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Implementing Health Maintenance Guarantee Programs in Rural Primary Healthcare: A Case Study of Community Health Centers in Eastern Indonesia

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Abstract

The Health Maintenance Guarantee Program plays a crucial role in ensuring equitable access to healthcare services, particularly for underserved rural communities. This study aims to analyze the implementation of the Health Maintenance Guarantee Program at a rural community health center in Eastern Indonesia. Using a qualitative case study approach, the research explores how policy objectives are translated into practical healthcare services at the grassroots level. Data were collected through in-depth interviews with healthcare workers, direct observations, and document analysis involving program implementers and community representatives. The analytical framework is based on Edward III's policy implementation model, which emphasizes communication, resources, disposition of implementers, and bureaucratic structure. The findings reveal that the implementation of the Health Maintenance Guarantee Program has generally improved access to basic healthcare services for low-income populations. However, several challenges persist, including limited medical facilities, inadequate human resources, and insufficient support from local government authorities. Communication between policy implementers and beneficiaries remains suboptimal, affecting public understanding of service entitlements under the program. Despite these constraints, healthcare workers demonstrate a strong commitment to delivering services within existing limitations. The study concludes that while the program has been implemented moderately well, its effectiveness depends on strengthening institutional capacity, improving infrastructure, and enhancing coordination among stakeholders. These findings provide important insights for policymakers seeking to improve health policy implementation in rural and remote areas, particularly in developing countries.

Keywords: Health Policy Implementation, Health Maintenance Guarantee Program, Primary Healthcare, Rural Health Services, Public Administration

INTRODUCTION

Ensuring equitable access to quality healthcare is a fundamental obligation of the state and a key indicator of social welfare and human development. In many low- and middle-income countries, disparities in healthcare access remain pronounced, particularly between urban and rural areas. These disparities are driven by a combination of geographical isolation, limited infrastructure, shortages of health personnel, and unequal fiscal capacity at the local level. To address these challenges, governments

have increasingly adopted health financing and guarantee programs aimed at protecting vulnerable populations and advancing universal health coverage (UHC) (World Health Organization [WHO], 2021; Agustina et al., 2020).

Universal health coverage emphasizes that all individuals should have access to essential health services without experiencing financial hardship. In practice, however, translating this principle into effective service delivery remains a complex policy challenge. Health guarantee programs often perform well at the level of policy formulation but encounter significant obstacles during implementation, particularly in rural and remote settings where institutional capacity is weak (Mills, 2018; Brinkerhoff & Bossert, 2018). As a result, gaps frequently emerge between policy objectives and actual health outcomes experienced by target populations.

In Indonesia, the government has introduced a series of health financing and social protection initiatives to reduce inequality and expand access to primary healthcare services. Community health centers (*puskesmas*) serve as the frontline institutions responsible for implementing national health policies and delivering basic healthcare at the community level. Their role is especially critical in rural areas, where alternative healthcare providers are scarce and communities rely heavily on public health services (Agustina et al., 2020; World Bank, 2018). Consequently, the effectiveness of health guarantee programs is largely determined by how well these policies are implemented at the primary healthcare level.

Despite significant progress in expanding health insurance coverage, recent studies indicate that the quality and consistency of program implementation vary widely across regions in Indonesia. Rural health facilities often face chronic shortages of medical personnel, limited diagnostic and treatment equipment, and underdeveloped referral systems, all of which constrain their capacity to deliver services in accordance with policy standards (Mahendradhata et al., 2021; Suryanto et al., 2023). These structural challenges are further compounded by administrative complexity and uneven support from local governments following decentralization reforms.

From a public administration perspective, policy implementation is not a mechanical or purely technical process but a dynamic interaction among institutions, actors, resources, and contextual conditions. Classic and contemporary implementation studies emphasize that policy success depends not only on the quality of policy design but also on the capacity of implementing organizations and the behavior of frontline actors (Pressman & Wildavsky, 2018; Lipsky, 2019). In health systems, where service delivery involves high levels of discretion and direct interaction with citizens, implementation challenges are particularly pronounced.

Edward III's policy implementation framework provides a useful analytical lens for examining these challenges. The framework identifies four key determinants of implementation effectiveness: communication, resources, disposition of implementers, and bureaucratic structure. Weaknesses in any of these dimensions can undermine policy outcomes, regardless of the clarity or ambition of policy goals (Howlett et al., 2020). Empirical research has demonstrated that ineffective communication can lead to limited public awareness of service entitlements, while inadequate resources and rigid bureaucratic procedures can restrict service delivery capacity, especially in decentralized governance systems (Walt et al., 2016; Peters, 2018).

In the context of rural healthcare, communication plays a critical role in shaping public understanding and utilization of health programs. Beneficiaries who lack clear information about eligibility criteria, covered services, and administrative procedures may underutilize available services or face barriers to access. Studies on rural health policy implementation consistently report that limited outreach and weak socialization mechanisms contribute to low program effectiveness and persistent inequalities (Prasetyo & Rahman, 2021; Kurniasih et al., 2022). These findings highlight the importance of examining how policy messages are transmitted from central authorities to local implementers and ultimately to community members.

Resource availability constitutes another fundamental determinant of implementation success. Health guarantee programs require adequate human resources, financial support, medical supplies, and physical infrastructure to function effectively. In rural primary healthcare settings, resource constraints are often severe, forcing healthcare workers to perform multiple roles and make difficult trade-offs in service provision (Mahendradhata et al., 2021; WHO, 2022). Without sufficient resources, even highly

committed implementers may be unable to meet service standards or respond effectively to community health needs.

The disposition of implementers—defined as their attitudes, commitment, and willingness to carry out policy objectives—has been widely recognized as a critical factor in sustaining policy performance under challenging conditions. Frontline health workers frequently operate as "street-level bureaucrats," exercising discretion in how policies are applied in practice (Lipsky, 2019). In rural settings, strong professional commitment and moral responsibility can partially compensate for resource shortages, enabling continued service delivery despite adverse conditions. However, prolonged workload pressures and lack of institutional support may eventually undermine motivation and lead to burnout (Howlett et al., 2020; Nowell et al., 2021).

Bureaucratic structure and administrative arrangements further shape the implementation environment. Formal rules, standard operating procedures, and coordination mechanisms are intended to ensure consistency and accountability in service delivery. At the same time, excessive procedural rigidity can limit responsiveness and adaptability, particularly in emergency situations or resource-constrained contexts (Peters, 2018; Andrews et al., 2017). Effective implementation therefore requires a balance between standardization and flexibility, allowing local implementers to adapt policies to contextual realities without undermining accountability.

Decentralization adds another layer of complexity to health policy implementation in Indonesia. While decentralization is intended to improve responsiveness and efficiency by bringing decision-making closer to communities, it has also introduced disparities in fiscal capacity and administrative competence among local governments. Regions with limited budgets and weak governance structures often struggle to support primary healthcare facilities adequately, thereby constraining the implementation of national health programs (World Bank, 2020; Suryanto et al., 2023). These conditions underscore the importance of examining health policy implementation at the local level to identify structural and institutional bottlenecks.

Although a growing body of literature has examined health policy implementation in Indonesia, much of the existing research focuses on national-level assessments or urban healthcare settings. Studies that provide in-depth, context-specific analyses of rural primary healthcare implementation remain limited. This gap is significant, given that rural communities face distinct challenges related to geography, infrastructure, and socioeconomic conditions that directly affect policy outcomes (Smith et al., 2016; Mills, 2018). Without empirical evidence from rural settings, policy reforms risk being based on incomplete or overly generalized assumptions.

In response to this gap, this study examines the implementation of the Health Maintenance Guarantee Program at a rural community health center in Eastern Indonesia. Using a qualitative case study approach, the research explores how national policy objectives are translated into everyday service delivery practices at the grassroots level. Guided by Edward III's policy implementation framework, the study focuses on communication processes, resource availability, implementer disposition, and bureaucratic structure as key dimensions shaping implementation outcomes.

By analyzing the interaction between policy design and local implementation capacity, this research seeks to contribute to the literature on health policy and public administration in decentralized systems. The findings are expected to provide practical insights for policymakers, health administrators, and development practitioners seeking to improve the effectiveness of health guarantee programs in rural and remote areas. Ultimately, strengthening policy implementation at the primary healthcare level is essential for achieving equitable health outcomes and advancing the broader goals of universal health coverage and sustainable development.

METHODS

Research Design

This study employed a qualitative research approach with a case study design to examine the implementation of the Health Maintenance Guarantee Program in a rural primary healthcare setting. A qualitative approach was chosen because the research aimed to explore in depth the processes, interactions, and contextual factors that shape policy implementation in real-world institutional

environments. Qualitative case studies are particularly appropriate for understanding how public policies are interpreted and enacted by implementers and experienced by beneficiaries within specific social, organizational, and geographical contexts (Creswell & Poth, 2021; Yin, 2018).

The case study design allowed for a holistic examination of policy implementation dynamics at the micro level, capturing variations between formal policy provisions and actual practices. This design is widely used in health policy and public administration research to analyze complex implementation processes that cannot be adequately explained through quantitative indicators alone (Gilson, 2016; Walt et al., 2016).

Research Setting

This study employed a qualitative research approach with a case study design to examine the implementation of the Health Maintenance Guarantee Program at the primary healthcare level. A qualitative approach was selected because the research sought to explore in depth the processes, interactions, and contextual factors influencing policy implementation in a real-world setting. Qualitative case studies are particularly suitable for understanding how public policies are translated into practice within specific institutional and socio-cultural environments (Creswell & Poth, 2021).

Research Design

The research was conducted at Tanah Goyang Community Health Center, located in Tanah Goyang Hamlet, Lokki Village, Huamual District, West Seram Regency, Maluku Province, Indonesia. This health center was selected purposively because it represents a rural and geographically remote primary healthcare facility that serves as the main provider of public health services for surrounding communities. The area is characterized by limited transportation access, low population density, and heavy dependence on government-funded health programs.

The selected site is particularly relevant for examining health policy implementation because it operates under conditions of constrained resources and limited institutional capacity—factors commonly associated with implementation challenges in rural health systems (Mills, 2018; World Bank, 2018). These contextual characteristics make the health center a suitable and information-rich case for analyzing the implementation of health guarantee programs at the grassroots level.

Analytical Framework

This study was guided by Edward III's policy implementation framework, which identifies four key determinants of successful policy implementation: communication, resources, disposition of implementers, and bureaucratic structure. This framework was used as an analytical lens rather than as a set of measurable variables, consistent with qualitative research principles (Howlett et al., 2020).

Communication refers to the transmission, clarity, and consistency of policy information among implementers and between implementers and beneficiaries. Resources include human resources, financial support, medical equipment, and physical infrastructure available for program implementation. Disposition of implementers encompasses the attitudes, commitment, and responsiveness of healthcare workers toward the program. Bureaucratic structure refers to formal rules, standard operating procedures, coordination mechanisms, and administrative hierarchies that shape service delivery. This framework has been widely applied in public policy and health system research to analyze implementation gaps and institutional performance (Pressman & Wildavsky, 2018; Peters, 2018).

Participants and Informants

The participants in this study consisted of individuals directly involved in or affected by the implementation of the Health Maintenance Guarantee Program at the Tanah Goyang Community Health Center. Informants were selected using purposive sampling to ensure that participants possessed relevant knowledge, experience, and involvement in program implementation. Purposive sampling is appropriate in qualitative research where the objective is to obtain rich, context-specific insights rather than statistical generalization (Palinkas et al., 2020).

Two main categories of informants were included. The first category comprised program implementers, including healthcare personnel and administrative staff working at the health center.

These informants included one general practitioner, two nurses, two midwives, and one administrative staff member. They were selected because of their direct responsibility for service delivery, program administration, and interaction with beneficiaries on a daily basis.

The second category consisted of program beneficiaries and community representatives. This group included patients who had accessed healthcare services through the Health Maintenance Guarantee Program and community leaders who were familiar with local health service conditions. Beneficiary informants were selected based on their experience using services at the health center and their ability to articulate perceptions of access, service quality, and administrative procedures.

In total, twelve informants participated in the study. This number was considered sufficient to achieve data saturation, as similar themes and patterns began to recur across interviews (Tracy, 2020). The inclusion of both implementers and beneficiaries enabled data triangulation and allowed the study to capture multiple perspectives on the implementation process, thereby enhancing the credibility of the findings (Nowell et al., 2021).

Data Sources and Research Instruments

The study utilized both primary and secondary data sources. Primary data were obtained through in-depth interviews and direct observation, while secondary data consisted of institutional documents related to the Health Maintenance Guarantee Program. These documents included policy guidelines, standard operating procedures, service reports, and administrative records.

The primary research instrument was the researcher, supported by semi-structured interview guides, observation checklists, and document review forms. Semi-structured interview guides were designed based on the analytical framework to ensure that key dimensions of policy implementation were systematically explored while allowing flexibility for informants to express their experiences and perspectives in their own words (Creswell & Poth, 2021).

Data Collection Techniques

Data collection was conducted through three main techniques: in-depth interviews, direct observation, and document analysis. In-depth interviews were used to explore informants' perceptions, experiences, and interpretations of program implementation. Interviews were conducted face-to-face at the health center and in the surrounding community, depending on informant availability. Each interview lasted between 30 and 60 minutes and was audio-recorded with participant consent.

Direct observation was carried out to examine service delivery processes, facility conditions, and interactions between healthcare workers and patients in their natural setting. Observations focused on patient registration, consultation procedures, and administrative workflows related to the program. Document analysis was used to compare formal policy provisions with actual implementation practices, thereby identifying gaps between policy design and field realities (Walt et al., 2016).

The combination of these techniques enabled methodological triangulation, which strengthens the trustworthiness and depth of qualitative findings (Nowell et al., 2021).

Data Analysis

Data analysis followed an iterative and interactive thematic analysis process. Interview recordings were transcribed verbatim, and transcripts, observation notes, and documents were systematically organized and coded. Initial coding focused on identifying patterns related to the four dimensions of Edward III's framework. These codes were then grouped into broader themes that captured key aspects of the implementation process.

The analytical process involved constant comparison across data sources to identify convergences and divergences in informant perspectives. Interpretation was conducted by linking empirical findings to the theoretical framework and existing literature on health policy implementation (Howlett et al., 2020; Gilson, 2016). This approach enabled the study to explain how contextual and institutional factors shaped implementation outcomes at the rural health center.

Trustworthiness and Ethical Considerations

To ensure rigor, the study applied several strategies to enhance trustworthiness, including data triangulation, prolonged engagement in the field, and reflexive analysis. Credibility was strengthened by comparing data from multiple informant groups and data collection methods. Dependability and confirmability were supported through systematic documentation of research procedures and analytic decisions (Tracy, 2020; Nowell et al., 2021).

Ethical considerations were carefully addressed throughout the research process. Informants were provided with clear information about the study objectives and procedures, and informed consent was obtained prior to data collection. Participant anonymity and confidentiality were ensured by using pseudonyms and removing identifying information from transcripts and reports. The study was conducted in accordance with general ethical principles for social and health research.

RESULTS AND DISCUSSION

Results

This section presents the empirical findings of the study on the implementation of the Health Maintenance Guarantee Program at Tanah Goyang Community Health Center, Lokki Village, Huamual District, West Seram Regency. The results are derived from in-depth interviews, direct observation, and document analysis, and are organized according to Edward III's policy implementation framework: communication, resources, disposition of implementers, and bureaucratic structure. This framework allows for a systematic presentation of how the program operates at the rural primary healthcare level.

Communication in Program Implementation

The findings indicate that communication related to the Health Maintenance Guarantee Program has been implemented primarily within the internal structure of the health center, while communication directed toward community beneficiaries remains limited and informal. Interviews with healthcare workers revealed that policy information is generally transmitted through routine staff meetings, informal discussions, and instructions from district health authorities. These communication channels help ensure that implementers possess a basic understanding of program objectives and administrative procedures.

An administrative staff member explained:

> *"Information about the program usually comes from the district health office. We discuss it internally, but there is no specific schedule for informing the community" (Administrative Staff, interview, 12 June 2024).*

This statement highlights that communication activities are largely inward-oriented and focused on implementers rather than beneficiaries. Observational data confirmed that no visible information materials—such as posters, banners, or brochures—were available at the health center to explain program benefits, eligibility criteria, or service coverage.

Interviews with community representatives and patients revealed a similar pattern. Most beneficiaries reported that they learned about the Health Maintenance Guarantee Program through informal channels, such as family members, neighbors, or personal interactions with healthcare workers during service encounters. A community leader stated:

> *"People here usually know about health services from other villagers. There is rarely a direct explanation from health officials" (Community Leader, interview, 14 June 2024).*

A patient further explained:

> *"I only found out that my treatment was covered after asking the nurse. There was no explanation before" (Patient, interview, 15 June 2024).*

These findings suggest that communication between implementers and beneficiaries is reactive rather than proactive. Information is often provided only when beneficiaries actively ask questions or when they are already accessing services. Similar communication patterns have been observed in rural health policy implementation, where limited outreach capacity constrains public awareness and program utilization (Prasetyo & Rahman, 2021; Kurniasih et al., 2022).

Availability and Adequacy of Resources

Resource availability emerged as one of the most significant constraints affecting program implementation. Data from interviews, observations, and document analysis revealed limitations in human resources, medical equipment, and supporting infrastructure at the health center.

In terms of human resources, the health center operates with a small number of personnel relative to its service coverage area. Healthcare workers are required to perform multiple roles, often beyond their formal job descriptions. This condition increases workload intensity and affects service efficiency, particularly during periods of high patient demand.

Table 1 presents the distribution of healthcare personnel at Tanah Goyang Community Health Center.

Table 1. Distribution of Healthcare Personnel

Position	Number
General Practitioner	1
Nurse	2
Midwife	2
Administrative Staff	1
Total	**6**

Source: Research Results, 2024.

A nurse described the operational impact of limited staffing:

> *"Sometimes one person handles registration, patient examination, and reporting at the same time, especially when many patients come" (Nurse, interview, 13 June 2024).*

This multitasking requirement often results in longer waiting times for patients and reduced opportunities for comprehensive patient education.

Facility and equipment limitations were also evident. Observations showed that the health center provides outpatient care, emergency services, and normal delivery assistance. However, inpatient services are not fully operational. Although three inpatient beds are available, only one is routinely used due to shortages of equipment and personnel for continuous patient monitoring. A midwife explained:

> *"We cannot fully operate inpatient services because we lack equipment and enough staff to monitor patients around the clock" (Midwife, interview, 14 June 2024).*

Document analysis confirmed that several essential medical devices were either unavailable or not functioning optimally. These findings are consistent with broader evidence that rural primary healthcare facilities often face persistent resource shortages that limit their ability to implement health policies effectively (Mahendradhata et al., 2021; Suryanto et al., 2023).

Disposition and Commitment of Implementers

Despite structural and resource constraints, the disposition of healthcare workers toward the Health Maintenance Guarantee Program was generally positive. Interviews consistently revealed a strong sense

of professional responsibility and moral commitment among implementers, particularly in serving low-income and geographically isolated communities.

A midwife emphasized this sense of responsibility:

> *"Even with limited facilities, we continue to serve because people here really depend on this health center" (Midwife, interview, 14 June 2024).*

Similarly, a nurse stated:

> *"We try to prioritize patients under the health guarantee program because many of them cannot afford treatment elsewhere" (Nurse, interview, 13 June 2024).*

These statements illustrate that implementers actively attempt to align their actions with program objectives, even when institutional support is limited. Observational data supported this finding, showing that healthcare workers frequently extend service hours and simplify procedures to ensure patients receive care.

However, several informants also expressed concerns about workload sustainability and lack of incentives. An administrative staff member noted:

> *"There are no additional incentives or recognition for handling this program, even though the workload is quite heavy" (Administrative Staff, interview, 12 June 2024).*

While commitment remains high, the absence of formal support mechanisms raises concerns about long-term motivation. Similar findings have been reported in studies of frontline health workers, where intrinsic motivation plays a key role in sustaining service delivery under constrained conditions (Lipsky, 2019; Howlett et al., 2020).

Bureaucratic Structure and Standard Operating Procedures

The findings indicate that the implementation of the Health Maintenance Guarantee Program is supported by formal standard operating procedures (SOPs) governing service delivery, patient registration, and referral mechanisms. Document analysis showed that these SOPs align with guidelines issued by higher health authorities and provide a basic administrative framework for program execution.

However, interviews and observations revealed discrepancies between formal procedures and actual practices. In daily operations, healthcare workers frequently adapt or simplify administrative steps to respond to local constraints, such as staff shortages or emergency situations. A nurse explained:

> *"In emergency cases, we simplify the administrative process so patients can be treated immediately" (Nurse, interview, 13 June 2024).*

While such flexibility enhances responsiveness, it also indicates partial deviation from formal procedures. Referral processes to higher-level healthcare facilities were identified as another bureaucratic challenge. Several informants reported delays due to administrative requirements and transportation constraints. A general practitioner stated:

> *"Referrals can take time because we must complete paperwork, and transportation to the referral hospital is not always available" (General Practitioner, interview, 15 June 2024).*

Observational data confirmed that referral documentation often requires coordination with district-level facilities, which can be time-consuming in remote settings. These bureaucratic conditions shape how the program is implemented in practice and influence patient experiences.

To provide an overview of the findings, Table 2 summarizes key conditions affecting the implementation of the Health Maintenance Guarantee Program at the study site.

Table 2. Summary of Program Implementation Conditions

Dimension	Key Findings
Communication	Limited outreach; reliance on informal information channels
Resources	Insufficient human resources and facilities
Implementer Disposition	High commitment despite workload pressures
Bureaucratic Structure	SOPs exist but are flexibly applied

Source: Research Results, 2024.

Overall, the results indicate that the Health Maintenance Guarantee Program has been implemented with moderate effectiveness at the Tanah Goyang Community Health Center. Access to basic healthcare services for rural communities has improved, particularly for low-income populations. However, persistent challenges related to communication, resource availability, and administrative coordination continue to shape implementation outcomes. These empirical findings provide a foundation for further discussion on the factors influencing policy implementation effectiveness in rural primary healthcare settings.

Discussion

This discussion interprets the findings of the study by linking the empirical results to Edward III's policy implementation framework and relevant health policy and public administration literature. The analysis focuses on how communication, resources, implementer disposition, and bureaucratic structure interact to shape the implementation of the Health Maintenance Guarantee Program in a rural primary healthcare context.

Communication and Information Dissemination

The findings demonstrate that communication represents one of the weakest dimensions of program implementation at the Tanah Goyang Community Health Center. Although internal communication among healthcare workers is relatively functional, external communication directed toward beneficiaries remains limited, informal, and largely reactive. Beneficiaries often learn about the program only when accessing services or through informal social networks, rather than through structured outreach mechanisms.

From an implementation perspective, Edward III emphasizes that effective communication requires clarity, consistency, and accuracy in transmitting policy objectives to both implementers and target groups. When policy messages fail to reach beneficiaries adequately, implementation outcomes are likely to diverge from policy intentions (Howlett et al., 2020; Pressman & Wildavsky, 2018). The findings of this study illustrate this dynamic, as limited outreach reduces public understanding of service entitlements and administrative procedures.

This condition is consistent with previous studies on rural health policy implementation, which highlight that weak socialization and information dissemination reduce program utilization and equity (Prasetyo & Rahman, 2021; Kurniasih et al., 2022). In rural settings, where literacy levels and access to information channels may be limited, proactive communication strategies are particularly important. The absence of systematic outreach activities at the study site suggests an implementation gap between policy design—which assumes informed beneficiaries—and field realities.

Resource Constraints and Implementation Capacity

Resource availability emerged as a central determinant shaping program implementation. The study found that shortages of healthcare personnel, limited medical equipment, and underdeveloped facilities constrained service delivery capacity and forced healthcare workers to perform multiple roles. According to Edward III's framework, resources are a prerequisite for effective implementation; without sufficient human, financial, and material resources, policy objectives cannot be fully realized.

These findings align with broader evidence on rural primary healthcare systems in Indonesia and other low- and middle-income countries. Studies consistently show that rural health facilities operate under chronic resource constraints that limit their ability to meet service standards and respond to community needs (Mahendradhata et al., 2021; Mills, 2018). Decentralization has further intensified these challenges by transferring service delivery responsibilities to local governments with unequal fiscal and administrative capacities (World Bank, 2020; Suryanto et al., 2023).

In this study, resource limitations did not result in the complete failure of program implementation but rather produced a condition of "moderate effectiveness," where basic services are delivered but with reduced efficiency and scope. This finding supports the argument that implementation outcomes should be understood as degrees of performance rather than binary success or failure (Howlett et al., 2020).

Disposition of Implementers and Street-Level Practices

Despite significant structural constraints, the disposition of healthcare workers emerged as a key enabling factor in sustaining program implementation. The findings indicate that implementers demonstrate a strong sense of professional commitment and moral responsibility toward serving low-income and geographically isolated communities. This positive disposition allows the program to continue functioning even in the absence of adequate resources and incentives.

This pattern reflects the role of frontline health workers as street-level bureaucrats who exercise discretion in applying policies under real-world constraints (Lipsky, 2019). In the study site, healthcare workers frequently adapt procedures, extend service hours, and prioritize vulnerable patients to ensure continued access to care. Such discretionary practices help bridge the gap between policy expectations and local realities.

However, the findings also reveal potential sustainability risks. The absence of formal incentive mechanisms and the persistence of high workload pressures may erode motivation over time. Existing literature suggests that while intrinsic motivation can temporarily compensate for structural deficiencies, long-term policy effectiveness requires institutional support, recognition, and capacity-building for implementers (Howlett et al., 2020; Nowell et al., 2021). Without such support, reliance on individual commitment alone may lead to burnout and declining service quality.

Bureaucratic Structure and Procedural Adaptation

The bureaucratic structure governing the Health Maintenance Guarantee Program provides a formal framework through standard operating procedures and administrative guidelines. Document analysis confirmed that these procedures align with higher-level policy directives and are intended to ensure consistency and accountability in service delivery.

In practice, however, the study found that these procedures are applied flexibly to accommodate local constraints, particularly in emergency situations or during staff shortages. While procedural flexibility enhances responsiveness, it also reflects a partial mismatch between formal rules and implementation capacity. Edward III argues that overly rigid bureaucratic structures can impede implementation, while excessive flexibility may undermine accountability (Howlett et al., 2020; Peters, 2018).

Referral procedures represent a particularly challenging aspect of bureaucratic implementation. Administrative requirements and transportation barriers delay referrals to higher-level facilities, affecting continuity of care. Similar challenges have been documented in rural health systems, where weak inter-organizational coordination limits effective service integration (Agustina et al., 2020; World Bank, 2018). These findings suggest that improving bureaucratic coordination is as important as strengthening internal procedures at the primary healthcare level.

Interaction of Implementation Dimensions

A key contribution of this study lies in illustrating how the four dimensions of Edward III's framework interact rather than operate independently. Limited resources exacerbate communication constraints, as staff shortages reduce capacity for outreach activities. At the same time, strong implementer disposition partially offsets resource and bureaucratic limitations, enabling continued

service delivery. This interaction underscores the importance of adopting a holistic approach to policy implementation analysis rather than focusing on isolated variables.

The findings reinforce arguments from implementation and governance literature that policy outcomes are shaped by complex institutional configurations rather than linear cause–effect relationships (Andrews et al., 2017; Sabatier & Weible, 2018). In decentralized health systems, local context plays a decisive role in mediating policy effects, making one-size-fits-all solutions ineffective.

Implications for Health Policy Implementation in Rural Areas

The discussion highlights several implications for improving health guarantee program implementation in rural primary healthcare settings. First, strengthening communication strategies through institutionalized outreach and community engagement is essential to ensure that beneficiaries fully understand their entitlements. Second, targeted investment in human resources and basic infrastructure is necessary to enhance implementation capacity and reduce reliance on individual discretion.

Third, supporting implementer disposition through incentives, training, and professional recognition can help sustain motivation and service quality. Finally, improving coordination between primary healthcare centers and higher-level facilities can reduce bureaucratic delays and enhance continuity of care.

Overall, this study confirms that the effectiveness of health guarantee programs depends not only on policy design but also on the capacity of local institutions to implement policies under challenging conditions. By situating empirical findings within Edward III's framework and existing literature, the discussion provides a nuanced understanding of why implementation gaps persist and how they may be addressed in rural health systems.

CONCLUSION

Conclusion

This study examined the implementation of the Health Maintenance Guarantee Program in a rural primary healthcare setting, with particular attention to how national health policy objectives are translated into practice at the grassroots level. By adopting a qualitative case study approach and applying Edward III's policy implementation framework, the research provides an in-depth understanding of the institutional and administrative dynamics shaping health policy implementation in rural contexts.

The study contributes to the literature on public administration and health policy by demonstrating that policy effectiveness in rural primary healthcare is not determined solely by formal policy design or coverage expansion. Instead, implementation outcomes are strongly influenced by local institutional capacity, organizational arrangements, and the adaptive practices of frontline actors. This finding reinforces the argument that health guarantee programs should be evaluated not only in terms of access and coverage but also in terms of implementation processes and contextual constraints.

Moreover, the study highlights the importance of examining rural healthcare settings as distinct implementation environments. Rural primary healthcare facilities operate under conditions that differ significantly from urban settings, including limited resources, geographical isolation, and greater dependence on public service providers. These characteristics necessitate context-sensitive policy approaches that account for local realities rather than assuming uniform implementation conditions.

Overall, this research underscores the need for a more nuanced understanding of health policy implementation in decentralized systems. Strengthening implementation capacity at the primary healthcare level is essential for ensuring that health guarantee programs achieve their intended social protection objectives. By providing empirical evidence from a rural setting, this study offers insights that can inform more responsive and equitable health policy design and implementation, particularly in underserved and remote areas.

Recommendation

Based on the conclusions of this study, several recommendations are proposed to improve the implementation of health guarantee programs in rural primary healthcare settings. First, policymakers should prioritize strengthening institutional capacity at the primary healthcare level. This includes ensuring that rural health centers are supported by adequate human resources, essential medical equipment, and basic infrastructure that align with the responsibilities assigned to them under national health policies.

Second, greater emphasis should be placed on institutionalizing community-oriented communication strategies. Health guarantee programs should be accompanied by structured and continuous outreach mechanisms that actively engage community members and local leaders. Improving public understanding of service entitlements can enhance program utilization and reduce information-related barriers to access.

Third, local governments and health authorities should develop mechanisms to support and sustain the motivation of healthcare workers in rural areas. Incentive systems, professional development opportunities, and workload management policies can help maintain implementer commitment and prevent burnout, thereby improving long-term service quality.

Fourth, coordination between primary healthcare facilities and higher-level health institutions should be strengthened to reduce administrative bottlenecks and improve referral systems. Clearer coordination mechanisms and logistical support are particularly important in geographically remote areas.

Finally, future research should expand beyond single-case studies to include comparative analyses across multiple rural regions. Combining qualitative insights with quantitative service data would provide a more comprehensive basis for evaluating policy effectiveness and guiding evidence-based health system reforms.

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