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Health Citizenship and Healthcare Access in Indonesia, 1945-2020

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Abstract

Health citizenship is understood over how the government provides access to healthcare. This paper aims to describe the development of health citizenship from the post-colonial until the democratization era in Indonesia by analyzing health accessibility. The social-history approach was applied to analyze contemporary study in Indonesian healthcare access from 1945 to 2020. This article analyses the dynamic over political regime changes context and its approach to deal with health accessibility based on acceptability, availability, and affordability issues. This study found that each political regime provides a different social-political context in prioritizing and administrating the accessibility of healthcare. Besides each regime appears issues of accessibility, all of which provoke inequity in healthcare. This paper argues that health citizenship development in Indonesia shows the underlying cause of inequity. Consequently, the minimal presence of public participation raises inequity. Inequity leads to healthcare access that provides pointless improvement. Narratives in health citizenship fulfillment call for public participation space in administering access to healthcare.

Keywords:
access; healthcare; health citizenship

Introduction

Health citizenship is defined as a concept that elaborates service delivery as a concrete form of social and cultural values in health that show the dynamic roles of the government and society in achieving good health (Harjula, 2016, p. 575). Health service has been seen as the government's duty and as a concept that refers to the importance of incorporating citizen's participation in health knowledge production, translation, and action to better understand and manage contextual determinants governing health inequities (Groleau, 2011).

In Indonesia, health citizenship studies are focused on elaborating health access issues, including issues derived from geographical setting (Efendi, 2012), health professionals distribution (Meliala, Hort, & Trisnantoro, 2013), healthcare availability (Misnaniarti et al., 2017), and health disparities (Suparmi, Kusumawardani, Nambiar, Trihono, & Hosseinpoor, 2018). Access to health services is people's right that needs more attention on health inequity issues since the government is responsible for providing accessible health care and accommodating people's participation. Moreover, the rights to health services are closely related to people's citizenship (Atterbury & Rowe, 2017; Jati, 2016; G. R. Sanchez, Vargas, Juarez, Gomez-Aguinaga, & Pedraza, 2017).

Meanwhile, citizenship studies related to health still focus on limited periods (van Klinken, 2018) and explain the individual perspective in gaining health citizenship (Berenschot, Hanani, & Sambodho, 2018). Compared to Berenschot's study about brokered citizenship in accessing

health care, this study describes the dynamic of health citizenship through government presence in providing access to health care. The government function and existence were interpreted via de jure and de facto (Kurniarini, Darini, & Dewi, 2015, pp. 3–5). This study compares the provision of health services from time to time. It elucidates how the government administered and fulfilled the peoples' right to health access and the rights to take a role in it. Patterns of inclusion and exclusion in healthcare provision role in society reflected in the health system and mapped welfare programs' visibility (Castillo & Solbakk, 2017, p. 167).

Access issues in the Indonesian health sector deal with various aspects (Christiani, Byles, Tavener, & Dugdale, 2017; Mboi et al., 2018; Sparrow, Suryahadi, & Widyanti, 2013; Titaley, Hunter, Heywood, & Dibley, 2010). Moreover, health access issues in Indonesia have evolved not only as government functions but also as people's roles (Arkedis et al., 2021). Thus, health citizenship narratives in Indonesia to be requisite for government effort in providing people's rights in the health sector.

Methods

This paper applied a social-history approach to health. The social-history approach expands amplification for analyzing comprehensive health history and better understanding social setting advancement of health issues (Boomgaard, 1993). The discourse on health citizenship in this discussion is placed on the government healthcare provision issue. The object of the studies is focused on the contemporary study of Indonesian healthcare access published in the academic journal from 1945 to 2020 that retrieved from surface web search using the keyword "Indonesian health access," and Bahasa Indonesia applied keywords "akses pelayanan kesehatan". Surface web search operated in ProQuest search tools (ABI/INFORM Collection®, Ebook Central®, Publicly Available Content Database®, Research Library®), Scopus database, and PubMed MEDLINE. Furthermore, as gaining health history social and political context, snow bowling search-based bibliography was applied to identify; first, initial health history works of Indonesian historians (such as Peter Boomgaard, Liesbeth Hesselink, and Hans Pols). Second, Indonesian government legislation is related to health access.

Time frame analysis was applied based on the political regime to elaborate accessibility, social context and political setting. Accessibility of the health access that is fundamentally linked to the formation of health citizenship is elaborated in three main topics: 1). acceptability, 2). availability, and 3). affordability (Harjula, 2016; Okpala, 2020). As a study limitation, this paper includes primary historical sources such as official publications, legislation, newspapers, and magazines instead of archives and special collection sources due to research limited resources. Therefore, editorials, comments, and letters of works obtained from literature searching are excluded. Exclusion also applied for books, articles, reports, and data that do not explicitly inform Indonesian health care access situation marked as irrelevant literature are excluded.

Result & Discussion

1945-1965: Acceptability and Nation-building agenda

The post-colonial era in 1945-1949 was a period of struggle for the independence of the Indonesian people. Even though Indonesia had been independent on August 17, 1945, at least until 1950, Indonesia struggled in power transition and fragmented health service provision (Departemen Kesehatan, 1978). Unstable conditions showed by government administration center displacement regarding political and security instability because of the independence war (Departemen Kesehatan, 1978). With all limitation conditions, the

government put more attention on promoting acceptability as a priority while improving the availability of health provision (Neelakantan, 2014).

Acceptability of health provision was considered a critical phase to enhance public acceptance of health services early in Indonesia's independence. Acceptability plays an essential role because it refers to social, cultural, and educational factors and is connected to patients-health professions relations, which is an essential part of accessibility (Dyer, Owens, & Robinson, 2016; Gulliford et al., 2002; R. M. Sanchez & Ciconelli, 2012). Regarding the limited availability of health services, one indication of low health service acceptability in Indonesia's post-colonial era was marked by traditional birth attendants and local healers' prominent role (Boomgaard, 1993). Health services provided were aimed at proving and encouraging public acceptance of health services, in addition to tackling several epidemics or endemic diseases. One of them was an outbreak of smallpox due to the cessation of smallpox vaccination in 1948 (Departemen Kesehatan, 1978)

Healthcare provision runs organically and fragmented. Doctors, nurses, pharmacists, and other health staff voluntarily run health services without systematic coordination (Departemen Kesehatan, 1980b). There was little coordination among health stakeholders in the capital and region because of political instability in the early independence era (Neelakantan, 2015b). The Soekarno era had limited funds in providing healthcare and became another challenge in providing healthcare (Sumarto & Kaasch, 2018). On the other hand, the Indonesian government under the Soekarno administration was very selective in receiving international aid for avoiding political intervention and threatening national sovereignty (Mackie, 1964). Soekarno, as president, encourages making some breakthroughs to develop health care services instead of preserving the colonial approach at funds limitation context (Neelakantan, 2014). President Soekarno's approach in health administration can be understood via the context of anti-colonialism policy mainstreaming. Soekarno's era was well-known for its anti-colonialism policy (Yeremia, 2020).

Acceptability was a prior issue in the early post-colonial era to boost people's acceptance of health services and driven by the state political interest. President Soekarno put health services considered to provide healing and nationalism. Health experts elaborated on Soekarno's big idea in national life. They developed their own identity considering the archipelagic diversity of the nation in terms of culture, religions and manners (Pols, 2018b).

Such efforts to elaborate on health issues in acceptability to engage nation-building can be seen from the related policy pattern. First, the promotion of health-related jargon "Rakjat Sehat, Negara Kuat" became a symbol sign that intended for the public to accept the pattern of modern health care and support Indonesia's nation-building (Neelakantan, 2017). Health services acceptance in overcoming epidemics and endemics enabled political interest in the initial process of identity pursuit as a nation. Second, in the provision of health services, Soekarno encouraged health experts to formulate a policy pattern with a different approach from the colonial government, especially in social medicine or public health (Lindblad, 2017). As a result, the pattern shown at the beginning of the independence of the Indonesian government is becoming entirely rational to see health as a vital tool in building nationalism since the colonial period (Pols, 2018a).

Unfortunately, there is a gap between policy ideas and their implementation. Nation-building through health issues was conducted without sufficient engaging people participation. Indonesian people to

be treated as an object instead of the subject in nation-buildings. This paper has not found convincing evidence of active community involvement in the nation-building framework in the early Indonesian independence era. People's involvement is only captured as their participation in government health programs such as vaccination (Neelakantan, 2015a). Moreover, health policy tendentious into java centrism in managing health services raises a question about equity issue for eastern Indonesia (Murakami, 2015).

There have been attempts to encourage equity and even distribution of health personnel to rural areas (Jenney, 1953). The growth of healthcare infrastructures that occurs shows the disparity in numbers between eastern Indonesia and western Indonesia. The development of this clinic even though developed by the ratio of the number but only 0.8-bed availability per 1,000 inhabitants (see table 1).

The Soekarno era presented bold plans and unfulfilled aspirations in Indonesian public health (Neelakantan, 2014). Independent spirit from foreign interference has encouraged technocrats in the health sector in this era to create new approaches in health services, especially social medicine (Neelakantan, 2017). During this period, an integrated health service pattern called Pusat Kesehatan Masyarakat – Puskesmas (Community Health Center) was started to be developed (Nugroho & Andarwati, 2014). Puskesmas was intended to make curative, promotive, and preventive services holistic and widen access to health services (Leimena, 1950). Thus, this era laid the foundation of access to health services and encouraged acceptability to health services and a government machine in building national identity.

Table 1.
Indonesia Health Center Growth, 1960-1964

No	Provinces	1960		1964	
		Public	Private	Public	Private
1	Jakarta Raya	46	155	56	17
2	West Java	708	70	714	109
3	Central Java	557	73	761	75
4	Yogyakarta	66	12	73	12
5	East Java	613	104	598	127
6	South Sumatera	245	17	166	11
7	West Sumatera	159	2	61	2
8	Riau	42	-	60	12
9	Jambi	37	2	42	2
10	North Sumatera	319	44	231	23
11	Aceh	75	-	98	2
12	South Kalimantan	90	4	126	11
13	Central Kalimantan	89	-	99	9
14	West Kalimantan	76	2	72	10
15	East Kalimantan	68	1	99	7
16	South Sulawesi	118	8	134	8
17	North Sulawesi	178	36	180	36
18	Bali	92	3	99	6
19	West Nusa Tenggara	30	-	44	2
20	East Nusa Tenggara	53	-	90	16
21	Maluku	55	-	68	2
22	West Irian	3	-	97	21

Source: Departemen Kesehatan, 1980b

1966-1997: Acceleration of Healthcare Availability

The new order that began in 1966 gives another context in healthcare management in Indonesia. Under the Soeharto administration, the state was managed with repressive developmentalism (Feith, 1981). Repressive-developmentalism political regime allows for political stability and security that supports health development—proven by several achievements in health development of infrastructure and facilities of health, population control programs, vaccination to control several endemic diseases. The number of Puskesmas experiencing acceleration was a decisive contribution of the Soeharto administration in broadening access to healthcare via INPRES Kesehatan launched in 1975 (A Booth, 2003). Even when facing the heterogeneity of society, population control can be carried out quite well due to the political system and ideology implemented by the government (Hull, 1987).

In terms of the health services administration, the new order did not have any breakthroughs. An integrated public health idea about providing primary health needs was initiated at the end of the Soekarno era but developed well in the Soeharto era (Halabi, 2009). The concrete policies from the government alignments started from the establishment of the primary health center (Puskesmas) and the launch of the doctor's service program (Haliman & Williams, 1983, p. 1455). Further, Puskesmas is equipped with networking such as Supporting Health Centers (Puskesmas Pembantu-Pustu) and Integrated Service Posts (Pos Pelayanan Terpadu - Posyandu). Posyandu was developed to call for community involvement in health services. Through the concept of health cadres, the government tries to reach more people in health services (P. Berman, Sisler, & Habicht, 1989). Health cadres are used to run some government programs in the health sector (Kim & Singarimbun, 1988). Health cadres can then indeed be used to identify health problems needed by the community but do not have the space to push the priority needs of the health service (P. A. Berman, 1984).

Access to healthcare to be improved during 1978-1987, the government of Indonesia has subsidized some healthcare facilities. Unfortunately, these subsidized schemes did not meet the goal of targeting low-income people (Hotchkiss & Jacobalis, 1999). Health facilities' costs are burdensome for low-income people, mostly villagers who live far away from health facilities. Consequently, villagers preferred to choose traditional medicine or self-healing medicine and delayed going to health facilities when they were sick (Walle, 1994, p. 286). This condition happens in severe illnesses and requires treatment at the hospital because hospital care is quite expensive. A study in 1995 showed that only 10% of the poor population in Indonesia received hospital care or 1:10 compared to the number of wealthy people who received hospital care (Aspinall, 2014, p. 807).

Health services for all Indonesian citizens have not been fulfilled yet in the Soeharto administration. First, this condition was shown by health insurance that only covered civil servants and retired civil servants and their relatives (Chernichovsky & Meesook, 1986, p. 616). Second, the number of health workers has not met the needs (Departemen Kesehatan, 1980a). Third, the cost to access healthcare has been relatively expensive. Based on Susenas data in 1980, the average cost of health services in Central Java was about IDR 418 for once visited health facilities. This average cost has not included transportation and food costs for patients who are hospitalized. Moreover, the monthly expenditure in Central Java was about IDR 24,795. In this era, the government also had not to give health insurance to all Indonesian citizens.

The New Order era has made bold success in broadened access to health care,

especially in the field of public health. For example, family planning can be pretty successful because it can suppress population growth properly (Hull, 1987). Thus, it showed accelerated access to health services quite well. The growth of service facilities is also quite massive, especially in health infrastructure coverage via Pusat Kesehatan Masyarakat – Puskesmas (Community Health Centers) (Jung, 2016). However, not all the government health policy responses could answer the disparity and inequities issue of health services among Indonesian citizens, although there was some improvement (Nababan et al., 2017). Starting from 1993, income-related inequalities in all types of healthcare utilization decreased only for public and private inpatient care utilization (Mulyanto, Kringos, & Kunst, 2019).

Availability issues in the Soeharto era remain to bring in equity problems instead of overcoming disparities in rural-urban areas. Facilities and human resources in the health sector are still concentrated in urban areas and the western part of Indonesia, especially Java. The symmetrical and centralized development policy made it less capable of coping with diverse needs and contexts in health services (A Booth, 2003). Government policy responses have not answered the limitation of the distribution of health services. People who live in cities have more access to health services than people who live in rural areas (P. A. Berman, 1984, pp. 420–421). It means the government failed to realize the diversity of social and economic contexts in Indonesia (Anne Booth, 2000).

Behind the scene of access to health services acceleration, there were contradictory problems. The development of health services supported by political stability, power centralism, and authoritarianism effectively encourages access to health services (Aspinall & Fealy, 2010, p. 5). The availability of health services becomes relatively easier to reach within the acceptability of the community that was influenced by the authoritarian regime. However, the success of health programs did not necessarily mean that the acceptability of health services is quite good. Acceptability is formed not from acceptance and active public participation but rather at adherence patterns of society under the authoritarian regime (Putri, Hubeis, & Sarwoprasodjo, 2019).

Universal Health Coverage Era: Affordability of Healthcare

National Health Insurance Initiation: 1998-2013

Indonesia made a dramatic change from centralization to decentralization after Habibie took over the presidency. Decentralization delivers another context of healthcare provision in Indonesia (Kristiansen & Santoso, 2006). Autonomy allowed the local government to build its initiatives for improvement (Fossati, 2016). The breakthrough in providing healthcare was enabled by decentralization. For example, Jembrana initiatives make insurance systems promote better healthcare access (Fuady, 2013). Subsequently, the insurance system became a popular idea and practiced in another region in Indonesia (Aspinall, 2014).

Local government drives in insurance issues made the central government adopt the concept. Although at the national level the government had launched the impermanent

Table 2.
Development of Health Service Access in Indonesia 1945-2020

Access	1945-1965	1966-1997	1998-2020
Issue	Acceptability	Availability	Affordability
Insurance Coverage	N/A	Limited to those who have health insurance and economic capacity	Universal Health Coverage

Source: Analysis based on a contemporary study of healthcare access

health insurance for lower economic citizens called by Jaring Pengaman Sosial Bidang Kesehatan-JPS BK (Social Safety net in Health) (Kementerian Kesehatan, 2012). To continue the temporary policy response, the national scale of insurance schemes was considered an appropriate response to the disparity problem (Jung, 2016, p. 484; Meliala et al., 2013, pp. 33–34; Rosser, 2012, pp. 257–258).

The national health insurance project needs ten years to be implemented. 2004 until 2014 was an exhausting phase in the designed insurance scheme. Instead of settled down the national insurance scheme, there was sectoral insurance launched, such as health insurance to solve maternal and neonatal problems called Jampersal - Child Birth Insurance (Mboi, 2015, p. 93) and Jamkesmas – Community Health Insurance for low income (Brooks et al., 2017). Meanwhile, national insurance discourse comes into political contestation among elites rather than elaborating substantive issues such as resource funds and insurance schemes (Wisnu, 2012).

Draining political contestation leads to public protest that organized non-government organizations and, mainly, some guild organizations. Moreover, mass media coverage on mass protest and demonstration in the late before BPJS act legalized show guild and non-government organization political pressure (Berita Satu, 2011). In the end, the national board for managing health insurance was formed. Formally, on November 25th, 2011, the national board for health insurance formed and officially operated on January 1st, 2014.

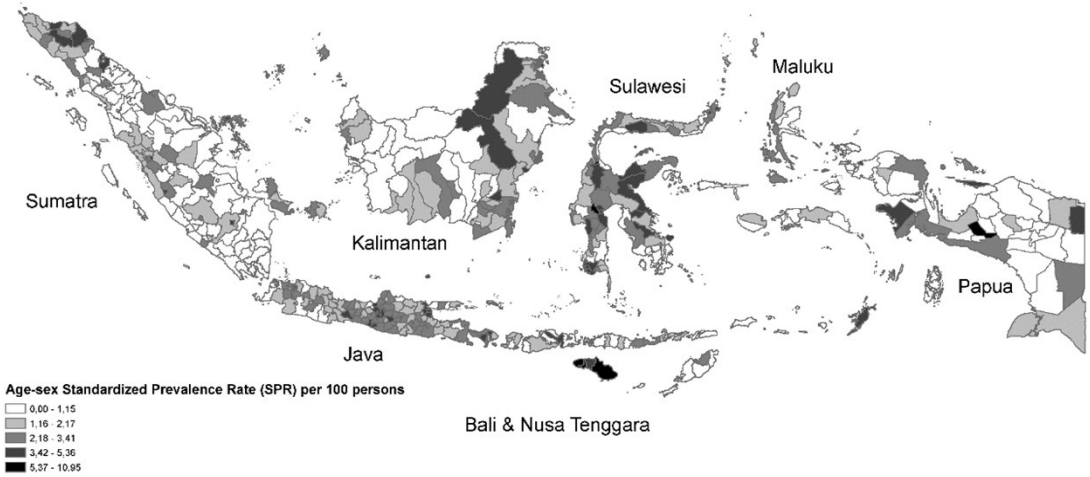
Questioning the Affordability of Healthcare: 2014-2020

After legislation of law no 24 2011 about Badan Penyelenggara Jaminan Sosial Kesehatan –BPJS Kesehatan (national board social insurance in health) was National Health Insurance (JKN-Jaminan Kesehatan Nasional) in Indonesia officially started. As derivative rules, Minister of Health Regulations number 28 of 2014, the participant of National Health Insurance (JKN-Jaminan Kesehatan Nasional) divided into the recipient of the Penerima Bantuan Iuran –PBI (subsidized group) and non- Penerima Bantuan Iuran – non-PBI (non-subsidized group). The PBI group consists of poor people who assume they could not afford to pay for insurance. The non-PBI group consists of formal workers and informal workers. Under the Indonesia Ministry of Social, the selection of PBI and non-PBI people is held. After that, BPJS registered people as PBI and Non-PBI based on the data of the Ministry of Social (Salim, Muchtar, Dartanto, & Susmono, 2013, pp. 8–10).

The existence of National Health Insurance (JKN-Jaminan Kesehatan Nasional) increases the government coverage of health services. Citizen accessibility to health services has been expanding through national health insurance (Suryanto, Plummer, & Boyle, 2016, p. 37). Until 2020, the insurance covered 82,53% out of 271,34 million people (Badan Penyelenggara Jaminan Sosial Kesehatan, 2021). The patterns of health security have increased people's awareness about health (Purnomo, 2015, pp. 180–187; Sunyoto, 2015, pp. 87–88). With this awareness, people were motivated to ask for qualified and equitable access to national health insurance (Ekawati et al., 2017, pp. 7–8).

Unfortunately, the National Health Insurance (JKN-Jaminan Kesehatan Nasional) implementation does not make access to health services more accessible automatically for all Indonesians. First, health insurance does widen access to health services, but it turns out that the acceleration of health services utilization. National Health Insurance (JKN-Jaminan Kesehatan Nasional) achieved outpatient healthcare utilization but failed at inpatient utilization (see Figure 1). Health expenditure is still experiencing non-public expenditure 46,4% compared to public health expenditures (Kementerian Kesehatan RI, 2020).

Figure 1.
Inpatient healthcare utilization at the district level in Indonesia



Source: Mulyanto, Kringos, et al., 2019

Second, there is a bitter truth about poor people helped by the brokerage to access health services. The brokerage informally mediates people in accessing National Health Insurance (JKN-Jaminan Kesehatan Nasional). The results of ethnographic research in Sari Endah village West Java show that brokerage assists people to know the procedures of JKN and make a deal with the administrative burden in accessing healthcare (Berenschot et al., 2018). Brokerage enables people to have the courage to argue, negotiate, and be self-confident when dealing with the administrative burden of accessing national health insurance. However, the brokerage phenomenon shows that National Health Insurance (JKN-Jaminan Kesehatan Nasional) does not meet the main goal yet. There are inequity issues in healthcare provision (Mulyanto, Kunst, & Kringos, 2019) that enabled constraints for Indonesian accessing National Health Insurance (Vidyattama, Miranti, & Resosudarmo, 2014, pp. 410–411).

The Remaining problem of Healthcare Provision in Indonesia

Periodic changes in health services accessibility were only followed by infrastructure improvement responses from post-colonial until the reformation era started in 1998. In Indonesia, healthcare developments imply unintentional in maintaining health disparities and inequity. A concentrated healthcare facility in urban areas (Suparmi et al., 2018), uneven distribution of health workers such as doctors (Meliala et al., 2013, p. 33), differences in urban and rural health services provision (Fossati, 2017, p. 193) shows Indonesian right for health care unfulfilled by the government yet. Healthcare availability does not become the main problem in health services accessibility. However, inequity remains to exist for the rural area, especially in eastern Indonesia.

There is no availability of healthcare without unquestionably accessible to the public—Healthcare in Indonesia presents affordability issues (Pisani, Kok, & Nugroho, 2017). Affordability is not only defined as geographically (Pardosi, Parr, & Muhidin, 2014) or economic constraint (Hartono, 2017) but also an administrative burden in experiencing national health insurance (Berenschot et al., 2018). The underlying context enabled affordability issues in Indonesian access to healthcare—namely, privatization logic in implementing health services. Privatization in

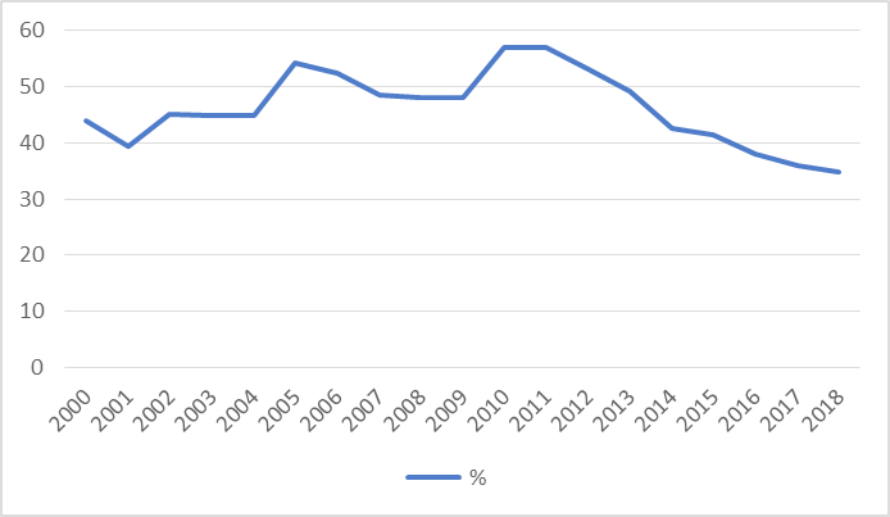
government-owned institutions (Ayuningtyas, 2009, p. 118; Zaenuddin, 2005, p. 5). Privatization in managing health services does not just happen in the late era. The private sector's role in providing health service can be traced even started in colonial-era (Hesselink, 2011), post-colonial (Chernichovsky & Meesook, 1986), and undeniable private sector outset unique role in the health system in Soeharto era (Anne Booth, 2000).

Privatization logic allows private investment in health services in the profitable area for health service delivery. Non-profitable areas such as rural and remote are consequently marginalized. Rural and remote area marginalization in health provision brings out inequity. The initial policy response to inequity did not meet the goal (Murakami, 2015, p. 42). The government's efforts have indeed slightly increased the availability of health care. However, they are still not able to answer the uneven availability of health services.

Private logic mainstreaming in delivering health services in Indonesia contributes to the inequity of health services and economic affordability. The nature of profit gain makes the availability of health care accessible to the public. This means that economic affordability is the following logical consequence. During the Soeharto era, health services subsidies could not remove barriers to access to health services yet, especially for the poor (Walle, 1994, p. 301). The National Health Insurance scheme (Jaminan Kesehatan Nasional - JKN) indeed later became a temporary solution in the future when the reform era was rolling. Health insurance schemes for the underprivileged, being members of JKN contribution aid recipients (Penerima Bantuan Iuran - PBI), indeed make these economic barriers capable of being reduced slightly.

The presence of JKN reduces economic barriers to health care affordability. Even though the public has had access to health does not necessarily use healthcare. The fact of the emergence of brokerage phenomena in an attempt to access health services (Berenschot et al., 2018, p. 141), illegal practices in the health service fee (Rosser, 2012, p. 264), and high proportion out of pocket spending in health (Agustina et al., 2019) show the affordability of health services are still a big issue to healthcare access.

Figure 2.
Out of Pocket Expenditures as % Indonesia Current Health Expenditures



Source: http://apps.who.int/nha/database/ViewData/Indicators/en

Despite fighting for the right to get involved in healthcare provision, Indonesia's experience presented mediated health citizenship. Indonesian need third-party help to lubricate government function in providing health care, as already stated by Berenschots' study. Admittedly, brokered citizenship in Berenscots' study is understood as vernacularized citizenship and demonstrated that citizenship operated formally and informally in people's everyday lives (Berenschot & van Klinken, 2018). In the end, the brokerage role in lubricating the government function raised a bold question about tricky access to JKN. In accessing healthcare via JKN, Indonesian people must deal with the administrative burden.

The administrative burden can be looked at as another underlying cause of affordability issues. Affordability issues come from its consequences on whether people can access publicly supported health insurance (Peeters, 2020). Administrative burden came as a bureaucratic administration process that generated learning, compliance, and psychological cost. It burdened the poor people in accessing healthcare (Herd & Moynihan, 2020).

The Struggling for Health Citizenship in Indonesia

Health issues have been essential in public service since Indonesia got independence. Moreover, health issues take part in Indonesia's nation-building. Notwithstanding its importance, health issues administered bear to put people as a government political interest (Fossati, 2016, p. 295; Samadhi, 2015, pp. 342–344) and designed by allegiance. From independence until Indonesia had an insurance scheme that applied for universal health coverage; the government administration did not put people as a subject in developing the healthcare system by enhancing public participation. At the same time, health citizenship requires accessibility and participation of people as citizens (Huisman & Oosterhuis, 2014). People's participation aims to ensure government accountability in providing healthcare (Street, Duszynski, Krawczyk, & Braunack-Mayer, 2014). Accountability is required to design and assure equity in healthcare (Groleau, 2011).

The Indonesian government's management of participation in healthcare provision has not adapted well yet. Participation is only viewed as people's acceptance and involvement in the government health program (Sujarwoto & Maharani, 2021). Health cadres have become more advanced evidence that some degree of participation is applied in healthcare provision (Irawan, Koesoema, Soegijoko, Riyani, & Utama, 2018). Unfortunately, the health cadres scheme is designed to operate health programs instead of actively making some policy responses to health problems in the community. Health cadres in many practices only operated health routine data in Posyandu program or health program socialization agent (Nirwana, Utami, & Utami, 2015).

Government works are stuck in availability, affordability, and acceptability issues to secure accessibility despite assuring public participation space in healthcare (Halabi, 2009). Previous studies revealed that people's involvement boosts community engagement or acceptability of health programs and improves the quality of health policy responses (Street et al., 2014). However, participation space is slightly limited in Indonesia's health administration (Arkedis et al., 2021; Kusumasari, Setianto, & Pang, 2018). Government pattern in manage health provision growth in inadequate public awareness and knowledge about health context (Bennett et al., 2015, p. 369; Hanandita & Tampubolon, 2014, p. 66; Harjaningrum et al., 2013, p. 1521; Kurniawan, Posangi, & Rampengan, 2017, p. 68; Pardosi, Parr, & Muhidin, 2016, p. 136; Wiradnyani, Khusun, Achadi, Ocviyanti, & Shankar, 2016, p. 2824). It seems like participation demands in public services do not meet the enabling context.

Modest public participation in healthcare explains that health citizenship in Indonesia still copes with accessibility issues despite encouraging public participation. Indonesian people remain to call for empowerment to get their rights. Unfortunately, it comes from informally and via non-government organizations. Brokered citizenship is one practice that the government functions to secure health accessibility and is slightly called "public participation."

Conclusion

Healthcare access from the post-colonial to post-reform era shows the development of health issues in Indonesia. It started as a limited "commodity" in nation-building issues, then shows slight growth in health care accessibility. Through accessibility issues about acceptability, availability, and affordability show improvement in health citizenship fulfillment. Regrettably, the accessibility improvement effort leftovers the inequity problem in healthcare. This paper argues one of the governments overlooking approach in public participation as an explanation.

Inequity issue makes health citizenship discourse in Indonesia call for public participation. Indonesian government experience in administering health provision and broadening access to health care does not meet the goal because they neglect public participation. In the post-colonial era, the public was only recognized as the object of nation-building issues (Neelakantan, 2014). In the Soeharto era, the public was used as a health development object via an authoritarian approach (Rifkin, 1986), and in the democratization era, the public was treated as a political commodity (Aspinall, 2014). Public participation mainly operated as a top-down agenda and articulated as passive participation (Sujarwoto & Maharani, 2021). Health accessibility is loosely mentioned as unfinished health citizenship because of its partial application.

Government administrations' big hole in providing access to healthcare, namely participation, requires improvement. Public participation completed health citizenship issues as well as making better responses to health care access. Inappropriate providing participation space in healthcare will reiterate inequity. At the same time, pay attention to health citizenship issues via public participation to minimize abuse of the elite and state as a political commodity. Health citizenship can be used by state elites to orchestrate control over the making of citizens as social citizenship does (Suwignyo, 2019). As a recommendation, the government health policy is supposed to enable deliberative participation instead of passive participation. Deliberative needs to be encouraged to engage in practical reasoning and scrutinize proposals and reasons to forge agreements on policies (Crocker, 2007).

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