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ANALYSIS OF THE IMPLEMENTATION OF PUBLIC HEALTH SERVICE POLICIES BASED ON POPULATION IDENTIFICATION NUMBERS IN BEKASI CITY: A LITERATURE REVIEW

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ABSTRACT
This study examines the implementation of the Community Health Service based on National Identification Number (LKM-NIK) policy in Bekasi City as a complementary policy to close protection gaps in Indonesia's National Health Insurance (JKN). Although Bekasi City has reached 99.87% or 2.592.517 persons (JKN-KIS) membership coverage and finances 386,389 beneficiaries through the local budget scheme (Juni 2026), this administrative achievement has not fully guaranteed substantive health protection for all residents. This study applies a descriptive qualitative approach using a Systematic Literature Review of 25 selected articles from Scopus. The findings show that LKM-NIK implementation is influenced by policy content clarity, targeting accuracy, financing sustainability, NIK data integration, cross-actor coordination, health facility capacity, and partner hospital compliance. From Grindle's perspective, the success of LKM-NIK is shaped by the interaction between policy content and implementation context. Therefore, LKM-NIK should be strengthened through accurate data governance, sustainable financing, clear public communication, and patient-experience-based evaluation.

INTRODUCTION

Health is no longer seen as a mere biological need, but as a fundamental investment in the formation of human capital that determines the quality of nation development. Referring to the World Health Organization (WHO) constitution, health is defined holistically as intact physical, mental, and social well-being. This paradigm is reinforced by empirical studies that prove that good health status has a significant positive correlation with economic growth and labor productivity. Therefore, guaranteed access to inclusive health or Universal Health Coverage (UHC) is a vital instrument of the state, not only for the fulfillment of human rights, but also as a structural strategy to break the chain of poverty and achieve sustainable social welfare. (WHO-AIMS Report on Mental Health System in Indonesia, 2018) Bloom et al. (2004) (Gostin et al., 2019)

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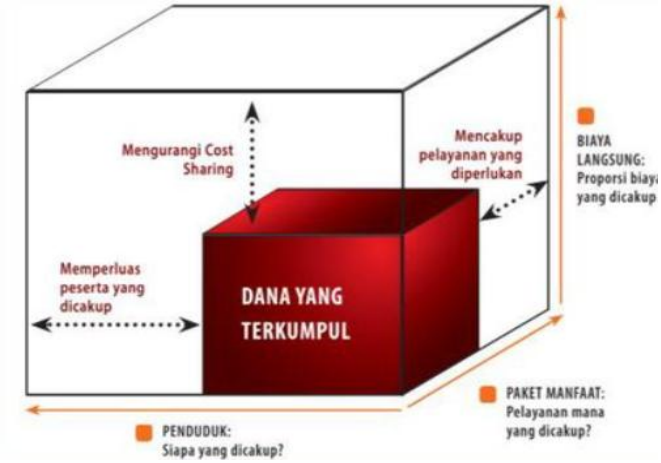

Figure 1. Dimensions of Universal Health Coverage According to WHO (Source: DJSN, 2012)

Conceptually, Figure 1 on the dimensions of UHC explicitly illustrates that the expansion of benefits, protected populations, and the portion of costs borne by the public are the three pillars that must go hand in hand for UHC to be truly meaningful. UHC is not just about physical accessibility, but a financial protection mechanism to prevent catastrophic health expenditures that are often a determinant of household poverty. (Kutzin, 2013)

In realizing UHC, Indonesia launched the National Health Insurance Program (JKN) in 2014 which was designed as a national-scale social insurance scheme with a single-payer system. JKN has developed into the backbone of Indonesia's health system with a very wide scope. This constitutional commitment does not only stop at the normative level, but is manifested concretely through expansive budgetary politics at the national level. (Harahap et al., 2024) (Pisani et al., 2016)

Graph 1. Health Budget Allocation Trends in 2025 (Source: media.kemenkeu.go.id, 2025)

The government's seriousness in placing health as a pillar of development is reflected in the trend of the allocation of the State Revenue and Expenditure Budget (APBN) shown in Graph 1. Analysis of budget trends shows an adaptive pattern of state intervention. The government has allocated a health budget of Rp218.5 trillion in the 2025 Fiscal Year, which is an increase of 16.5% compared to 2024. This increase marks a shift in focus towards the sustainable transformation of the health system. (Mahendradhata et al., 2021)

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However, the magnitude of this central intervention is faced with complex decentralization challenges. Local governments are encouraged to integrate Regional Health Insurance (Jamkesda) into JKN (National Social Security Council, 2016). Despite the challenges of insynchronization in terms of management, benefit packages, and membership targets, the Bekasi City Government showed compliance by bearing contributions for 638,389 people through the PBI APBD, bringing the City of Bekasi to achieve a JKN-KIS administrative membership rate of 99.87% (2,595,517 people) in June 2026. (Fossati, 2016)

Although the UHC achievement figures appear to be almost perfect, the reality on the ground shows that these administrative achievements do not fully reflect the equitable distribution of access and quality of services. Access disparities still occur, especially in vulnerable groups and communities that face administrative barriers, such as the absence of a Population Identification Number (NIK). This creates a protection gap for residents who have the status of patients without a guarantor or need exempt services. (Alayda et al., 2024; Samodra & Wirantari, 2024)

To close the grey area, the Bekasi City Government has created a complementary policy for Public Health Services based on Population Identification Numbers (LKM-NIK). This policy replaces its predecessor program, the NIK-Based Health Card (KS-NIK), because it is considered to trigger overlap and budget deficits. This historical experience became an institutional precedent in the formation of MFIs. (Hutajulu et al., 2024; Riswandi, 2020)

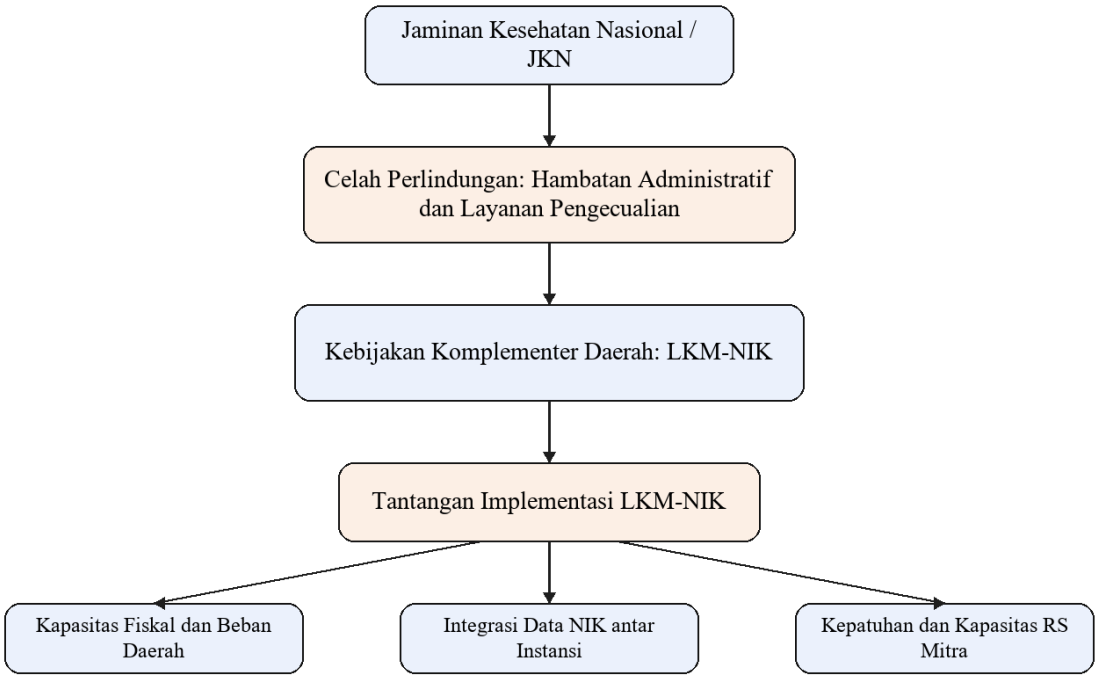

Figure 2. The Concept of the Birth of the MFI-NIK Complementary Policy in Bekasi City
Source: Author Data Processing, 2026

Figure 2 illustrates the conceptual flow of how the MFI-NIK policy was born in response to the gap in JKN protection. However, at the implementation stage, these policies are directly confronted with the complexity of decentralization that magnifies the variation in service performance. The dense urban characteristics of Bekasi City demand an adaptive policy response that goes beyond technical problems. The challenges of managing hospital information systems and the participation space of actors in health facilities greatly affect the smooth running of services. This practice is in line with those who view implementation as a process of continuous interaction between the content of the policy and its context. Departing from this complexity, this study aims to formulate the following

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problems: (1) How is the implementation of the MFI-NIK policy in Bekasi City?; and (2) What factors affect the success or failure of the implementation of the policy in the midst of the dynamics of regional autonomy. (Kristiansen & Santoso, 2006) (Mead et al., 2022; Miharti et al., 2016) (Handayani et al., 2014; Veronesi & Keasey, 2013) Grindle (2017)

METHOD

This study uses a secondary data-based document study with *a Systematic Literature Review* (SLR) approach. The SLR method was chosen because it allows the process of collection, evaluation, and synthesis of literature to be carried out in a systematic and structured manner to gain a comprehensive understanding of health policy implementation. The scientific literature is used as the main data source to examine the dynamics of health insurance, the decentralization of health services, as well as various administrative barriers that affect people's access to health services. (Nurhayati & Rahman, 2023)

Data collection was carried out through the Scopus database accessed on May 31, 2026 using a combination of keywords related to *Universal Health Coverage* (UHC), health insurance, policy implementation, health governance, decentralization, digital identity, and equitable access. The initial search process resulted in 11,321 documents. Furthermore, a *screening stage* was carried out based on the suitability of metadata and general relevance to the implementation of public health insurance policies and local government governance so that the number of documents was reduced to 277 literature.

The next stage is *eligibility* selection and inclusion through the assessment of the relevance of the title and abstract. Priority is given to articles that discuss UHC, JKN/BPJS, health decentralization, as well as administrative obstacles such as the issue of Population Identification Numbers (NIK) and gaps in access to health services. Based on these criteria, 25 articles were obtained that were designated as the main source of the study. All articles were then analyzed in depth to identify empirical findings, compile a conceptual synthesis, and explain the role of regional complementary policies in covering various protection gaps in the national health system.

RESULT AND DISCUSSIONS

Table 1. Key Issue Mapping from 25 Selected Articles

Focus issues	Main article	Lessons for MFI-NIK
Financing and financial protection	Khatri, Endalamaw, et al. (2025) , , , Derkyi-Kwarteng et al. (2021) Kaiser et al. (2023) Ahsan et al. (2021)	Administrative coverage must be translated into real cost protection, including for groups that are not affordable by JKN.
Capacity of health workers and facilities	Pepito et al. (2025) , , , N. Ahmed et al. (2024) Feng et al. (2026) Benedict et al. (2025)	Implementation requires ready human resources, facilities, and referrals; Without it, scope doesn't automatically become access.
Governance, actors, and coordination	Koduah et al. (2023) , , , Khatri, Khanal, et al. (2025) (Khatri et al., 2023) Ifeagwu et al. (2024)	Policy success depends on cross-sector coordination, accountability, evidence, and inter-stakeholder trust.
Quality and service experience	Fisher et al. (2020) , , , Haider et al. (2021) Kipo-Sunyehzi (2021) Shabiye et al. (2021)	Success indicators should include quality of service, speed of claims, availability of medications, and patient experience.
Vulnerable and exclusionary groups	Mngomezulu & Matadi (2026) , , , , . Muinde & Prince (2023) Olu	Universal language is not enough; Special policies are needed for

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	et al. (2024) Amu et al. (2022) Goodson et al. (2022)	citizens with administrative, social, economic, and information barriers.
Regional policy and local learning	Saraan et al. (2024) , , , , . Ahsan et al. (2021) Chukwuma (2023) Leung et al. (2024) Groisman et al. (2025)	Normatively good policies need to be translated into clear, measurable, and local capacity procedures.

Context of the LKM-NIK Numbers of Bekasi City

The above literature findings need to be linked to the empirical context of Bekasi City. Based on the background on which this article was written, Bekasi City is in a situation that appears to be administratively strong, but implementively still faces a protection loophole. Some important numbers can be used to explain the position as shown in Table 2.

Table 2. Indicators of the Policy Context of LKM-NIK in Bekasi City

Indicator	Numbers/descriptions	Meaning of policy
National PBI target in the JKN ecosystem	96.8 million people	The state places vulnerable groups as a priority for UHC financing.
Local governments that have integrated JAMKESDA into JKN since 2017	433 districts	Regional-national integration has become mainstream, but local problems remain.
Bekasi City Budget for Fiscal Year 2024	IDR 6.3 trillion	The city of Bekasi has a relatively strong fiscal base for regional health interventions.
Increase in APBD compared to the previous year	5%	Fiscal space is increasing, but it must be maintained in order for health programs to be sustainable.
Mandatory allocation for the health sector	10%	Formal commitments to health affairs are already available in the regional budget.
PBI APBD/Jamkesda participants borne by Bekasi City	427,893 inhabitants	Local governments finance vulnerable groups on a large scale.
Proportion of PBI APBD/Jamkesda participants to the population	16,94%	Almost a fifth of the population is directly related to regional financing support.
Scope of JKN-KIS Bekasi City membership	99,62%	Administrative achievement is very high, but it has not removed all service barriers.
Deficit of the previous KS-NIK programme	around IDR 200 billion	Past experience serves as a warning about the accuracy of goals and fiscal sustainability.
Basis of the MFI-NIK policy	Bekasi Mayor Regulation Number 96 of 2021, stipulated on December 30, 2021	MFI-NIK was born as a complementary policy after the experience of KS-NIK and the integration of JAMKESDA-JKN.

Source: *Author Data Processing, 2026*

The data shows that the problem of MFIs does not lie in the absence of fiscal commitment or low administrative coverage. Instead, the problem arises because the very high administrative scope must translate into real protection

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for groups that are in the loopholes of the system. With 99.62% JKN-KIS coverage, there is still a small space in percentage, but the space can contain very serious cases socially, such as residents without NIK, participants who fail to verify, patients who need exemption services, or patients who have been referred to non-partner facilities. This is what makes MFIs important: not because JKN has failed as a whole, but because the national system still needs a regional corrective mechanism.

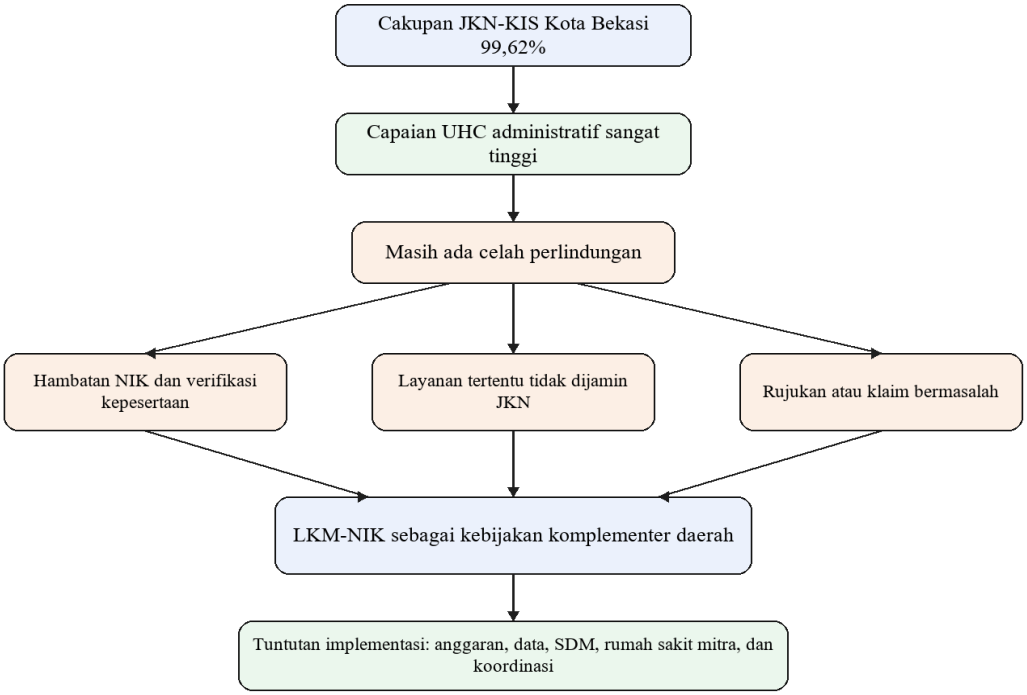

Figure 3. The Paradox of Administrative UHC and Substantive Protection of MFIs in Bekasi City
Source: Author Data Processing 2026.

Figure 3 shows that MFIs are somewhere between administrative UHC achievements and substantive protection needs. The flow starts from the achievement of JKN-KIS membership which is almost full, then moves to the identification of protection loopholes. The gap is not always large in percentage, but it can be important in policy because it concerns citizens who are administratively difficult to enter the national scheme or face unsecured service needs. Therefore, MFIs must be read as an implementation instrument that depends on the ability of regions to manage NIK data, claim financing, coordination of partner hospitals, and communication to residents.

Universal Health Coverage and Coverage Gaps

Nepal already has policies in line with the UHC goals, but the fragmentation of social protection schemes, low coverage of health insurance programs, and high direct payments remain weak in financial protection. suggests that the expansion of insurance coverage in the United States increases coverage for people with chronic diseases, but regional differences still lag behind. It shows that urban areas do not automatically have high insurance coverage, because education, access to information, and the media strongly determine participation. All three studies send the same message: expanding coverage is an important step, but not enough to guarantee equitable access. Goodson et al. (2022) Amu et al. (2022)

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In the context of Bekasi City, the achievement of 99.87% of JKN-KIS can be understood as a strong administrative success. Unfortunately, there are still residents who do not get protection due to NIK obstacles, verification failures, inactive participants, or services that are excluded from JKN. This situation is in line with the criticism that universal language in UHC can mask the reality of exclusion if the implementation system still differentiates citizens based on administrative ability, social class, or access to information. Thus, MFIs can be positioned as an effort to transform administrative achievements into substantive protection. Muinde & Prince (2023)

However, complementary policies such as MFIs also carry risks. indicates that the insurance participant can still pay directly for services that should have been covered due to implementation gaps. It also shows that the perceptions of the implementer and the beneficiary can be different. The bureaucracy may judge services from whether consultations, diagnostics, medications, and referrals are really readily available. Therefore, the evaluation of MFIs is not enough to look at the number of beneficiaries, but must look at the journey of residents from verification, referrals, services, to claim settlement. Derkyi-Kwarteng et al. (2021) Kipo-Sunyehzi (2021)

Financing and Fiscal Sustainability

One of the most powerful common threads of the 25 articles is the importance of financing sustainability. It shows that a fragmented financing system can keep people's direct spending high despite existing social protection policies. shows that coverage for informal workers is stronger when there is a universal political commitment, full subsidies, financing from public income, and compulsory coverage. shows the opposite side: the funding policy taken to close the JKN deficit can have a negative impact if it reduces local resources, is complicated in implementation, and does not yield as much contribution as expected. (Khatri, Endalamaw, et al., 2025) Kaiser et al. (2023) Ahsan et al. (2021)

This learning is very relevant for MFIs. The city of Bekasi has a 2026 APBD of IDR 6.8 trillion, a mandatory health allocation of 10%, and finances 368,398 PBI APBD/Jamkesda participants. (participants until July 2026) This figure shows a significant regional commitment. However, the experience of KS-NIK, which once caused a deficit of around Rp200 billion, is a warning that regional health policies must have benefit limits, target accuracy, claim control, and clear financing coordination. If MFIs do not have a strong verification and control mechanism, this policy can repeat the problems of previous programs.

In this framework, MFIs need to be understood as fiscal policy as well as social policies. As a fiscal policy, local governments must ensure that claims financing does not exceed the capacity of the APBD and does not create uncertainty for partner hospitals. As a social policy, local governments must ensure that budget restrictions do not sacrifice the most vulnerable groups. This is where the implementation dilemma arises. If the conditions are too loose, the fiscal risk increases. If the requirements are too strict, vulnerable residents will fail to access protection. The literature shows that such dilemmas cannot be solved by formal regulation alone, but requires data governance, monitoring, and inter-agency negotiation.

The findings add an important dimension to the relationship with the service provider. Healthcare facilities are willing to engage in insurance schemes if payments are adequate, regular, and the contract is clear. Conversely, low rates, late payments, and claim denials can discourage service providers or lower the quality of service. This means that MFIs must maintain the trust of partner hospitals through clear claims procedures and predictable payments. If a partner hospital feels the policy is too complicated or payment is uncertain, then the burden may ultimately fall back on the patient. Shabiye et al. (2021)

Decentralization, Governance, and Coordination of Actors

The literature reviewed suggests that decentralization can open up local innovation space, but also magnify capacity variations between regions. shows that the decentralized health system in the Philippines faces issues of labor, recruitment, budget, and community workforce integration. emphasized that health system governance must include strategic planning, regulation, use of evidence, accountability, and coordination. adding that multisectoral action at the macro, meso, and micro levels is needed to link health policies with other sectors. Pepito et al. (2025) Khatri, Khanal, et al. (2025) Khatri et al. (2023)

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In the context of MFIs, coordination of actors is a central issue. This policy cannot be carried out only by the Health Office. Identity verification requires a connection with the Disdukcapil. Membership status requires a relationship with BPJS Kesehatan. Referrals and claims require the cooperation of partner hospitals. Socialization requires regional apparatus and primary service facilities. Residents' complaints require responsive communication channels. In other words, MFIs are cross-organizational policies. The more organizations involved, the greater the risk of discrepancies in interpretation, slow service flows, and weak accountability.

Saraan et al. (2024) shows that the Medan Berkah Health Insurance Program faces obstacles in the form of low community participation, limited resources, lack of coordination, and limited access to information. This finding is very close to the context of Bekasi. City policies designed to expand health protections often fail not because the policy objectives are weak, but because citizens don't understand procedures, facilities don't have the same information, and implementing actors don't move in one clear workflow. Therefore, MFI-NIK needs a coordination system that contains the division of roles, service time standards, referral mechanisms, claim procedures, and problem solving channels.

The findings reinforce the importance of communication, organization, power, and trust. UHC cannot be run with instructions from above alone. Health workers, hospitals, and residents must understand policy objectives, benefit limits, and how to use services. Budget transparency and indicators are also important so that policies are not perceived as programs that are only strong at the slogan level. In the implementation of LKM-NIK, public trust can be built if residents know their rights and limitations, hospitals know their claim procedures, and local governments can explain the performance of the program openly. Ifeagwu et al. (2024)

Service Capacity and Service Quality

Service capacity is an important theme because administratively successful UHC can still fail if facilities are unable to serve the needs of citizens. shows that UHC pilots in Kenya do not automatically increase the availability of health workers as standardized. shows a mismatch between the need for non-communicable disease services and the capacity of the health system in the Philippines. shows that even mature UHC systems still face problems when primary services are too episodic and not robust enough to handle long-term needs. indicates that mental health services require integration into primary services, training, referral strengthening, and adequate funding. I. A. Ahmed et al. (2024) Feng et al. (2026) Fisher et al. (2020) Benedict et al. (2025)

This learning is important for the City of Bekasi because MFIs not only deal with who is entitled to be financed, but also how residents get services. If residents have passed verification but partner hospitals are limited, referrals are unclear, or the services needed are not available, then the policy has not resulted in substantive protection. If the claim cannot be paid because the patient has already been referred to a non-partner hospital, then the problem is not only the patient's fault, but also concerns information design, referral coordination, and facility network readiness.

Haider et al. (2021) teach that UHC measurement should not stop at the availability of facilities. Facility surveys can show services are available, but they don't necessarily describe utilization, patient burden, quality, and financial burden. For MFIs, success indicators should not only be the number of participants assisted or the number of partner hospitals. More substantive indicators need to include verification time, number of approved and rejected claims, reasons for rejection, most funded types of services, number of problematic referral cases, verifier workload, and patient experience accessing services.

Kipo-Sunyehzi (2021) It also shows that the quality of service is seen differently by the implementers and beneficiaries. Implementers tend to emphasize referrals, monitoring, efficiency, reimbursement, and compliance with guidelines. Beneficiaries place more emphasis on consultation, diagnostics, medication, and officer attitude. This difference needs to be considered in the evaluation of MFIs. If the local government only assesses the administrative aspect, then the experience of the residents can be missed. Conversely, if the evaluation incorporates the patient's experience, the government can find the service points that most often raise complaints.

Administrative Obstacles and NIK Data Governance

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The special character of MFI-NIK lies in the use of the Population Identification Number as the basis for identification. This makes data governance a core issue. Not all of the literature reviewed address NIK directly, but many articles show that verification, registration, information, and membership administration are determinants of access. indicates that access to information affects insurance participation. emphasizes the importance of examining policy-to-practice pathways, including regulatory details, payment terms, and access variations. Shows that digital innovation and integrated health records promise to expand access, but must be tailored to local capacity. Amu et al. (2022) Leung et al. (2024) Groisman et al. (2025)

In the context of Bekasi, NIK is an entrance as well as a potential obstacle. On the one hand, the NIK base helps local governments identify residents and reduce overlap. On the other hand, residents without a NIK, problematic NIKs, out of sync data, or membership status that fails to be approved can be thrown out of protection. This leaves MFIs facing an administrative paradox: instruments intended to clarify goals can also create new barriers if the data system is unresponsive.

This problem needs to be seen in the framework of street-level bureaucracy. shows that policies that formally guarantee services can change at the practice level as implementers face resource limitations, work pressures, and practical norms. In LKM-NIK, verifiers, health center officers, hospital officers, and data operators are in the forefront position that determines whether residents can enter services or not. If they don't have clear guidelines, adequate data access, and a proportionate workload, then implementation can turn into a series of caustic decisions. Therefore, MFI-NIK data governance needs to include three things. First, data integration between the Health Office, Disdukcapil, BPJS Kesehatan, and partner hospitals must have a clear update procedure. Second, residents whose data is problematic need to have a quick correction route, especially in emergency situations or services that cannot be delayed. Third, local governments need to document the types of verification failures so that recurring problems can be solved systemically. Without these three things, NIK-based policies risk becoming administratively strong policies, but weak in responding to the vulnerability of citizens. Derkyi-Kwarteng et al. (2021)

Content of the MFI-NIK Policy

In terms of policy content, the MFI-NIK has a relatively clear goal, which is to become a complementary scheme to close the gap in JKN protection. This policy is not intended to replace JKN, but rather to help residents who are not fully covered by the national scheme or need services that are not guaranteed. The benefits of the policy are direct because it concerns the financing of health services. However, these benefits are also selective because not all residents and not all services can be automatically covered. In Grindle's perspective, selective benefits like this can give rise to demands, negotiations, and allocation conflicts because they concern who gets what, when, and through what procedures.

The degree of change expected from MFIs is also quite large. This policy demands changes to the way local governments manage data, the way health facilities understand referrals, the way citizens access assistance, and the way hospitals file claims. These changes are not only technical, but also institutional. shows that the more complex the content of the policy, the greater the need to manage actor participation, organizational feasibility, and economic feasibility. Therefore, MFIs must have implementation guidelines that can be understood by all actors, not just general regulations. Koduah et al. (2023)

The content of the policy is also related to the accuracy of the target. The experience of KS-NIK which caused a deficit of around Rp200 billion shows that wide coverage without control can create fiscal pressure. However, too strict control can make vulnerable residents unhelped. This is where MFIs need to maintain a balance between social protection and fiscal sustainability. suggests that full subsidies and mandatory coverage can support informal workers, but still require a robust financing design. Remind that funding solutions that do not consider the impact of implementation can create new problems. Kaiser et al. (2023) Ahsan et al. (2021)

Context of the Implementation of MFI-NIK

In terms of implementation context, Bekasi City has advantages in the form of fiscal commitment and high JKN-KIS coverage. However, the city also faces urban pressures, population mobility, the need for advanced services,

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and the complexity of institutional coordination. In Grindle's framework, this context determines how actors use resources and power to implement policies. The Health Office has a coordinating role, Disdukcapil holds identity data, BPJS Kesehatan holds JKN membership information, partner hospitals hold access to services, and residents bring needs and complaints. Each actor has different interests and limitations.

Ifeagwu et al. (2024) shows that communication, organization, power, and trust are essential elements in the implementation of UHC. In LKM-NIK, communication determines whether residents understand the procedure. The organization determines whether the interagency workflow is clear. Power determines who can decide difficult cases. Trust determines whether hospitals, residents, and the government trust each other that this policy can be fair. Without these four elements, MFIs can turn into policies that run slowly and are only understood by a small number of implementers.

The context of implementation also relates to the compliance of partner hospitals. Indicates that the service provider requires regular payments, adequate rates, clear contracts, and quality assurance. If partner hospitals do not understand the procedures of the MFI-NIK or feel that the claim is too risky, they may limit services or direct patients to other mechanisms. This will weaken the purpose of protection. Therefore, local governments need to strengthen contractual relations, coaching, and evaluation with partner hospitals. Shabiye et al. (2021)

Factors Affecting Successful Implementation

Based on the synthesis of the literature, there are several main factors that affect the success of MFIs. The first is clarity of goals and benefits. Citizens, health facilities, and implementers must know who can use MFIs, what services are covered, what services are not covered, and what documents are required. Unclear benefits will confuse residents and increase the risk of problematic claims. The second is data capacity and verification. Because this policy is NIK-based, the success of implementation is highly dependent on the integration of population and membership data. Data errors must have a quick correction mechanism. Otherwise, the most vulnerable residents can actually become victims of administrative obstacles.

The third is the sustainability of financing. Local governments need to ensure that the 10% health budget and the PBI APBD financing scheme can support MFI-NIK claims without repeating the KS-NIK deficit problem. Claims control needs to be done transparently, but it must not eliminate the function of social protection. The fourth is the capacity of the implementer and facilities. The findings, , and show that human resources and facility capacity determine whether coverage can be transformed into a service. In MFIs, this includes the number and capabilities of verifiers, the readiness of health centers, the compliance of partner hospitals, and the capacity of referral services. The fifth is cross-sectoral coordination. MFIs need joint work between the health sector, population, hospitals, BPJS Kesehatan, and regional apparatus. and shows that UHC requires multi-sector governance and action. Without coordination, residents' problems will move from one table to another without resolution. The sixth is public communication and trust. indicates that public information affects insurance participation. shows the importance of trust and transparency. In MFIs, socialization must be simple and operational, for example, explaining the flow of services, a list of partner hospitals, types of services that can be assisted, and complaint channels. Pepito et al. (2025) I. A. Ahmed et al. (2024) Feng et al. (2026) Khatri et al. (2023) Khatri, Khanal, et al. (2025) Amu et al. (2022) Ifeagwu et al. (2024)

Discussion Synthesis

All literature findings show that MFIs can be understood as complementary policies born from the need to fill the gap between administrative UHC and substantive protection. This policy is important because JKN as a national scheme is not always able to answer all local cases, especially for residents who face barriers to identity, membership status, exclusion services, and referral problems. However, the success of MFIs does not automatically occur just because there are regulations and budgets.

In Grindle's perspective, MFIs will be successful if the content of their policies can be implemented in the available local context. The content of the policy should be clear in its benefits, objectives, procedures, and limits. The context of implementation must support through resources, coordination, 2878compliance with the community,

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and responsiveness to the needs of citizens. If one side is weak, the implementation will result in a gap. For example, the benefits of a policy are clear but the data is out of sync; budgets are available but partner hospitals are not compliant; or a complete procedure but the residents do not understand the flow.

Thus, the results of this SLR show that the challenge of MFIs does not lie in the question of whether local governments need to be present, but rather how their presence is arranged so that it is on target, sustainable, and easy for residents to use. Policies that are too loose can cause fiscal pressure like the experience of KS-NIK. Policies that are too strict can eliminate their social function. Overly administrative policies can fail to capture the patient experience. Policies that rely too much on health actors alone can fail because the problems of NIK, membership, and referrals are cross-sectoral.

Therefore, MFIs need to be directed to be adaptive protection instruments. Adaptive means being able to correct problematic data, adjust service flows to the patient's situation, control claims without sacrificing vulnerable citizens, and improve coordination based on periodic evaluations. This principle is in line with the findings on the importance of the interaction of policy content, actors, and context, and is in line with Grindle's position on implementation as an ongoing political-administrative process. Koduah et al. (2023)

Academically, the results of this discussion confirm that the study of MFIs fills an important space in the literature on the implementation of regional health policies in Indonesia. Many UHC studies focus on national schemes, macro financing, or membership coverage. Meanwhile, MFIs show that after almost universal coverage is achieved, the next issue lies in the details of local implementation: identity verification, referrals, claims, partner hospitals, communication, and citizen experience. In other words, the post-UHC stage of administration requires regional policies capable of working on small but decisive gaps.

Practically, these findings lead to several implications. The Bekasi City Government needs to strengthen cross-institutional databases, compile performance indicators that are not only administrative, build a quick response mechanism for problematic NIK cases, clarify contractual relationships with partner hospitals, and open public information about service flows. In addition, the evaluation of MFIs needs to include the patient's perspective so that policies not only look successful in terms of bureaucratic reports, but are also felt to be useful by residents.

In the end, MFIs can be an important example of how local governments carry out corrective functions in the national health insurance system. When JKN becomes the backbone of UHC, local governments are still needed to ensure that residents on the margins of the system are not left behind. However, such corrective functions will only be effective if they are implemented with strong governance, prudent financing, accurate data, and responsive coordination of actors. This is the crux of the discussion of the 25 selected articles: UHC is not just about achieving coverage figures, but about ensuring that these numbers turn into real access, quality, and protection for society.

CONCLUSION

Based on the results of *the Systematic Literature Review* of 25 selected articles, it can be concluded that the Bekasi City MFI-NIK is an important complementary policy to close the protection gap in the implementation of National Health Insurance (JKN). Although the *Universal Health Coverage* (UHC) of Bekasi City has reached 99.87% or equivalent to 2,592,517 people, with the number of participants financed through the PBI APBD/Jamkesda scheme as many as 386,389 people (June 2026 data), these administrative achievements have not fully guaranteed substantive health protection for the entire community. Various obstacles, such as the problem of Population Identification Numbers (NIK), failure to verify membership, services that are not guaranteed by JKN, and problems with referrals and claims, show that the achievement of UHC still requires adaptive and responsive local policy support.

The implementation of LKM-NIK is influenced by two main aspects, namely the content *of policy* and the *context of implementation*. In terms of policy content, clarity of objectives, program benefits, service procedures, and financing control mechanisms are important factors so that the program does not repeat various problems that previously arose in the implementation of KS-NIK. In terms of implementation context, the success of the program is highly determined by accurate data integration, inter-agency coordination—including the Health Office, Population and Civil Registration Office, BPJS Kesehatan, health centers, and partner hospitals—and the capacity of

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implementing resources. These findings are in line with Grindle's policy implementation framework which asserts that successful implementation is influenced by the linkages between policy design, resources, actors involved, and institutional responsiveness. Therefore, MFIs need to continue to be strengthened through integrated data governance, sustainable financing schemes, effective public communication, and policy evaluations that are oriented to patient experience and needs.

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