Institutional analysis of Indonesia’s proposed road map to universal health coverage

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EXECUTIVE SUMMARY

The Indonesian government is committed to introducing universal health coverage (UHC) by 2019 to cover a projected population of 257.5 million. Currently, around 63 per cent of the population, or 151.5 million people, are covered by some form of health insurance. A national system to be called INA-Medicare will integrate existing schemes, combining contributions from the formal and informal workforce with the government’s contributions for the poor into a single pooled fund. Regional government schemes will also be progressively integrated.

The government launched its Road Map toward National Health Insurance—Universal Coverage in 2012. It describes the design and progressive implementation of UHC. The details of the UHC design are being developed in implementing regulations, as well as a range of designated activities.

This study reviews the Road Map and related laws and regulations, where available, and identifies key policy, design and institutional issues. The results indicate that the overall design and institutional arrangements for the health financing aspects of the program are largely consistent with global UHC recommendations. However, limitations are identified.

Key issues are the absence of a calculation of fiscal capacity and the potential shortfall in government contributions; the lack of planning to address expansion of the contributor base to include the informal sector; and the lack of focus on addressing inefficiencies.

The design is also less complete and clear on the impacts of UHC on other aspects of the health system, particularly equity (both the availability and capacity of facilities) and ensuring access for the poor. While Indonesia’s UHC can be considered a work in progress, in the absence of a clear commitment to equity, there is a risk of reductions in service (coverage or benefit package) to match fiscal capacity.

The government needs to focus greater attention on these issues and strengthen engagement with local government, civil society and other stakeholders to better support public trust in, and the sustainability of, the system.

**Acronyms**

- **Askes / PT Askes**: Private health insurance company managing current insurance schemes of civil servants
- **BPJS**: National health insurance agency
- **DJSN**: National Social Security Council
- **DRG**: Diagnosis related group (hospital service output measure)
- **UHC**: Universal Health Coverage
- **ILO**: Internal Labour Organisation
- **INA Medicare**: Indonesian Medicare system
- **INA-CBG**: Indonesian version of DRG
- **Jamkesmas**: National social health insurance program
- **Jamkesda**: Regional/local social health insurance program
- **JPK Jamsostek**: National agency for workforce safety and health
- **Kegotong-royongan**: Mutual assistance
INTRODUCTION

Indonesia is one of several low- and middle-income countries aiming to improve their health financing systems and implement universal health coverage (UHC) so that all people can access quality health services without the risk of financial hardship. The 2005 World Health Assembly Resolution (WHA 2005) and the 2010 World Health Report (WHO 2010) provided momentum for this goal, with a focus on social health protection and equity in access to health care (WHO 2010). Momentum has increased with the release of the 2010 World Health Report on universal coverage and the approval of the United Nations General Assembly Resolution on UHC in December 2012. The movement toward UHC is becoming a key focus of the post-Millennium Development Goals (MDGs) development agenda (Latko, Temporao et al 2011; Vega 2013).

The government has committed to achieving universal coverage by 2019. Challenges to UHC in Indonesia include a fragmented health financing system, decentralisation, demographic transition, high out-of-pocket spending and low levels of government spending on health. Indonesia also fares relatively poorly on reaching the health MDG, with the least progress being made on MDG 5, to reduce maternal mortality by three-quarters (Rokx, Schieber et al 2009).

Despite these challenges, Indonesia has made substantial progress on UHC through the establishment of a clear policy framework. The government has passed two key laws: (1) Law on the National Social Security System No. 40/2004 in 2004; and, after considerable delays, (2) Law to establish the Social Security Agency (BPJS) in October 2011, Law 24/2011. Health insurance for the poor and for the near poor (Jamkesmas) has been expanded to reach 76.4 million people (32 per cent of the population). With the passing of the second law (Law 24/2011), the government has developed a guide to the implementation of UHC. This is known as the Road Map toward National Health Insurance—Universal Coverage 2012-2019 (Peta Jalan Jaminan Kesehatan Nasional 2012-2019, hereafter ‘Road Map’).

The Road Map was developed under the aegis of the National Social Security Council, and represents the agreed position of the various ministries involved, including Finance, Health, Labour, Social Welfare and Internal Affairs. The Road Map outlines the processes and activities needed to implement UHC. The two foundational steps in the Road Map are: (1) creation of the organising body responsible for the management and implementation of UHC-BPJS (Badan Penyelenggara Jaminan Sosial), which is to be operational by 1 January 2014; and (2) establishment of full population coverage with social health insurance by 2019, a system to be known as INA-Medicare (Jaminan Kesehatan Nasional).

There has been considerable discussion in the literature on the design and organisational arrangements for UHC (Mathauer and Carrin 2010; Kuztin 2012). The publication of the Road Map provides an opportunity for a review of the proposed design and implementation arrangements. Such a review may be useful for policy makers in Indonesia and provide lessons for regional policy makers grappling with the same challenges.

This study provides an assessment of the adequacy of Indonesia’s proposed design, institutional framework and mechanisms for UHC as set out in the Road Map and the laws and regulations already created. The analysis identifies the extent to which the design is clear, is consistent with recommendations in the literature and provides a feasible and effective mechanism for implementation.

METHOD

This study is a documentary analysis, drawing primarily on the Road Map. The analysis also draws on UHC literature and recommended approaches from sources such as the World Health Organization, World Bank and International Labour Organization, considering both global and Indonesia-specific data. Given the early and evolving nature of Indonesia’s implementation of UHC, news reports and other research reports were identified through internet research. The National Social Security Council (DJSN) website provided updates on the release of regulations identified in the Road Map.

The analysis was guided by the conceptual framework (OASIS) developed by Mathauer and Carrin (2011) on institutional design and organisational practice for UHC. Because the Road Map is a design document for a prospective system, and several aspects require further elaboration (for example, through regulations),
not all aspects of the Mathauer and Carrin framework could be applied.

According to Mathauer and Carrin, financing for UHC needs to address three key functions: resource collection, pooling of funds and purchasing/provision of services. These are regarded as integral to reaching the goal of ‘improved and more equitable health outcomes, including the achievement of the health-related Millennium Development Goals’ (Mathauer and Carrin 2011). The present analysis is confined to the institutional design of the proposed UHC system, since the organising agency for implementation of UHC (the BPJS) has not yet been established.

While this study uses the Mathauer and Carrin framework for analysis, for the purpose of this report, the analysis is organised under the headings: system design; translating the design into a functioning health financing system; and the impact of the health financing elements of the UHC strategy on the rest of the system.

FINDINGS

System Design

Indonesia’s low tax base, with a 12 per cent tax-to-gross domestic product ratio, affects the funds available for the expansion of health insurance coverage. The informal sector is large—accounting for around 60 per cent of all labourers or about 60 million people (Rokx, Schieber et al 2009)—and a large proportion of the population is considered poor or near poor.

Indonesia’s total health expenditure is estimated at 2.5 per cent of GDP. It has risen slowly, from 1.9 per cent of GDP in 1996 to 2.2 per cent by 2006. The government expects this proportion to increase to 4 per cent of GDP after the national social security system becomes operational in 2014, and it notes the experiences of other countries in funding UHC, where state expenditure for health is typically 6 to 11 per cent of GDP, with tax ratios of over 20 per cent.

The Road Map provides the framework for the implementation of UHC. It takes a broadly two-phased approach, with eight targets set for 2014 and 2019. Currently, around 151.5 million Indonesians are covered by some form of health insurance (Table 1). A key target for 2019 is that all of the population (an estimated 257.5 million) be covered under a single scheme managed by BPJS as a non-profit entity.

The intermediate target for 2014 is that at least 121.6 million people be insured by BPJS, through unifying the management of existing schemes for the formal workforce (civil servants, the military and police, labourers) and of government-funded health insurance for the poor (Jamkesmas), as well as some of the regional health insurance schemes (Jamkesda).

The other targets for 2014 are: preparation of necessary implementing regulations; the operation of BPJS by 1 January 2014; equal medical benefits for all, with some differences in non-medical benefits; preparation by the Ministry of Health (MoH) of an action plan for health facility development and its gradual implementation; at

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<th>TABLE 1. HEALTH INSURANCE COVERAGE IN INDONESIA, 2012</th>
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<td>TYPE OF HEALTH INSURANCE</td>
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<tr>
<td>Participants in Health Insurance for Civil Servants (Askes PNS)</td>
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<td>TNI/Polri (military and police)</td>
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<tr>
<td>Jamkesmas Participants* (Ministry of Health) (health insurance for the poor)</td>
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<tr>
<td>JPK Jamsostek Participants (workers’ social security)</td>
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<tr>
<td>Jamkesda/PJKMU Participants (regional governments’ health insurance)</td>
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<td>Corporate Insurance (self-insured)</td>
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<td>Commercial Health Insurance Participants</td>
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<td>Total</td>
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* These recipients are expected to increase from 76.4 million to 86.4 million in 2013 as part of the transition to universal coverage (Faizal 2013)

Source: Republic of Indonesia 2012, Road Map toward National Health Insurance, 2012-2019
least 75 per cent of participants and of health facilities are satisfied with the services of BPJS; and the financial management of BPJS is transparent, efficient and accountable.

By 2019, the targets are: BPJS is fully trusted by the public; the entire population is insured; equal medical and non-medical benefit packages for all participants; equal distribution of health facilities; laws and regulations adjusted as required; at least 85 per cent of participants and 80 per cent of health facilities are satisfied with the services from BPJS; and the financial management of BPJS has achieved the optimal level of transparency, efficiency and accountability.

The benefits package is to be comprehensive, covering promotional, preventive, curative and rehabilitative services. It will exclude specific conditions, such as those resulting from abuse of addictive substances, and cosmetic procedures. There is no expectation of co-payments unless participants choose to pay for an upgrade in services, and additional payments are required for workers who wish to cover more than five family members.

While government-owned health facilities will be included, BPJS will select the doctors and private health facilities to be contracted under the scheme, and it will pay health facilities prospectively through capitation and service output payments (diagnosis related groups [DRGs] using the Indonesian definitions (INA-CBG)). Public trust in the system will be facilitated through auditing, monitoring and supervision by the supervisory board and the National Social Security Council (DJSN) and the accommodation of complaints by participants, doctors and health facilities through various community channels. The key design elements of the UHC system described in the Road Map are summarised in Table 2.

Many of the commitments in the Road Map require elaboration through presidential and government regulations, with nine expected by June 2013. Several plans are to be developed and actions taken by individual ministries or through inter-agency cooperation. To date, two regulations have been released: the presidential regulation concerning the beneficiaries for health contributions (101/2012); and the presidential regulation concerning health insurance (12/2013).

Overall, this study identified a number of unresolved issues with the system design, namely: the lack of a costing analysis for UHC implementation; uncertain coverage of the informal sector; potential issues with targeting and determining satisfaction with services; ongoing supply-side funding for public facilities; and a design narrative that lacks an explicit focus on equity.

### Costing

The design was not fully costed prior to the public release of the Road Map, although a fiscal study is planned for the anticipated health expenditure.

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<th>TABLE 2. ELEMENTS OF INDONESIA’S NATIONAL HEALTH INSURANCE SYSTEM</th>
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<td><strong>Resource contributions</strong></td>
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<td><strong>Formal sector</strong></td>
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<td><strong>Informal sector</strong></td>
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The perationalisation of many Road Map commitments depends on affordability and it may be undermined if the fiscal analysis reveals problems with the cost of UHC. If the commitments made in the Road Map cannot be honoured (or honoured in the given time frames), trust in the system and government will diminish. For example, if the government intends to reduce benefits and/or increase contributions to address revenue shortfalls, this will reduce public trust in the system.

The provisions in the laws regarding contributions to BPJS specify that if there are sufficient funds to cover five years, contributions can be reduced. They further state that, should contributions be inadequate, participants and employers will need to increase their contributions. The laws do not provide a definition of ‘adequate’ funds nor offer guidance on how this should be determined, or the process for increasing funds, including communication with the public and stakeholders. These factors will be critical to maintaining the public trust needed for the success of the program. The BPJS law (24/2011) allows for adjusting benefits and contributions as a last resort in order to maintain operations (Article 56, Paragraph 3) (President of the Republic of Indonesia, 2011).

A partial analysis was undertaken specific to the calculation of the amount of government contributions to cover costs of the poor. Subsequently the government agreed in the Road Map that these contributions would range between Indonesian Rp22,000 and Rp27,000 (A$2.20-2.70) per person per month. This was based on a study of contribution adequacy undertaken by the National Social Security Council (DJSN), University of Indonesia, together with other universities, the World Bank, a team from PT Askes and JPK Jamsostek and the National Team for Poverty Reduction Acceleration. However, following the release of the Road Map, protracted inter-ministerial negotiations on the government contributions ensued, a revised contribution level of Rp15,500 per person per month being subsequently agreed upon (Sutriyanto 2013; Wicaksano 2013).

1 The Ministry of Finance and National Planning and Development Board (Bappenas) will address the fiscal impacts of the management of health insurance, while the Ministry of Social Affairs and Bappenas will analyse contribution assistance for the poor and underprivileged population, both in association with DJSN and designated for 2012.

Informal sector

The Road Map contains apparent contradictions regarding coverage of the informal sector, which makes up 62 per cent of all workers. While it appears to endorse government payment of contributions for this sector, it also provides a calculation of their expected contributions (5-6 per cent of monthly wages). In addition, the Road Map refers to government plans to undertake an assessment of the expansion of health insurance participation for informal labourers, earmarked for 2015, and anticipates that regions with high fiscal capacity may be able to cover non-wage labourers.

The regulation to formalise the Law for the Recipients of Government Contributions (101/2012) (President of the Republic of Indonesia, 2012) was expected to include the informal sector, given the stated complexities of revenue collection from this sector. This follows the example set by other countries, and was intended as an interim measure until the tax and administration system improves.

However, the Presidential Regulation on Health Insurance (No. 12/2013), issued subsequent to the Road Map, states that the contribution from the informal workforce will not be covered by the government, but individuals will need to pay their own contributions (President of the Republic of Indonesia, 2013).

In the Road Map, the government notes the complexities involved in including the informal sector in a contributions scheme. These include unstable incomes of non-wage labourers, which undermine their ability to make regular contributions, and the financial vulnerability of these labourers if exposed to high health care costs. While a decision to exclude this sector from government assistance takes pressure off the government’s revenue demands, it leaves unresolved the complexities involved in attempting to collect contributions from this sector, such as the likely inefficiencies and administrative costs.

Several questions arise from this decision. If informal workers are unable to pay regular contributions, will they be subject to user fees to access services? Will there be penalties for those who do not contribute? Some workers may currently be covered by Jamkesda schemes, but the government plans to dismantle these schemes for integration into the BPJS. What are the implications for social health protection across this
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sector? Is the decision not to insure the informal sector likely to increase the number of poor? Should informal sector labourers be exposed to high health costs?

**Targeting the poor**

One of the key barriers to accessing health insurance by the poor has been the lack of understanding of the schemes and their entitlements. This has been particularly so for the poor and those living in remote areas, as evidenced by the under-utilisation of Jamkesmas benefits by the poor (Harimurti, Pambudi et al 2013). Approaches for reaching the poor, particularly efforts that address issues through access to Jamkesmas, are not specifically acknowledged in the design. One of the activities planned in the Road Map is a mapping of groups and subgroups within the community, which may include the differential issues faced in accessing existing schemes. As with many of the activities listed in the Road Map, it is not yet clear how this will be undertaken. The DJSN will be the lead agency, in coordination with the Ministry of Communication, Ministry of Health and PT Askes.

Satisfaction with services is a key target in the Road Map. If the measurement of satisfaction is primarily derived from the complaints mechanism (itself poorly developed), then it is not likely to be representative, especially of the poorer populations. Thus feedback may not improve access for the poor or address equity within the new system.

**Ongoing supply-side funding of public facilities**

Supply-side funding is currently an issue with the implementation of Jamkesmas. Along with supply-side constraints, this distorts the actual cost of the scheme and limits incentives for providers to improve services (Harimurti, Pambudi et al 2013). This may also provide a perverse incentive for local government to reduce its budget allocation to health on the basis that its health facilities will receive insurance funds.

Under UHC, public hospitals will continue to receive budget allocations from the government, in effect receiving supply-side funding as well as insurance funds. However, the private sector will receive only insurance funds, which may not cover full costs, unless the government renegotiates a cost structure with private hospitals that takes the additional supply costs into account.

**Equity in design**

Overall, the design lacks an explicit statement of the intended outcomes of UHC or a particular focus on achieving equity of access to health care and social health protection (although these are noted in the program principles and the laws). The stated targets focus on numbers covered and the achievement of equal benefits and satisfaction with services. The limited reference to equity throughout the design, a principle that should underpin approaches to UHC, may well impact on how implementation is approached.

**Translating the Design into a Functioning Health Financing System**

Overall, the key challenges identified in the translation of the design into a functioning system relate to: proposed changes to existing contributions; lack of inter-institutional arrangements; integration of regional schemes into BPJS; and PT Askes’ role in the overall integration of the existing health insurance schemes.

**Changes to contributions**

While there is detailed guidance on the unification of systems and databases for establishing BPJS, less consideration is given to potential issues with the different contribution and benefit packages of the different systems.

Currently, the JPK Jamsostek contribution for formal sector workers is paid only by the employer. Law 40/2004, however, stipulates that contributions are to be ‘jointly borne’ by employers and workers (President of the Republic of Indonesia, 2004). The proposed changes to standardise the schemes imply that employees under JPK Jamsostek will also need to start making payments. There are also potential increases for employer contributions. The Road Map has set the expected contributions from employers and employees at 5-6 per cent of monthly salaries (2-3 per cent for labourers and 3-4 per cent for employers), which is an increase on current contributions.

There may be a strategy to manage this issue under the forthcoming ‘socialisation’ and education plans, but this is not clear. For JPK Jamsostek, this could mean promoting the increased benefits provided under the unified scheme, as JPK Jamsostek is currently the only insurer not to cover ‘catastrophic benefit’ (for example,
Because many local governments already contract PT Askes to manage their health insurance schemes, there is an assumption in the Road Map that many regions are already prepared for integration into BPJS. However, considerable efforts will be needed for BPJS to negotiate with the local governments. Many will be reluctant to relinquish their current schemes, which afford governments the opportunity to campaign on delivering free health care (Aspinall and Warburton 2013). One potential incentive for local governments is the recommendation for them to reallocate the funds previously allocated to local insurance to investments in their health facilities and personnel to improve quality. The other incentive is that the national insurance scheme should bring better coverage than the Jamkesda. However, trust as to when this materialises, particularly for regions where local schemes now provide universal coverage, will remain an issue.

The extent to which regional governments have been consulted during its development is unclear from the Road Map itself. However, newspapers have reported concerns among stakeholders such as the Regional Health Insurance Association over the centralised management of the Road Map. The association has committed to continue providing insurance, although the government has guaranteed coverage for the poor from 2014. It argues that the BPJS law does not ban regions from also guaranteeing health insurance (University of Gadjah Mada 2012).

The MoH intends to pilot UHC in three provinces from July 2013: Aceh, Gorontalo and West Java (Faizal 2013).

**PT Askes integration of health insurance schemes**

PT Askes currently manages contributions from around 17 million civil servants and for some of the regional insurance schemes. By January 2014, PT Askes will transform into BPJS and manage more than 120 million participants from existing schemes. One of the challenges for BPJS is unifying the current schemes, standardising the contribution values and ensuring a large single pool of funds for *kegotong-royongan* (mutual assistance). Current contribution values are: Jamkesmas Rp6500, JPK Jamsostek Rp19,000 and PT Askes Rp36,000 per person per month. PT Askes will need to manage the pooling of these funds for 2014 and in doing so work closely...
with the other fund managers, MoH, JPK Jamsostek and local governments. The largest of the programs, Jamkesmas, is non-contributory and will require negotiations on the size of government contributions in the annual budget, which substantially broadens the scope of PT Askes.

The current health insurance programs also vary in their purchasing or provision functions. For payment to facilities, some use a contract mechanism. PT Askes and JPK Jamsostek do this; regional health insurance funds do not. There are variations in capitation, such that Jamkesmas uses INA-CBG for second level facilities, while civil servants’ health insurance uses a service package. Some but not all include private facilities. The alignment of data systems and agreement on participants will need to be negotiated, and the role of PT Askes moving from a for-profit to not-for-profit agency will require a substantial expansion of the organisation’s capacity.

**Potential Impacts on the Rest of the System**

The study identified several issues relating to the potential impact of UHC on other aspects of health system performance. Chief among these are the potential for inequities, the participation of the private sector and addressing inefficiencies.

**Potential for inequities**

Experience with the Jamkesmas scheme has demonstrated that, despite nominal comprehensive coverage for the poor, the poor have faced barriers in accessing certain services (such as out-of-pocket payments for medicines not available at the facility) and in experiencing stigma in self-identifying as poor (Rokx, Scheiber et al 2009).

The Road Map proposes that health service access and quality be dealt with through the MoH’s Action Plan. The MoH also has the responsibility to deliver on the expected increase in demand for services following introduction of national health insurance. However, the process for improving service quality and access through the Action Plan and the monitoring and evaluation of its progress is unclear. Poor quality and unequal distribution of government health facilities have been issues with which the MoH has been struggling for some decades, without much progress. Significant further government investment in health infrastructure and workforce will be needed.

**Private sector participation**

Although the private sector is to be included in UHC, the Road Map is unclear on the level of discussions undertaken with the private sector and the degree to which the sector is willing to participate, particularly private hospitals.

It is not clear if reimbursements to the public and private sectors will be the same or whether these will take into account the different costs incurred. As discussed earlier, the intention of the government to continue supply-side funding to public hospitals means that unless the private hospitals are compensated for this discrepancy (public hospitals receiving both supply-side funding and insurance payments), the incentive for private sector participation is weakened.

The government is planning to negotiate the payments with the Health Facilities Association, and payments are expected to differ according to geographic region (given regional variations in expenses) for both public and private facilities.

**Addressing inefficiencies**

The Road Map provides some incentives for improving efficiencies. For example, it introduces prospective payment methods using DRGs (or INA-CBG) for hospitals, and capitation payments for primary health care facilities. However, depending on how capitation payments are calculated, they may not be adequate to cover full costs at primary facilities. As there is no regulation prohibiting co-payments, there is a potential for such facilities informally to adopt such payments (although implicitly the national health insurance scheme does not anticipate this). There is a specific prohibition in the Presidential Regulation on Health Insurance on non-BPJS health facilities charging a service fee in the event they provide emergency care, but there is no specific mention of the service fees rules for routine care.

One area that could be addressed to gain efficiencies is pharmaceuticals. There is a tendency for spending on medicines to rise with the introduction of universal schemes, and spending on medicines accounts for a large part of the inefficiencies in health financing (Rokx,
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Schieber et al 2009; WHO 2010). There are differences in the standard of drugs used for each health insurance program; regional health insurance programs use only generic drugs, for example, and they use different drug lists. How these will be aligned under the new system is unclear. The Health Insurance Regulation (12/2013) does not provide detail on use of drugs, only that the list will be revised in two years. The Road Map refers to drug manufacturers in Indonesia producing excess to need, and the need to pay a fair economic price for drugs and consumable medical materials. It is not clear whether or how this issue will be addressed, although there is an expectation that the MoH will be regulating this area further. The MoH Strategic Plan 2010-14 refers to the need to improve the rational use of medicine, but the approach is not clearly defined (Ministry of Health, Republic of Indonesia, 2010).

DISCUSSION

This study was limited to analysis of existing documents, principally the Road Map, relevant laws and regulations, and reports in the literature and newspapers. Several areas that lacked clarity in the publicly available documents may be addressed in internal documents. Nevertheless, the considerable uncertainty generated by the publicly available documents reflects poorly on the transparency of the process to achieve UHC and the engagement of the public.

The Road Map proposes that a system of universal health coverage will be in place by 2019. With several regulations and actions still to be taken, the design can be expected to evolve. As this study has identified, some aspects of the design have already been modified following the release of Presidential Regulation on Health Insurance (12/2013). While Indonesia has a commitment to, and a framework for, UHC, adjustments will necessarily be made as negotiations and fiscal analyses progress.

Issues identified in this study can be compared with those identified in the literature on the design and process for introduction of UHC.

Design Issues

Literature on the design of UHC focuses not only on health financing (Kutzin 2012) but also on the other aspects of UHC that need to be addressed, such as quality, access to services and institutional arrangements (WHO 2010; Harimurti, Pambudi et al 2013).

Analysis of the proposed UHC design using the Mathauer and Carrin (2011) framework indicates that Indonesia has identified and followed several key recommendations for instituting UHC, including mandating a compulsory scheme with prospective payments, expanding coverage of the poor (starting under Jamkesmas), instituting capitation and DRG payments and the intention to limit direct payments. It has also addressed the three elements of health financing, by defining collection, pooling and payment mechanisms. The establishment of a single pooled fund with its own managing institution is a bold and potentially effective approach to addressing fragmentation.

Several aspects of the design need closer attention for the sustainability of the system and for equity principles to be realised. The government will need to examine critically the coverage of, and collection of contributions from, the informal sector, and decide on how this will be negotiated. This may be a staged approach, with the ultimate aim of ensuring that this sector has adequate social health protection.

While the government’s ability to raise revenue will impact on UHC-related decisions, the affordability and the sustainability of the system is also dependent on efficiency. Kutzin (2012), for example, raises the importance of efficiency and accountability to the sustainability of progress in UHC. Efficiency measures are not a strong focus of the Road Map, which suggests the government may be more focused on raising revenues for health than improving the use of existing resources.

As health insurance extends to cover more of the poor and potentially new contributors, demand for services can be expected to rise. The capacity of the MoH to accommodate increases in demand for services is not certain given the complexities of strengthening the health system and in the absence of the MoH Action Plan. Existing weaknesses in the health system mean there is a risk that increased demand for health services will lead to increased out-of-pocket expenditure and to poor quality care (Lagomarsino, Garabrant et al 2012).
Implementation

The UHC literature emphasises the need for flexibility, the lack of a single pathway to UHC and the avoidance of prescription and the careful sequencing of policy implementation (Rokx, Schieber et al 2009; Kutzin 2012). However, there tends to be a focus on health financing technical and institutional aspects rather than broader social and political aspects.

Savedoff, de Ferranti et al (2012) provide a framework that specifically includes the broader political and economic aspects. They identify four common patterns in the process of achievement of UHC: (1) UHC emerges from negotiations rather than design; (2) domestic pressures for the provision of UHC are widespread, varied and persistent; (3) there is a large role for government; and (4) the UHC process is incremental and takes time. This study has identified several aspects of these patterns in the introduction of UHC in Indonesia.

Evolving design

One issue that has been the subject of protracted negotiations is the amount the government will contribute for the poor, which departs from the design recommendation. Another example is the original intention to cover the informal workforce, which was subsequently revised. In both cases, it is unclear how decisions were reached, but they are possibly trade-offs related to affordability, and thus ‘pragmatic compromises’ (Savedoff, de Ferranti et al 2012). For both issues, the negotiations and resulting decisions have taken place in the absence of key information, such as an analysis of the affordability of UHC. This suggests that decisions may be taken for political reasons rather than being underpinned by sound technical evidence, and this has implications for the sustainability of the system and the type of system that materialises.

Role of domestic pressures

The evolution of UHC in Indonesia has been influenced by domestic pressures. Local governments have developed their own schemes, which have sought to fill gaps in Jamkesmas coverage. Civil society groups have been closely engaged in advocacy to progress to UHC following the SSJN law (40/2004) and throughout the seven-year delay between this law and the BPJS law (24/2011). Civil society has pressured the government to finalise the BPJS law, and there have been ongoing pressures for the government to release the regulations from the Road Map.

However, the engagement of civil society in the development of the UHC system has been limited overall, with the approach largely driven by the central government. This study found that the paramount role of the central government has translated into a top-down approach to decision making and implementation. This has resulted in a focus on ‘socialisation’ (or informing) rather than consulting to raise awareness of UHC and of participants’ rights and responsibilities.

Local governments have reacted against this centralised decision making. This is not surprising given the precedent of a local government constitutional court challenge to the SSJN Law (40/2011) in 2005. The challenge questioned the implication that UHC would be centrally administered and so preclude local government schemes (Coordinating Ministry for People’s Welfare 2006). The need for a large government role in achieving UHC does not imply the lack of a need for engagement with stakeholders outside central government. Engagement with local government is crucial, particularly given Indonesia’s decentralisation. Also important is participative engagement with civil society, representatives from the informal sector and workers affected by increased or new contributions.

Expanding the role of government

Savedoff, de Ferranti et al (2012) also refer to UHC being accompanied by a large role for government, ‘with extensive involvement in the financing, regulation, and sometimes direct provision of health-care services’. The Road Map identifies a large and ongoing role for the government across all aspects of the health system. While the government will provide payments to both public and private facilities to deliver health care, it is committed to financing insurance for the poor and increasing its health expenditure, to reforming many aspects of the health system, including those of the health workforce, such as through improving distribution of health workers, and to better regulation of the quality of care.

The willingness and capacity of the government to fund, manage and provide services is considered an essential
condition for UHC, notwithstanding the problems encountered by governments in undertaking this role. This does not preclude private sector involvement, and the government has recognised, to an extent, the need for engagement with this sector. However, in implementing UHC the expression of kegotong-royongan needs to be consistent with achieving equity and protecting the poor.

**Time needed**

The final pattern identified by Savedoff, de Ferranti et al (2012) is that achieving UHC is incremental and takes time; examples given range from 26 years for South Korea to 118 years for Belgium, although the pace of implementation has advanced in recent times. It is yet to be seen whether the time frame for full population coverage in Indonesia is realistic. In the absence of strong inter-agency relations or a framework to guide negotiations, such as the legitimacy and stewardship of the National Social Security Council, delays in reaching consensus across agencies are likely to continue.

A key aspect identified in this study and not commented on by Savedoff, de Ferranti et al (2012) is building trust between government, providers and the public. The government needs to gain the trust and confidence of the population through timely release of regulations and follow-through on actions described in the Road Map, although this needs to be balanced against the competing need for considered decision making. Demonstrating that resources are being used more efficiently and that corruption is being actively addressed (a long-term process) is also crucial to improving participants’ confidence in the use of their contributions. Improved participatory engagement with local government and non-state actors, including the private sector, and strengthening inter-ministerial cooperation and negotiations are necessary to build and maintain that trust.

**Impact on the Health System and Achievement of Health Goals**

The question remains whether Indonesia’s health insurance coverage can reach its entire population by 2019, and if so, whether the type of coverage achieved will fulfil the principles of UHC.

Despite the strong institutional framework and clear direction for health financing arrangements, the Road Map’s lack of a clear statement of expected outcomes raises potential risks, particularly for equity. As Kutzin (2012) notes, there is no one approach suitable for attaining UHC, which for some countries may lead to a focus on expanding coverage while undermining equity. Equity for UHC in Indonesia is potentially threatened by: the decision to exclude the informal sector; a lack of attention to the lessons of Jamkesmas and in general to the weaknesses in health service delivery; the calculation of payments to health facilities; and approaches to socialisation and the complaints’ mechanism.

Although proposed coverage extending to the private sector is welcome, a lack of clarity on the funding of public and private hospitals and primary health care facilities could permit inequities. It may provide a perverse discouragement of local government investment in health if insurance payments are based on a government’s budget allocations for its health facilities. There is also the potential for health facilities to raise funds through user fees, especially if the population can afford to pay in the wealthier areas, leading to issues of regional equity. If private hospitals are not adequately remunerated, they may opt out of the system, refuse care or demand user payments.

Broader economic factors such as Indonesia’s growth rate will impact on the government’s capacity to increase health expenditure and to meet the anticipated rise in total health expenditure relative to GDP. This has implications for equity. While the government reallocated funds from its fuel subsidy to resource the expansion of Jamkesmas, attempts to reduce this subsidy are electorally unpopular despite its benefits favouring the wealthier and, as noted in the Road Map, its burden being far greater than the proposed government insurance contributions for the poor.

**CONCLUSION**

This study demonstrates that the design and institutional arrangements for health financing aspects of Indonesia’s UHC program are largely consistent with UHC recommendations. The potential that the Road Map offers to provide protection for the poor and combine government and public contributions is in line with the principle of kegotong-royongan.
Key issues identified with the design of health financing are: the absence of a calculation of fiscal capacity and the potential shortfall in government contributions; the lack of planning to address expansion of the contributor base to include the informal sector; and the lack of focus on addressing inefficiencies.

The design is also less complete and clear on the impacts of UHC on other aspects of the health system, particularly equity of service delivery (the availability and capacity of facilities) and ensuring access for the poor. While Indonesia’s UHC can be considered a work in progress, in the absence of a clear commitment to equity, there is a risk of reductions in service (coverage or benefit package) to match fiscal capacity. The government needs to focus greater attention on these issues before the design evolves much further.

The development of the Road Map and the direction provided by the DJSN provide the basis for operationalisation. How this proceeds is contingent on factors identified in this study, including the ambitious timelines that could compromise implementation; the impression that the process is largely central government driven (with its own internal coordination issues); and the limited consultation with other levels of government, key stakeholders and the public. While trust and credibility are identified as key requirements to ensure the sustainability of UHC, these could be put at risk through the current approach.
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