draws from intersectional approaches to healthcare policy, emphasizing the importance of culturally sensitive and geographically responsive medical interventions (Hardianto & Sulistyowati, 2023). By focusing on Indigenous populations' specific needs, KO SEHAT represents an innovative model of affirmative healthcare policy that addresses systemic inequities through targeted resource allocation and specialized service delivery.

Against this complex healthcare landscape, this research undertakes a comprehensive examination of the KO SEHAT program's implementation at BLUD RSUD Nabire, recognizing the critical importance of contextual, localized approaches to healthcare policy. The study emerges from a growing scholarly recognition that effective healthcare interventions must transcend generic policy frameworks, instead addressing the unique socio-cultural, geographical, and systemic challenges specific to marginalized communities.

THEORETICAL REVIEW

Healthcare accessibility represents a profound challenge that intersects complex social, economic, and geographical dimensions, particularly in marginalized regions of developing countries (Crisp et al., 2018; Bambra et al., 2020). In the context of Indonesia, and specifically Papua, healthcare disparities reveal a deeply entrenched narrative of systemic inequity that extends far beyond mere geographical constraints (Renwarin et al., 2020). The landscape of healthcare in Indigenous Papuan communities emerges as a critical site of intersection between historical marginalization, contemporary policy interventions, and the fundamental human right to health (Hardianto & Sulistyowati, 2023).

The historical trajectory of healthcare in Papua is characterized by a persistent disconnection between policy intentions and ground-level realities. Indigenous populations have navigated a challenging terrain marked by limited infrastructure, cultural misunderstandings, and systemic barriers that have systematically limited their access to comprehensive medical services (Julianty et al., 2021). This context demands a nuanced understanding that moves beyond simplistic interpretations of healthcare accessibility, recognizing instead the intricate web of social, cultural, and economic factors that shape health experiences (Wahyuni et al., 2019).

Local health insurance initiatives like the KO SEHAT program represent a significant paradigm shift in addressing these deeply rooted challenges (Moniaga & Sahetapy, 2022). These localized approaches signal a more sophisticated understanding of healthcare delivery, one that acknowledges the unique contextual requirements of Indigenous communities. Unlike broader national insurance schemes, such targeted interventions recognize the importance of cultural sensitivity, administrative flexibility, and community-specific needs (Widyaningsih et al., 2021). They embody a more responsive approach to healthcare policy, one that seeks to bridge historical gaps through carefully designed, context-specific mechanisms.

The theoretical underpinnings of such interventions draw from multiple interdisciplinary perspectives. The Input-Process-Output (IPO) model, originally developed by von Bertalanffy (1950), provides a systematic framework for understanding policy implementation, allowing researchers to examine the intricate interactions between policy design, institutional practices, and community outcomes (Peters, 2019). Simultaneously, social equity theories offer a critical lens for understanding how healthcare interventions can address historical marginalization and systemic inequities (Sen & Ostlin, 2020).

Empirical research has consistently highlighted the multifaceted nature of healthcare challenges in regions like Papua (Crisp et al., 2018). These challenges extend far beyond simple infrastructure deficits, encompassing complex issues of cultural communication, economic constraints, and historical trauma (Bhugra & Bhui, 2021). Indigenous populations face a unique set of barriers that require sophisticated, holistic approaches to healthcare delivery. These barriers are not merely practical but deeply rooted in historical processes of marginalization and systemic exclusion (Paradies et al., 2015). The research landscape reveals

significant gaps in our understanding of localized health initiatives (Marmot et al., 2020). While existing studies provide valuable insights, there remains a critical need for comprehensive investigations that explore the nuanced interactions between policy design, implementation, and community experience. Key areas of inquiry include the long-term impacts of targeted healthcare interventions, the adaptive strategies employed by communities, and the complex ways in which healthcare policies are interpreted and enacted at the local level (Blas & Kurup, 2019).

This study's conceptual framework emerges from this complex intellectual terrain. It seeks to integrate multiple theoretical perspectives, recognizing that understanding healthcare accessibility requires a holistic approach (Willis et al., 2021). By combining systems-based analysis, social equity theories, and community-centered methodologies, the research aims to generate insights that go beyond traditional policy evaluation (Baum et al., 2019).

The significance of this approach lies in its potential to reveal the complex dynamics of healthcare policy implementation in marginalized regions. It represents more than an academic exercise; it is a critical exploration of how healthcare systems can be redesigned to address historical inequities, respect cultural diversity, and provide meaningful, accessible healthcare to Indigenous communities (Farmer et al., 2020). Ultimately, the literature review underscores a fundamental truth: effective healthcare interventions must be deeply contextual, culturally sensitive, and responsive to the unique experiences of marginalized communities (Sen et al., 2018). The KO SEHAT program represents not just a policy intervention, but a potential pathway towards more equitable and inclusive healthcare systems (Moniaga & Sahetapy, 2022).

METHODOLOGY

Navigating the complex landscape of healthcare policy research requires a methodological approach that can capture the nuanced realities of policy implementation in marginalized regions. This study embraced a qualitative case study methodology, recognizing the profound importance of understanding healthcare interventions through the lived experiences of those directly impacted (Lincoln & Guba, 1985; Stake, 2010). The research emerged from a critical need to move beyond surface-level policy analysis, instead delving into the intricate social, cultural, and institutional dynamics that shape healthcare accessibility in Indigenous Papuan communities.

The methodological journey began with a careful consideration of research design, rooted in an interpretive paradigm that acknowledges the subjective nature of social experiences (Denzin & Lincoln, 2017). Unlike positivist approaches that seek to establish universal truths, this research sought to illuminate the complex interactions between policy intentions and ground-level realities. The Input-Process-Output (IPO) model provided a comprehensive analytical framework, offering a systematic lens through which to examine the KO SEHAT program's implementation (von Bertalanffy, 1950; Peters, 2019).

Central to the research design was the selection of BLUD RSUD Nabire as a critical site of inquiry. This hospital represents more than a mere healthcare

facility; it is a microcosm of the broader challenges and opportunities in delivering healthcare to Indigenous populations in Papua. The research site was carefully chosen to provide rich, contextually grounded insights into the KO SEHAT program's implementation (Yin, 2018). Nabire's unique geographical and social landscape—characterized by isolation, cultural complexity, and historical marginalization—offered an ideal setting for a deep, nuanced investigation.

Participant selection was approached with methodological intentionality, employing purposive sampling to identify information-rich sources that could provide comprehensive insights into the program (Patton, 2015). The research assembled a diverse cohort of 12 key informants, carefully curated to represent multiple perspectives: hospital management, healthcare professionals, patients, local health officials, and community representatives. This approach ensured a multifaceted understanding of the program, capturing the experiences and interpretations of those most intimately involved with its implementation (Miles et al., 2014).

Data collection emerged as a complex, multidimensional process. In-depth, semi-structured interviews formed the primary method of inquiry, designed to elicit rich, narrative accounts of participants' experiences (Kvale, 2007). These interviews were supplemented by comprehensive document analysis and non-participant observation, creating a robust, triangulated approach to data gathering. Conducted primarily in Bahasa Indonesia, the interviews were carefully structured to respect cultural nuances and create a space of trust and openness (Roulston, 2010).

The analytical approach drew from Braun and Clarke's (2006) thematic analysis methodology, a rigorous approach to qualitative data interpretation. This process was far more than a mechanical coding exercise; it represented a sophisticated hermeneutic engagement with the data, seeking to uncover underlying patterns, meanings, and interpretations. Researchers moved iteratively between data collection and analysis, allowing emerging insights to shape and refine the research understanding (Charmaz, 2014).

RESULTS

Based The landscape of healthcare intervention in marginalized regions is fraught with complexity, nuance, and profound human experiences. The KO SEHAT program at BLUD RSUD Nabire emerges as a compelling narrative of institutional aspiration, community resilience, and the intricate challenges of addressing deeply rooted healthcare disparities in Indigenous Papuan communities.

At the heart of the program's implementation lies a profound attempt to transcend historical healthcare inequities. The journey begins with a recognition of systemic barriers that have long prevented Indigenous Papuans from accessing comprehensive medical services. Hospital administrators and healthcare professionals articulated a vision of transformation, one that extends far beyond mere medical treatment to address the deeper social and cultural dimensions of healthcare access.

The initial stages of program implementation revealed a complex interplay of institutional readiness and contextual challenges. While the hospital demonstrated significant commitment to the program's objectives, the ground-level reality exposed a landscape of intricate obstacles. Administrative infrastructures, deeply ingrained in existing systemic practices, struggled to accommodate the program's innovative approach. Cultural communication emerged as a critical challenge, highlighting the vast gulf between policy intentions and lived experiences of Indigenous communities.

Healthcare professionals navigated a delicate balance between institutional expectations and the practical realities of patient care. Their narratives spoke to a profound commitment tempered by frustration. One physician poignantly described the program as "a bridge between intention and implementation, fraught with both promise and challenge." The additional administrative burden, coupled with delayed compensation and limited resources, created a complex emotional and professional landscape for medical staff.

Patient experiences offered the most intimate glimpse into the program's impact. Indigenous Papuan patients articulated a nuanced perspective that simultaneously celebrated the program's potential and acknowledged its limitations. Their stories revealed a deep appreciation for reduced financial barriers to healthcare, balanced against the frustration of navigating complex administrative processes. One patient eloquently described the KO SEHAT program as "a ray of hope, though not yet a fully illuminated path."

The program's implementation exposed critical systemic challenges. Socialization deficits emerged as a fundamental barrier, with limited community awareness and insufficient program explanation creating significant obstacles. Documentation requirements became a labyrinthine process, often deterring potential beneficiaries. Cultural and linguistic barriers further complicated the implementation, highlighting the need for more sensitive, contextualized approaches to healthcare delivery.

Resource constraints presented another significant challenge. Limited funding, incomplete medical inventories, and staffing limitations created ongoing tensions in service delivery. The hospital found itself constantly negotiating between ambitious program objectives and practical implementation constraints. This dynamic revealed the broader challenges of implementing innovative healthcare interventions in resource-limited settings.

Yet, within these challenges, the research uncovered profound moments of transformative potential. The KO SEHAT program represented more than a mere healthcare intervention; it was a critical step towards addressing historical marginalization. It signaled an institutional recognition of the unique healthcare needs of Indigenous Papuan communities, offering a glimpse of a more equitable healthcare future.

The program's impact extended beyond immediate medical services. It challenged existing paradigms of healthcare delivery, pushing institutions to reconsider their approach to community health. Cultural sensitivity emerged as a critical dimension, highlighting the importance of understanding healthcare

not just as a technical intervention, but as a deeply human, contextual experience.

As the research concluded, it became clear that the KO SEHAT program represented a complex journey of institutional learning and community engagement. It was neither a complete success nor a simple failure, but a nuanced exploration of the possibilities and challenges of addressing healthcare disparities. The program stood as a testament to the ongoing work of creating more equitable, responsive healthcare systems.

The findings underscore a fundamental truth: effective healthcare interventions must be deeply rooted in local contexts, responsive to community needs, and committed to ongoing adaptation and learning. The KO SEHAT program at BLUD RSUD Nabire offers a powerful case study in the complexities of healthcare policy implementation, challenging us to reimagine approaches to medical service delivery in marginalized communities.

DISCUSSION

The landscape of healthcare intervention in marginalized regions is a complex tapestry of human experiences, institutional challenges, and transformative potential. The KO SEHAT program at BLUD RSUD Nabire emerges as a profound narrative of healthcare policy implementation, revealing the intricate dynamics of addressing systemic healthcare disparities in Indigenous Papuan communities (Renwarin et al., 2020).

At the heart of this exploration lies a deep understanding of healthcare accessibility as more than a mere technical challenge. Researchers have long recognized that effective healthcare interventions must transcend infrastructural provisions, delving into the complex social, cultural, and institutional barriers that impede medical access (Julianty et al., 2021). The KO SEHAT program illuminates this complexity, presenting a nuanced journey of institutional adaptation and community engagement.

The program's implementation revealed a delicate dance between policy intentions and ground-level realities. Healthcare professionals navigated a challenging landscape, balancing institutional expectations with the practical realities of patient care. Their experiences echoed broader research on local health initiatives, which emphasize the critical role of frontline workers in mediating policy implementation (Hardianto & Sulistyowati, 2023). Each interaction became a moment of potential transformation, challenging existing paradigms of healthcare delivery.

Sociocultural dimensions emerged as a critical lens for understanding healthcare access. Patient narratives spoke to the profound importance of culturally sensitive medical services, highlighting the need for interventions that recognize the unique contextual experiences of Indigenous communities (Crisp et al., 2018). The program represented more than a medical intervention; it was a dialogue between institutional systems and community experiences, attempting to bridge historical gaps in healthcare equity.

The identified barriers to program implementation offered a window into the systemic challenges of healthcare delivery in marginalized regions. Administrative complexities, limited program socialization, and resource constraints created a challenging landscape for policy implementation (Wahyuni et al., 2019). These challenges were not mere operational obstacles but manifestations of deeper systemic inequities that have historically marginalized Indigenous populations.

Yet, within these challenges, the research uncovered moments of profound transformative potential. The KO SEHAT program challenged existing healthcare paradigms, pushing institutions to reconsider their approach to community health. It represented a critical step towards addressing historical healthcare disparities, offering a model of more responsive, culturally sensitive healthcare interventions (Sen et al., 2018).

The theoretical implications of the research extend beyond the specific context of BLUD RSUD Nabire. The Input-Process-Output (IPO) model proved particularly illuminating, offering a comprehensive framework for understanding the complex interactions between policy design, institutional practices, and community experiences (Peters, 2019). It revealed healthcare policy implementation as a dynamic, interactive process rather than a linear, top-down intervention.

Practical implications emerged as a critical outcome of the research. The study highlighted the need for:

1. Enhanced community engagement strategies
2. Improved administrative training
3. More flexible implementation approaches
4. Increased resource allocation
5. Sustained commitment to cultural sensitivity

These recommendations speak to the broader challenge of creating healthcare systems that are not just technically proficient but fundamentally responsive to community needs (Moniaga & Sahetapy, 2022).

The research acknowledges its inherent limitations. As a single-site case study, it offers depth of understanding while recognizing the challenges of broader generalizability. Future research opportunities beckon, promising deeper explorations of:

1. Comparative studies across different regional contexts
2. Long-term impact assessments
3. Detailed analyses of policy adaptation strategies

Ultimately, the KO SEHAT program at BLUD RSUD Nabire stands as a powerful testament to the complexities of healthcare policy implementation. It reveals the profound challenges and potential of targeted healthcare interventions in marginalized regions, emphasizing the need for nuanced, context-sensitive approaches to addressing healthcare disparities.

The journey of the KO SEHAT program is more than a story of policy implementation. It is a narrative of human resilience, institutional learning, and the ongoing work of creating more equitable healthcare systems. It challenges us to reimagine healthcare not as a service to be delivered, but as a collaborative dialogue between institutions and communities (Paradies et al., 2015).

CONCLUSIONS AND RECOMMENDATIONS

The journey of healthcare policy implementation is rarely a straightforward path. It is a complex narrative of human experiences, institutional challenges, and transformative aspirations. The KO SEHAT program at BLUD RSUD Nabire emerges as a profound testament to the intricate challenges of addressing healthcare disparities in marginalized Indigenous communities.

At the heart of this research lies a deep exploration of healthcare accessibility, revealing layers of complexity that extend far beyond simple medical service delivery. The program represents more than a policy intervention; it is a nuanced dialogue between institutional intentions and community realities. Each interaction, each administrative process, each moment of medical care becomes a critical point of negotiation between historical marginalization and contemporary healthcare aspirations.

The research uncovered a landscape of remarkable potential and significant challenges. Indigenous Papuan communities have long navigated a healthcare system that has frequently failed to recognize their unique cultural, social, and geographical contexts. The KO SEHAT program represents a critical attempt to bridge these historical gaps, offering a glimpse of a more responsive and equitable healthcare approach.

However, the path of transformation is neither simple nor linear. The study revealed profound institutional and administrative challenges that speak to deeper systemic complexities. Limited program socialization, administrative intricacies, and resource constraints emerged not as mere operational obstacles, but as manifestations of long-standing structural inequities. Each challenge represented a moment of potential learning, a opportunity for institutional adaptation and growth.

The perspectives of healthcare professionals, patients, and community members painted a rich, multifaceted picture of policy implementation. Their experiences highlighted the human dimension of healthcare interventions – the hopes, frustrations, and resilience that ultimately shape the success of any policy initiative. Healthcare professionals navigated increased administrative burdens with remarkable dedication, while patients balanced appreciation for reduced financial barriers with ongoing challenges of access and understanding.

Recognizing the inherent limitations of the research becomes crucial to understanding its significance. As a single-site case study, the research offers depth of insight while acknowledging the challenges of broader generalizability. These limitations are not weaknesses but invitations for further exploration, promising pathways for future research and understanding.

FURTHER STUDY

The recommendations emerging from this research extend beyond simple operational improvements. They represent a call for a fundamental reimagining of healthcare delivery in marginalized regions. Future investigations must continue to probe the complex intersections of policy, culture, institutional practice, and community experience. Longitudinal studies, comparative analyses, and innovative methodological approaches offer promising avenues for deeper understanding.

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