

Evaluation of the Implementation of the National Health Insurance Program by the Social Security Administration Agency for Health in Medan City

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Abstrak

Studi ini mengevaluasi implementasi program kesehatan gratis berbasis identitas penduduk di Kota Medan yang terintegrasi dengan BPJS Kesehatan. Menggunakan desain kualitatif deskriptif, data dikumpulkan melalui wawancara, observasi, dokumentasi, dan triangulasi yang melibatkan dua belas informan yang dipilih secara purposif. Temuan menunjukkan bahwa program tersebut mencapai cakupan kesehatan universal sebesar 98,96% dan meningkatkan perlindungan finansial serta akses layanan kesehatan. Namun, implementasi masih terhambat oleh data populasi yang tidak lengkap, pemahaman rujukan yang terbatas, kapasitas fasilitas yang tidak merata, beban tenaga kerja, dan standar layanan minimum yang belum terpenuhi. Studi ini menyimpulkan bahwa keberlanjutan program membutuhkan data terintegrasi, perawatan primer yang lebih kuat, peningkatan staf, koordinasi yang lebih baik, dan evaluasi berorientasi kualitas yang berkelanjutan di seluruh lembaga layanan kesehatan yang berpartisipasi di Medan

Keywords: BPJS Kesehatan; implementation evaluation; public healthcare; universal health coverage; Medan City

Abstract

This study evaluates the implementation of Medan City's population-identity-based free healthcare program integrated with BPJS Kesehatan. Using a descriptive qualitative design, data were collected through interviews, observation, documentation, and triangulation involving twelve purposively selected informants. The findings show that the program achieved 98.96% universal health coverage and improved financial protection and healthcare access. However, implementation remains constrained by incomplete population data, limited referral understanding, unequal facility capacity, workforce burden, and unmet minimum service standards. The study concludes that program sustainability requires integrated data, stronger primary care, improved staffing, better coordination, and continuous quality-oriented evaluation across participating healthcare institutions in Medan

Keywords: BPJS Kesehatan; implementation evaluation; public healthcare; universal health coverage; Medan City

Introduction

The implementation of Universal Health Coverage (UHC) through the Medan Berkah Health Insurance Program reveals a paradox between the successful expansion of population coverage and the uneven quality of services at the implementation level. Introduced in December 2022, the program enables residents holding a Medan City identity card to access healthcare services through facilities collaborating with BPJS Kesehatan, with coverage in this study reaching 98.96 percent. Empirically, the expansion of health insurance has increased the

likelihood of communities using public healthcare facilities, particularly when dealing with chronic diseases (Dalimunthe et al., 2025; Kosasih et al., 2022). However, near-universal population coverage does not automatically result in equitable service utilization, as healthcare needs, socioeconomic status, and service availability continue to shape patterns of access (Cheng et al., 2025; Ritonga et al., 2025). Field realities in Medan City indicate that some patients are discharged before being medically assessed as recovered, while hospitals continue to face shortages of inpatient rooms and intensive care units, low remuneration for healthcare workers, and difficulties involving pediatric patients who do not yet possess a national identification number. Data from Dr. Pirngadi Regional General Hospital also show an increase in unregistered patients from 22 individuals in 2022 to 208 individuals in 2025, alongside the failure to achieve several minimum service standards. These problems are consistent with findings that the National Health Insurance system continues to face challenges related to financing pressures, the unequal distribution of healthcare workers, provider payment mechanisms, and weaknesses in participant information systems (Dalimunthe et al., 2024; Susilo et al., 2025). Therefore, coverage achievements must be assessed together with administrative quality, facility capacity, and the actual experiences of beneficiaries to ensure that program success extends beyond formal enrollment status.

Recent literature on the National Health Insurance system and UHC in Indonesia has examined the expansion of membership, healthcare utilization, financial protection, and inequalities in access, but it has not fully explained how these issues interact in the implementation of local health programs. Studies on service quality within the UHC framework indicate that expanded coverage must be accompanied by quality measurements that include patient safety, service effectiveness, patient experience, and the health system's capacity to respond to the needs of different population groups (Marsella et al., 2025; Yanful et al., 2023). National-level analyses demonstrate that increasing insurance coverage continues to coexist with regional variations in service availability, health expenditure, and system capacity (Pratiwi et al., 2021). Health financing studies have also found that the benefits and burdens of healthcare funding are not distributed uniformly across income groups, meaning that UHC achievement must be understood through the dimension of equity rather than solely through aggregate enrollment rates (Asante et al., 2023). Furthermore, catastrophic health expenditure may continue to occur when insurance protection is not accompanied by effective access, high-quality services, and control of households' out-of-pocket expenditure (Fattah et al., 2023). Other studies emphasize that disparities in education and literacy concerning the concepts and procedures of the National Health Insurance system increase the risk of unequal enrollment and healthcare access among low-income groups (Putri et al., 2023). Nevertheless, most previous

studies have examined coverage, financing, utilization, and quality as separate dimensions and have not evaluated the relationships among program needs, resource preparedness, service processes, outcomes, and evaluation quality within a single municipal government case. Consequently, theories of access, financing equity, and healthcare utilization remain insufficient to explain why high coverage in Medan City continues to coexist with administrative problems, limited hospital capacity, weak coordination, and unmet service standards.

This study aims to understand, interpret, and analyze the implementation of the public social health insurance program in Medan City through an assessment encompassing the context, input, process, product, and quality of program evaluation. Within the context dimension, the study evaluates the program's relevance to public health needs, population administration problems, local government objectives, intended beneficiaries, and the foundations of program sustainability. Within the input dimension, the analysis focuses on the adequacy of funding, healthcare personnel, facilities, information technology, organizational structures, and the distribution of authority among the Medan City Government, the Regional House of Representatives, the Health Office, BPJS Kesehatan, and hospitals. The use of the Context–Input–Process–Product model enables the evaluation to assess not only program outputs but also the objectives, resources, procedures, and factors that systematically shape program performance (Lee et al., 2022). Within the process dimension, the study examines registration and referral procedures, healthcare delivery, public information dissemination, complaint-handling mechanisms, institutional coordination, monitoring, and corrective actions undertaken when deviations occur. Within the product dimension, the study investigates the achievement of population coverage, financial protection, satisfaction, service quality, unintended consequences, and prospects for sustainability. The assessment is complemented by a metaevaluation to determine whether the evaluation process generates information that is useful, appropriate, accurate, and trustworthy. This approach is important because metaevaluation can reveal the strengths and weaknesses of assessment procedures and enhance the credibility of evaluation findings (da Silva et al., 2023). Accordingly, the study does not merely determine whether the program has succeeded or failed but explains which components function effectively, which components remain problematic, and which improvement decisions are required.

This study is important because the success of a public health program cannot be assessed solely on the basis of the percentage of residents formally registered as participants. It must also be evaluated according to the system's ability to transform administrative entitlements into healthcare services that are available, high-quality, equitable, and sustainable.

Research involving persons with disabilities in Indonesia demonstrates that expanded National Health Insurance membership does not always guarantee equitable coverage and financial protection for groups with greater healthcare needs (Ritonga, Dalimunthe, et al., 2024). Evidence derived from national claims data also indicates that income status and membership categories are associated with differences in the utilization of secondary and tertiary healthcare services, suggesting that the expansion of coverage must be assessed together with the distribution of actual benefits (Nugroho et al., 2023). Strengthening primary healthcare is essential to the success of UHC because a well-functioning primary care system can reduce pressure on hospitals, improve patient satisfaction, and provide a foundation for evidence-based decision-making through performance indicators (Solikha et al., 2025). In the context of Medan City, problems involving incomplete national identification data, limited public understanding of administrative procedures, overcrowded facilities, insufficient treatment rooms, and the failure to achieve several service standards demonstrate that expanded access has generated organizational demands that extend far beyond merely increasing the number of participants. The CIPP model is relevant because it connects problems, resources, processes, and outcomes while identifying program strengths and weaknesses as a basis for continuous improvement (Chanthalangsy et al., 2024). The central argument of this study is that the achievement of 98.96 percent coverage will have substantive meaning only when accompanied by integrated population data, strengthened healthcare workforce and facility capacity, effective interinstitutional coordination, improved public communication, and consistent service supervision. Therefore, a comprehensive evaluation is required to maintain financial protection while preventing a decline in service quality resulting from the successful expansion of population coverage.

Methods

This study evaluates the implementation of Medan City's population-identity-based free healthcare program, administered through Universal Health Coverage or the Medan Berkah Health Insurance Program and integrated with BPJS Kesehatan. The program was examined because expanded coverage has not fully resolved problems such as premature patient discharge, limited inpatient and ICU capacity, low remuneration for some health workers, children without National Identification Numbers, administrative irregularities, limited public understanding of procedures, and unmet hospital service standards. The study was conducted from February to June 2026 across the Medan City Government, Commission II of the Regional House of Representatives, the Health Office, BPJS Kesehatan Medan Branch, and Dr. Pirngadi Regional General Hospital.

A descriptive qualitative design was used to explain and interpret program planning, resources, service procedures, coordination, implementation barriers, and community benefits (Weyant, 2022). Primary data were obtained through in-depth interviews, non-participant observation, field notes, participation in evaluation meetings, and visual documentation. Secondary data included regulations, policy evaluation reports, budget realization documents, enrollment and claims records, unregistered-patient data, Minimum Service Standards reports, performance targets, satisfaction indexes, information materials, and complaint records.

Twelve purposively selected informants represented legislators, the Health Office, BPJS Kesehatan, hospital administrators, and a patient beneficiary. Data collection involved semi-structured interviews, direct observation, document review, and visual documentation. Trustworthiness was strengthened through triangulation by comparing interviews, observations, documentary evidence, and responses across informants.

Data were analyzed interactively using Miles, Huberman, and Saldaña's stages: data collection, condensation, display, and conclusion drawing and verification. Findings were organized according to the CIPP dimensions context, input, process, and product and assessed against metaevaluation criteria. Analysis continued iteratively until the program's achievements, weaknesses, implementation barriers, and areas for improvement were explained consistently and supported by converging empirical evidence. This design enabled the study to connect policy intentions with institutional practices and beneficiaries' experiences within the city's public healthcare system.

Results

Institutional Governance and Program Architecture

The implementation of Medan City's identity-based free healthcare program is organized through an interinstitutional network rather than a single implementing agency. The municipal government provides political direction and local financing, Commission II of the Regional House of Representatives performs legislative, budgetary, and supervisory functions, the Health Office coordinates technical implementation, BPJS Kesehatan manages enrollment and service financing, and contracted health facilities deliver care to beneficiaries. Dr. Pirngadi Regional General Hospital occupies a central position because it is owned by the municipal government and functions as a principal referral facility for residents using the Universal Health Coverage or Medan Berkah Health Insurance Program. Community members constitute the final beneficiaries while also supplying complaints and experiential information used in evaluation meetings. Interviews indicated that these institutions communicate through coordination forums, monitoring visits, performance reports, complaint channels, and hearings

when implementation problems require cross-agency decisions. Nevertheless, the division of authority remains differentiated: hospitals and BPJS Kesehatan may report operational constraints, but changes to local policy, budget allocations, and service standards remain within the authority of the municipal government and legislative institutions. This governance arrangement demonstrates that program implementation depends on the alignment of financing, population administration, enrollment verification, clinical services, and public supervision. The institutional network therefore provides a functional foundation for implementation, although its effectiveness remains dependent on consistent information exchange and coordinated corrective action.

The overall implementation profile shows that the program has expanded access to healthcare since its introduction in December 2022, particularly for residents who were previously uninsured, inactive, or unable to pay contributions independently. The program allows eligible residents to obtain care by presenting a National Identification Number that can be verified through the population and BPJS Kesehatan databases. Evaluation is conducted through real-time monitoring of active membership and service use, coordination between the Health Office and BPJS Kesehatan, supervision of contracted healthcare facilities, community satisfaction surveys, and direct complaint mechanisms. Informants from the legislative body, Health Office, hospital, and BPJS Kesehatan consistently stated that service delivery continued during the 2025–2026 evaluation period and that complaints were used as triggers for administrative verification or institutional meetings. However, field evidence also identified unresolved problems, including allegations of patients being discharged before recovery, insufficient inpatient and intensive care capacity, low remuneration for some health workers, and children without registered identification numbers. These findings indicate that administrative expansion has progressed more rapidly than the adjustment of service capacity and operational coordination. The government responded through warnings against patient rejection, monitoring of health facilities, and plans to strengthen service delivery in 2026. Accordingly, the program achieved a broad access function, but its implementation quality remained uneven across administrative, organizational, and clinical dimensions.

Context Evaluation

Context evaluation revealed that the program responds to a genuine need for financial protection and simplified access, yet the use of population identity as the principal gateway produces a specific administrative vulnerability. Informants repeatedly identified an active and valid National Identification Number, accurate family registration, and conformity between actual residence and civil-registration records as prerequisites for rapid enrollment and claims processing. A legislative informant explained that some married residents remained registered

in their parents' family cards, while some newborns had not yet been reported to the Population and Civil Registration Office. Hospital staff similarly reported that patients frequently arrived without the documents or primary-care referrals required for non-emergency treatment. The administrative problem was not temporary: records from Dr. Pirngadi Hospital show that unregistered patients increased from 22 in 2022 to 131 in 2023, 193 in 2024, and 208 in 2025. The pattern suggests that program expansion brought more residents into contact with the health system while exposing unresolved deficiencies in civil registration and public understanding. Stakeholders attempted to address this problem through outreach involving neighborhood heads, urban villages, subdistricts, the Population and Civil Registration Office, social media, and hospital information services. Context evaluation therefore confirms the program's relevance, but it also demonstrates that effective access depends on administrative inclusion before illness occurs. Population documentation is not merely a supporting requirement; it is a structural component of the program's operational accessibility.

Table 1. Number of Unregistered Patients at Dr. Pirngadi Regional General Hospital, 2022-2025

Year	Number of unregistered patients
2022	22
2023	131
2024	193
2025	208

The context findings also show that the program was designed to provide both financial assurance and a sense of security during treatment. Informants stated that eligible residents received services without direct medical charges because contributions were supported through national and regional financing arrangements. A patient interviewed at Dr. Pirngadi Hospital confirmed that no service fee had been imposed during treatment, while hospital and government representatives emphasized that administrative uncertainty should not prevent emergency care. Beyond material benefits, respondents described moral support through respectful treatment, empathetic communication, emotional reassurance, spiritual assistance, and complaint-handling mechanisms. Hospital staff were instructed to serve patients without discrimination, and BPJS Kesehatan personnel reported that front-office and back-office employees received procedural training. Nevertheless, the evidence also revealed contextual tensions. The local budget carries a continuing financing burden, residents do not always understand referral procedures, and communication from management levels does not consistently reach every frontline worker or community group. Stakeholders recognized that policy standards may require modification when implementation conditions change, although

providers and BPJS Kesehatan do not possess authority to revise policy independently. Thus, context evaluation does not simply indicate that the program is socially desirable; it shows that legitimacy is sustained through the interaction of financial protection, humane treatment, legal authority, and public understanding. These elements collectively determine whether residents perceive the program as an accessible right rather than a complicated administrative concession.

Input Evaluation

Input evaluation found that the program possesses a recognizable financing and organizational base, but the adequacy and distribution of inputs vary across implementing units. The municipal budget supports local contribution payments, while national resources and other legally available revenue streams complement program financing. Commission II reviews expenditure and service reports, the Health Office coordinates budget implementation and facility supervision, BPJS Kesehatan verifies participation and claims, and hospitals submit reimbursement claims based on services delivered. Respondents generally considered the available budget sufficient to maintain the program, and patients reported receiving care without direct payment. The evaluation process included internal hospital meetings, legislative hearings, audits, and cross-agency review when expenditure or service performance was questioned. However, providers had limited knowledge of the complete financing structure because their operational role centered on delivering services and submitting claims. This separation of responsibilities supports accountability, but it may also fragment understanding of the relationship between expenditure, claims growth, and service capacity. The program therefore demonstrates fiscal commitment, yet financial sufficiency cannot be assessed only from the continuity of payments. It must also be considered in relation to workload, infrastructure, waiting time, staff incentives, and unmet service standards. Input evaluation consequently indicates that the financing architecture is functional, while the conversion of funds into balanced organizational capacity requires stronger shared performance information among budget authorities, purchasers, and providers.

The most persistent input constraints concerned population data, referral readiness, human resources, and facility capacity. All institutional groups identified unregistered or mismatched identification data as a major source of delay, particularly for children, residents whose domicile records were unclear, and families whose household documents had not been updated. Hospital respondents also noted that some patients arrived for outpatient care without referrals from primary healthcare facilities because they did not understand the tiered referral system or lacked confidence in local health centers. These patterns increased the administrative and clinical burden at the referral hospital. Respondents further described shortages or imbalances in personnel, heavy patient volumes, limited inpatient and intensive care capacity,

and concerns regarding low remuneration for some workers. Although the hospital maintained professional teams and hierarchical reporting procedures, the growing volume of beneficiaries could reduce the time available for consultation and explanation. Government and provider responses included administrative assistance, temporary time allowances for document completion, proposed door-to-door verification, staff training, improved socialization, and closer monitoring of facility commitments. The evidence therefore shows that input weaknesses are interconnected rather than isolated. Inaccurate civil data slow enrollment, weak public understanding increases inappropriate referral demand, and concentrated demand places additional pressure on hospital personnel and infrastructure. Effective input improvement consequently requires integrated interventions across civil registration, primary care, workforce management, digital systems, and referral capacity.

Process Evaluation

Process evaluation demonstrated that the program remained operational and was supported by recurring monitoring, complaints management, and interinstitutional coordination. Legislative representatives reported observing services directly, receiving community complaints, and convening related agencies when problems could not be resolved at facility level. The Health Office supervised contracted providers and coordinated participant-data verification, while BPJS Kesehatan conducted membership checks, claim verification, and participant outreach. Dr. Pirngadi Hospital used internal reporting lines, management meetings, information desks, and complaint services to address implementation difficulties. Informants consistently stated that emergency patients should not be rejected because of inactive membership, contribution arrears, or incomplete documents; when documents were missing, patients could receive treatment while families were given time to complete administrative requirements. At the same time, the program did not oblige every private hospital in Medan to participate, because coverage applied to facilities contracted by BPJS Kesehatan. This arrangement broadened access through a substantial provider network but concentrated public responsibility on government hospitals and participating facilities. Process findings therefore show a functioning implementation chain, although its reliability depends on frontline knowledge, the availability of contracted capacity, and the speed of coordination when eligibility or referral questions arise. The program's continuity is evident, but process quality must be judged by consistency across facilities rather than by the absence of formal service suspension.

Hospital performance data provided a more differentiated picture of process quality. The January-March 2026 Minimum Service Standards report documented strong performance in several areas, including twenty-four-hour emergency services, rapid emergency response,

surgical safety, laboratory services, blood availability, poor-patient services, waste management, and administrative reporting. However, six service areas were identified as not fully achieving the established standards: outpatient services, inpatient services, radiology, pharmacy, nutrition, and medical records. Examples included customer satisfaction below the ninety-percent target in outpatient and inpatient care, delays in radiology results, pharmaceutical waiting times beyond standards, diet-delivery errors, and incomplete medical records within twenty-four hours. The report therefore contradicts any interpretation that broad program coverage automatically reflects uniform service quality. Informants nevertheless described mechanisms for improvement, including technical training, direct supervision by unit heads, management evaluation, complaint channels, and performance reporting to the Health Office and legislative body. Patients generally reported courteous treatment and no direct rejection, but high service volumes were perceived as increasing pressure on personnel. Process evaluation consequently identified a mixed pattern: basic access and many safety indicators were maintained, while several patient-centered and operational indicators remained below target. These results support the need to retain detailed service-level monitoring rather than relying exclusively on aggregate enrollment or utilization indicators.

Table 2. Service Areas that Had Not Fully Achieved the Minimum Service Standards, January-March 2026

No	Service area	Evaluation status
1	Outpatient services	Not fully achieved
2	Inpatient services	Not fully achieved
3	Radiology services	Not fully achieved
4	Pharmaceutical services	Not fully achieved
5	Nutrition services	Not fully achieved
6	Medical-record services	Not fully achieved

Product Evaluation

Product evaluation indicates that the program produced substantial gains in coverage, financial protection, and service use, while leaving important questions regarding quality and sustainability. Medan City recorded UHC coverage of 98.96 percent, exceeding the national benchmark of 98 percent but remaining slightly below the municipal performance target of 99 percent. Program records reported 89,945 people registered and 35,018 patients served through participating hospitals inside and outside the city. Respondents associated these outcomes with easier access, reduced anxiety regarding treatment costs, and greater certainty that residents

could receive care using their identification number. The municipal government also received recognition for its UHC achievement, and stakeholders continued monitoring through legislative visits, hospital evaluations, BPJS participant outreach, digital complaint channels, and JKN Mobile. Nevertheless, the product dimension revealed unintended pressures: patient numbers increased, referral hospitals experienced crowding, room and intensive-care availability became contested, and some workers faced heavy workloads or inadequate incentives. Complaints about early discharge, service limitations, and uneven information indicated that program benefits were not experienced identically by all users. Product evaluation therefore supports continuation of the program, but not an assumption that expansion alone represents completion. The program's future value depends on whether high enrollment can be translated into timely services, accurate targeting, adequate staffing, reliable primary care, and measurable improvement in the six service areas that remained below standard.

Table 3. Principal Program Achievement Indicators

Indicator	Achievement
Residents registered in the program	89,945
Patients who received services	35,018
Medan City UHC coverage	98.96%
National UHC benchmark	98%
Medan City performance target	99%

Discussion

The central finding is that Medan City has achieved near-universal administrative coverage without yet achieving uniformly effective access. Coverage of 98.96 percent demonstrates strong political and fiscal commitment, but reports of incomplete civil documentation, limited bed and intensive-care capacity, unmet service standards, and uneven public understanding show that enrollment is only the first layer of universal health coverage. This interpretation is consistent with Susilo et al. (2025), who found that Indonesia's national insurance system had reached near-universal enrollment while continuing to face organizational, financing, purchasing, and information-system challenges that affect the translation of membership into services. The Medan case adds a local-government perspective by showing how these national pressures appear within a city-funded access arrangement. The program succeeds when residents can activate protection through their identification number and receive treatment without direct payment, yet it becomes vulnerable when the identity cannot be verified, referrals are absent, or participating facilities have insufficient capacity.

Accordingly, the distinction between nominal coverage and effective coverage is essential. Nominal coverage describes the population recorded in the insurance system, whereas effective coverage requires the timely receipt of appropriate and acceptable care. Medan's achievement should therefore be interpreted as an advanced stage of coverage expansion that now requires a policy shift toward service readiness, quality assurance, and consistency across facilities rather than continued reliance on enrollment figures as the principal indicator of success.

The prominence of identification and family-registration problems reveals that administrative literacy operates as a determinant of healthcare access. Residents may possess a formal entitlement to free care but remain uncertain about the need for an active National Identification Number, updated family card, valid domicile, or primary-care referral. The steady increase in unregistered patients at Dr. Pirngadi Hospital indicates that this barrier persisted even as the program became more widely known. Nugraha (2024) similarly demonstrated that education and the ability to understand insurance procedures predicted national health insurance membership among poor Indonesians, particularly because enrollment and subsidized eligibility require legal documents and interaction with several government offices. The Medan findings extend this argument from membership to service activation: documentation and procedural knowledge remain relevant after a population has nominally reached UHC. Socialization should therefore be redesigned as an administrative-access intervention rather than treated as general publicity. Neighborhood heads, urban villages, subdistrict offices, civil-registration personnel, primary health centers, hospitals, and BPJS Kesehatan need a shared workflow for identifying undocumented residents before medical emergencies occur. Repeated communication through social media remains useful, but it cannot replace household-level verification and assistance for groups with limited literacy or digital access. The program will become more equitable when administrative readiness is produced proactively by public institutions instead of being left to families during episodes of illness.

The concentration of patients at referral hospitals demonstrates that UHC expansion must be accompanied by stronger primary care and referral management. Several informants reported that residents bypassed health centers because they lacked referrals, did not understand the tiered system, or had greater confidence in hospital services. This behavior contributes to congestion at Dr. Pirngadi Hospital and reduces the capacity available for complex or emergency cases. Solikha et al. (2025) found that primary healthcare performance measurement in Indonesia remains uneven and that service-delivery indicators need to capture access, continuity, coordination, comprehensiveness, quality, and patient experience. The Medan case supports this multidimensional approach because expanding insurance coverage changed where and how people sought care without automatically strengthening the first level of service. Improving primary care requires more than reminding patients to follow referral rules. Health

centers must demonstrate reliable opening hours, adequate personnel, medicines, diagnostic capacity, responsive communication, and clear escalation pathways so that residents perceive them as credible entry points. Referral hospitals should also share utilization and bottleneck data with primary facilities to identify conditions that could be managed locally. Through such integration, the program can reduce avoidable hospital crowding while preserving rapid access for patients who genuinely require specialist treatment. The practical implication is that UHC performance should include measures of referral appropriateness and primary-care resolution, not merely total hospital utilization.

The financing findings indicate that public subsidies successfully protected users from direct payment, but fiscal effectiveness must be evaluated together with distributional fairness and provider capacity. Respondents considered the financing commitment adequate for maintaining services, yet they also reported growing claims, facility pressure, and uncertainty among providers regarding the wider financing structure. Cheng et al. (2022) showed that Indonesia's health-financing system generates substantial redistribution but still faces equity concerns regarding who contributes, who benefits, and how resources are allocated. The Medan program illustrates this issue at the local level because broad eligibility can protect vulnerable households while also risking imprecise targeting if residents with greater ability to pay receive the same subsidy without periodic verification. Corrective policy should not reduce the universality of access during illness; rather, it should improve contribution classification, participant-data updating, and the allocation of additional funds toward facilities carrying the highest service burden. Cost-effectiveness should also be assessed through outputs such as waiting times, bed availability, claim-processing speed, staff incentives, and compliance with service standards. A budget can appear sufficient because claims are paid while remaining inadequate for infrastructure expansion or workforce retention. Financial evaluation must therefore connect expenditure to service readiness and equity, ensuring that pooled funds protect patients while strengthening the providers expected to deliver the promised benefits.

The workforce findings explain why coverage expansion can create new quality risks when personnel, incentives, and organizational support do not grow at the same pace. Informants described heavy patient volumes, limited consultation time, low remuneration for some workers, and the possibility that frontline staff would provide incomplete explanations when fatigued. Although the hospital reported professional teams, training, and hierarchical supervision, these mechanisms do not eliminate structural workload pressures. Nu'man et al. (2024), in a rapid review of systematic reviews, concluded that health workers experience substantial burnout and mental-health problems associated with poorer patient outcomes, medical errors, reduced safety, lower satisfaction, and diminished efficiency. The implication for Medan is that workforce well-being should be treated as a program-performance variable

rather than an internal employment matter. Monitoring should include patient-to-provider ratios, overtime, absenteeism, turnover intention, training coverage, incentive timeliness, and staff-reported exhaustion. Corrective measures may involve redistributing personnel, expanding administrative support, simplifying verification procedures, adjusting incentives, and strengthening primary care so that referral hospitals are not burdened with avoidable demand. Patient-centered conduct and empathetic communication remain important, but expecting professionalism without sufficient staffing and organizational protection places responsibility on individuals for problems created by the system. Sustainable UHC requires a workforce policy that protects both beneficiaries and the people who provide care.

The CIPP-based synthesis shows that the program should be continued, but its next phase must move from expansion-oriented governance toward adaptive quality governance. Context evaluation established strong public need and legal legitimacy; input evaluation identified workable financing alongside weaknesses in data, staffing, and infrastructure; process evaluation confirmed continued service delivery but exposed variation in operational standards; and product evaluation demonstrated high coverage with unresolved consequences for capacity and user experience. Fanji Farman et al. (2025) found that income disparities continued to shape the use of secondary and tertiary services under Indonesia's National Health Insurance, indicating that formal inclusion does not remove differences in realized benefit. The Medan findings similarly show that beneficiaries experience the same program differently depending on documentation, information, referral pathways, and facility capacity. Metaevaluation is therefore necessary to ensure that monitoring information is useful, accurate, ethically obtained, and capable of producing corrective decisions. A strengthened evaluation system should integrate civil-registration data, enrollment status, facility utilization, claims, waiting times, complaints, workforce indicators, and Minimum Service Standards into a shared dashboard reviewed by all responsible institutions. Public reporting should distinguish coverage, access, quality, and equity rather than combining them into a single success narrative. Through this model, evaluation becomes a continuous governance mechanism that detects implementation gaps, assigns responsibility, and verifies whether corrective actions improve outcomes. The principal contribution of the study is thus an integrated explanation of how local political commitment can achieve rapid coverage while requiring equally deliberate investment in administrative inclusion, service capacity, and accountability.

Conclusion

This study concludes that the implementation of Medan City's population-identity-based free healthcare program has significantly expanded access to health services and strengthened financial protection for residents. Through collaboration among the municipal government,

Commission II of the Regional House of Representatives, the Health Office, BPJS Kesehatan, and participating healthcare facilities, the program has achieved 98.96% UHC coverage and enabled eligible residents to obtain treatment without direct payment. Nevertheless, the findings show that high enrollment has not yet produced uniformly effective and equitable service delivery. Administrative problems involving unregistered National Identification Numbers, outdated family records, limited understanding of referral procedures, and weak public socialization continue to delay access. At the institutional level, the program also faces constraints related to inpatient and intensive-care capacity, workforce burden, staff remuneration, service waiting times, and the incomplete achievement of several Minimum Service Standards. The CIPP evaluation confirms that the program is relevant to community needs and supported by adequate policy and financing commitments, but weaknesses remain in input readiness, process consistency, and product quality. Therefore, future improvement should prioritize integrated population data, proactive administrative assistance, stronger primary healthcare, balanced referral flows, adequate staffing, improved incentives, facility expansion, and continuous quality monitoring. Evaluation should move beyond enrollment indicators by incorporating access, service quality, workforce well-being, complaints, waiting times, and equity of benefit distribution. Overall, the program should be continued because it provides substantial social value, but its sustainability depends on transforming near-universal administrative coverage into reliable, timely, humane, and high-quality healthcare for all Medan residents without exclusion

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