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EVALUATION OF UNIVERSAL HEALTH COVERAGE POLICY : A COMPARISON STUDY BETWEEN INDONESIA AND THAILAND

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yang diusulkan dalam skema PENELITIAN KERJASAMA LUAR NEGERI untuk tahun anggaran 2015/2016 **bersifat original dan belum pernah dibiayai oleh lembaga / sumber dana lain**.

Bilamana di kemudian hari ditemukan ketidaksesuaian dengan pernyataan ini, maka saya bersedia dituntut dan diproses sesuai dengan ketentuan yang berlaku dan mengembalikan seluruh biaya penelitian yang sudah diterima ke kas negara.

Demikian pernyataan ini dibuat dengan sesungguhnya dan dengan sebenar-benarnya.

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SUMMARY

This research basically is the second year stage of evaluation study on UHC both Indonesia and Thailand. The results for the first year shows that there is tendency of overburden of public finance for both Indonesia and Thailand. Both of Thailand and Indonesia experienced the financial burden in implementing UHC Policy. The problem is more on the bulk amount of fund to cover the UHC from the annual budget which is accounted of the Annual National Gross Domestic Products (DGP), and become the burden for the National Budget allocated each year. Second, the quality of service is still in poor quality for Indonesian case and there is unequal distribution of government health facilities particularly in primary health care in Thailand. Third, the procedures of UHC for referral services is still complicated for the patients to get advance health care.

Thus, by considering the Universal Health Coverage (UHC) Policy is an important health policy issue among ASEAN Countries, including Indonesia and Thailand, this second year proposal seeks to provide policy model of UHC in these 3 important aspects particulary financial model, improvement quality service and simplify referral service of current situation. Thailand has been implemented UHC for almost fourteen years, and on the other hand, Indonesia is entering the third year implementation of UHC. Even though both of them started UHC at the different year, but both of countries can have lesson learn by evaluating their implementation either their preparation for UHC. The facts shown, UHC brings benefit for the people, but still there are UHC off-track in both countries, despite nominal comprehensive coverage for the poor, patients had difficulty accessing certain services, poor quality and unequal distribution of government health facilities.

The long term goal of this research is to have a sustainable research collaboration with Thammasat University to produce international publication base on research, reference book and to fill the MoU between Universitas Muhammadiyah Yogyakarta and Thammasat University Thailand. The short term goal of this research is to response to the problems related to UHC both in Indonesia and Thailand. This research in particular will try to address the evaluation of two things, first, how do the distinctive model of UHC implementation both in Indonesia and Thailand. Second is how do the distinctive results of UHC impact both in Indonesia and Thailand.

The analytical approach of this study is derived from a qualitative research methods. In this research, the qualitative model will use the interview guide and focus discussion group to explore the information. FGD will be conducted both in Indonesia and Thailand with the certain respondents and and key informen. Finally, this research will also performing the procedures of triangulation to mean convergence among researchers (agreement between field notes of one investigator and observations of another) and convergence among theories.

In order to achieve through the goal of this study, the policy model is utilized. It is considered the most effective way to help analyze, reformulate, implement, control, and provide feedback on the UHC in Indonesia and Thailand. To serve this goal, the scope of this research project for two years has 5 phases of study: The first year has been utilized the 1st phase of the study that provided a comparative analysis of the similarities and differences in the UHC of Indonesia and Thailand. The second phase explore the extent and policy related regarding gaps and problems of UHC by utilizing the result of first phase. The third phase evaluated policy in order to fill these gaps by

decreasing or eliminating obstacles to the UHC system of Indonesia and Thailand. For the second year, the reseach will explore the fourth phase that will design draft of policies and strategy for improvement of UHC implementation regarding each urgent issue and over all in Indonesia and Thailand, and the fifth phase will result improving of implementation model of UHC policy regarding as comparative analysis of policy in Indonesia and Thailand.

Keywords: Policy Evaluation- Policy Model – Universal Health Coverage

FOREWORD

Assalamu'alaikum wr.wb.

Gratitude to Allah s.w.t. for His invaluable blessing for us so the final report of the research entitled Evaluation Of Universal Health Coverage Policy :A Comparison Study Between Indonesia And Thailand has been finished.

The objectives of the research is to evaluate the UHC policy in Indonesia and the comparsion to Thailand. The result for the first year reearch shows that the evaluation of UHC in the two countries results in varies remarks, but most of the results have higher remarks in Thailand. The second year research focus on the identifying the factors which affect the implementation of UHC in the two countries.

We would like to thank for Higher Education Ministry of Indonesia who fully support the research. In addition, We also appreciate and thank to the Dean as well as staffs of Political Science at Thammasat University Thailand, as a research partner, for his kindness to support the international collaborative research.

Finally, we wish that the research will give both academic and practical contribution in the future.

Wasalamu'alaikumwr.wb.

Yogyakarta, November 1st , 2016

Principal Researcher,

Dr. Dyah Mutiarin

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1

A. BACKGROUND AND SIGNIFICANCE

The implementation of Universal Health Coverage (UHC) both in Indonesia and Thailand began to take on a more definite shape for health service provision at large. 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[1]. Indonesia in 2014 marked a consecutive National Health Insurance as part of Universal Health Coverage (UHC) until now as its second year implementation. Even though the progress the Indonesian government has made since the rollout of the National Health Insurance Program (JKN) at the beginning of 2014, yet various issues remain such as health care infrastructure, health chain supply, drugs supply, sufficient and proper funding of the program[2].

A research conducted by National Team for the Acceleration of Poverty Reduction[3], found that the implementation of JKN needs to be accompanied by major reform in the health- care system, those are : health-care service facilities, human resources in health, cost of health care rates, drugs supply, and strengthening the referral system. Base on data of Indonesian Ministry of Health, strengthening primary health-care service facilities is also essential for effective health services delivery. The number of primary health-care service facilities working with BPJS Kesehatan as of January 2014 was 15,861, including 9,598 public health centres and 6,263 clinics, doctors or dentists. This could potentially increase to 23,768 between 2014 and 2019. However, both the quantity and the quality of primary health-care facilities need attention. The number of health-care facilities with referral services is adequate at the moment but these services will need to expand by 2019. As of 1 January 2014, 1,701 health-care service facilities were working in cooperation with BPJS Kesehatan. These included 533 government hospitals, 109 specialist and mental health-care hospitals, 104 national

[1] Institutional analysis of Indonesia's proposed road map to universal health coverage, Amanda Simmonds and Krishna Hort, 2013.
[2] Universal healthcare coverage in Indonesia One year on, The Economist Intelligence Unit Limited 2015.
[3] The Road To National Health Insurance (JKN), 2015, National Team for the Acceleration of Poverty Reduction/TNP2K.

armed forces hospitals and 45 national police force hospitals. A further 504 facilities could potentially be added to this list, including 56 government hospitals, 42 private hospitals, 396 specialist and mental health-care hospitals and 10 national armed forces hospitals. The referral system also needs to become more efficient and effective in delivering health services (MoH 2012)[4].

Study that had done by World Bank [5] shown that Indonesia's system is characterized by a mix of public–private provision of services, with the public sector taking the dominant role, especially in rural areas and for secondary levels of care. However, private provision is increasing. Health service utilization rates are generally low nationally. About 14 percent of the population used outpatient care in the month before the 2010 Susenas survey. Around 60 percent of outpatient visits occurred at private facilities (typically clinics/midwives and nurses) and the rest at public facilities, mostly at primary care level. Susenas data also show that the better-off used private facilities for ambulatory services: 69.5 percent compared to 51.6 percent among the bottom three deciles. Public facilities continue to dominate inpatient care, except for the top three deciles, a larger proportion of which use private facilities for inpatient care.

Meanwhile Thailand, which has been implemented the Universal Coverage (UC) as part of Universal Health Coverage since 2002, has marked development of the health insurance system that can provide useful lessons for other lower- and middle-income countries. Universal coverage was achieved in Thailand in 2002, after the newly elected government introduced the "30-Baht for All Diseases Policy" in 2001. This 30-Baht policy extended health insurance coverage by establishing a Universal Coverage Scheme (UCS) to cover about 45 million Thais who were not already covered by the Civil Servant Medical Benefit Scheme (CSMBS) and the Social Security Scheme (SSS), by requiring only a 30-baht (about US$1) copayment per visit. The policy also implemented major reform toward demand-side health care financing and strategic purchasing of health services, with closed-end payment mechanisms. Instead of providing budgetary funding to public sector health care providers based on its size, staff number, and historical performance, the 30- Baht Policy introduced a capitation

[4] ibid, page 14.

[5] Universal Health Coverage for Inclusive and Sustainable Development, Country Summary Report for Indonesia, Puti Marzoeki, Ajay Tandon, Xiaolu Bi, and Eko Setyo Pambudi, Health, Nutrition and Population Global Practice World Bank Group, August 2014.

payment that pays providers based on the number of people under their responsibility (contracting unit)[6]. Thailand's experience reforming its health care financing and coverage expansion can provide valuable lessons for many other low- and middle-income countries that are exploring options to improve the health coverage of their population.

However there are also some challenges of UHC implementation in Thailand. The UCS covers 75% of the Thai population, provides a comprehensive (and growing) package of services and deepening financial risk protection, and relies on general tax as its source of funding. In its first 10 years the scheme was adequately funded, aided greatly by GDP growth and strong political commitment.

In other hand, the path ahead for universal health coverage in Thailand should remain focused on equity, evidence, efficiency and good governance (Health Insurance System Research Office/HISRO, 2012). The study by HISRO (2012) stated that for ambulatory care in health centres, district hospitals, and provincial hospitals were pro poor while university hospitals seem to pro rich. This result can be implied that district health centres, district hospitals, and provincial hospitals performed well in terms of pro poor utilization. This might be due to the geographical proximity to rural population who are vastly poor. This pattern was consistent before and after UHC implementation meant that pro poor utilization was maintained. However, the pro rich pattern of university and private hospital might be explained that main customers of these hospitals are CSMBS and SSS patients who are better off than UC scheme patients. This pattern was similar in hospitalization of inpatients (Thammatach - aree, 2011).

From the previous research during the first year of comparation evaluation on UHC implementation between Indonesia and Thailand in 2015, it is found that with the official estimates indicate that there are 76.4 million poor and near-poor beneficiaries of the 252.8 million total population in 2014, the National Health Agency/BPJS in Indonesia is managing formerly Jamkesmas to cover almost one third of the population. Based on the estimate that the government finance is targeted to cover 86.4 million with the PBI premium of Rp 19,225 per person per month, the central government's contribution to BPJS would equal to Rp 19.9 trillion. Since the government budget in 2014 was only Rp 44.9 trillion, it implies that almost half of the overall government

[6] Health Financing Reform in Thailand: Toward Universal Coverage under Fiscal Constraints, Piya Hanvoravongchai, The World Bank, Washington DC, January 2013.

health budget would be used to finance the BPJS. Then, the consequence is straightforward: the share for financing other areas of spending such as salaries and operating costs for centrally-financed hospitals, investments in improving supply and much-needed preventive and promotive interventions would have to be shrunk. The 2015 budget is allocating Rp 47.8 trillion.

While in Thailand, with the government's attempt to help all Thai citizens to have health security coverage, the number of registered population for UC scheme will be increased every year and as a consequence the cost of health care using tax-based compulsory finance will rise respectively. The money allocated for UC scheme has increased from 56,091 million baht in 2003 to 154,258 million baht, about three times when it was first started. As previously elaborated, as more people (about 73 percent of population) joined the UC scheme, it is the government's obligation to provide health care benefits as it promised during the election campaign in 2002. Though, looking at financial of UC Scheme, it seems to be alarming, but this money is only accounted for 1.1percent or 1.2 percent of the Annual National Gross Domestic Products (DGP), and only about 6percent of the National Budget allocated each year.

However, a closer look at the UC coverage from the data provided by NHSO, the amount of health coverage per person per year has increased more than 100percent from year 2002 to 2014, from 1202.40 Baht to 2895.09 Baht, due to the expansion of the coverage and the benefits package to include minor care to chronic diseases. The success story of Thailand should be given credits to all those behind the reform and a continuous developments of new ideas and the efficiency of funds management.

Over all, Universal Health Coverage (UHC) in ASEAN countries has been a crucial issue of how a country provides health care policy for their citizens at large. The access to quality health service, provision of heath services, benefit to health scheme, and institutional design are amongst the features of UHC in its implementation (Lagomarsino, 2012; Simmonds and Hort, 2013). Indonesia and Thailand as developing countries in ASEAN experience UHC with the same rationality face the same problems in healthcare. The problem of inequality and poor quality still remains as the basic problem for both UHC in Indonesia and Thailand (Prakongsai et al. 2009; Limwatananon et al. 2009; Pitayarangsarit, 2012; Harimurti et al.2013; Road Map toward National Health Insurance, UC 2012-2019; Simmonds and Hort, 2013).

This research as per the first year found some important findings that Thailand has one of the most complex health care systems in Asia, prior to reform, there were about

six different health benefits schemes, targeting different groups of people with different benefit packages, compare to Indonesia which has started UHC Policy in 2014, and it only has one scheme of UHC Policy with two different category of participants. The Evaluation of UHC in Indonesia and Thailand results in varies remarks, but most of the results have higher remarks in Thailand. The perception of respondents on implementation both UC and JKN are varies. It has 5 parameters in the measurement such as: 1.Standart of Procedures of public hospital, 2. Communication between agencies of UHC Healthcare, 3. Medical human resources readiness, 4. Convenient Facilities and infrastructure, and 5. Medicine sufficiency. In Thailand, the result shown that the most higher remark is in parameter Standard of Procedures of public hospital 4.68, while the lowest remark is in parameter Convenient Facilities and infrastructure is 4.35. In Indonesia the highest remark is in parameter Convenient Facilities and infrastructure 4.20, while the lowest is parameter Communication between agencies of UHC Healthcare 3.77 only. The quality of service in Thailand shows the better result compare to Indonesia. Continuous care services in Thailand has the highest result of 4.67, while the highest result of Indonesia in the same parameter has the result for 4.17. Both of Thailand and Indonesia experienced the financial burden in implementing UHC Policy. The problem is more on the bulk amount of fund to cover the UHC from the annual budget which is accounted of the Annual National Gross Domestic Products (DGP), and become the burden for the National Budget allocated each year.

This research basically is the second year stage of evaluation study on UHC both Indonesia and Thailand. The results for the first year shows that there is tendency of overburden of public finance for both Indonesia and Thailand. Both of Thailand and Indonesia experienced the financial burden in implementing UHC Policy. The problem is more on the bulk amount of fund to cover the UHC from the annual budget which is accounted of the Annual National Gross Domestic Products (DGP), and become the burden for the National Budget allocated each year. Second, the quality of service is still in poor quality for Indonesian case and there is unequal distribution of government health facilities particularly in primary health care in Thailand. Third, the procedures of UHC for referral services is still complicated for the patients to get advance health care.

Thus, by considering the Universal Health Coverage (UHC) Policy is an important health policy issue among ASEAN Countries, including Indonesia and Thailand, this second year proposal seeks to provide policy model of UHC in these 3 important aspects particulary financial model, improvement quality service and simplify referral service of current situation. This research generally is an evaluation study on UHC both Indonesia and Thailand. Under the MoU between Universitas Muhammadiyah Yogyakarta and Thammasat University since 2012, this research, beside a form of networking with foreign partner university, is also a milestone for 2014 and 2015. The milestone follow the activities stated in the MoU such as collaboration post graduate studies, collaboration in exchange of student, conducting joint research, exchange of staff member, joint scientific meeting, and exchange of academic information. This research has been started with a background study by the students of both from Universitas Muhammadiyah Yogyakarta and also from Thammasat University on the Back Ground Study on Public Health Services in 2013. Below is the research roadmap on Public Health Policy of the two parties.

Table 1.1 Collaboration Research Project of Universitas Muhammadiyah Yogyakarta and also from Thammasat University.

Year	Milestone	Output
2012	Preliminary Research Meeting on Public Health Policy at Thammasat University	Baseline data of Public Health Policy in Indonesia and Thailand
2013	Back Ground Study on Public Health Services in Indonesia and Thailand	Draft Paper on Public Health Services in Indonesia and Thailand
2014	Evaluation of Universal Health Coverage Policy : A Comparison Study Between Indonesia And Thailand	Article for International Publication. Article for International Seminar.
2015	Evaluation of Universal Health Coverage Policy : A Comparison Study Between Indonesia And Thailand	Article for International Publication. Article for International Seminar.
2016	Enhancing Health Coverage Policy for Modeling Advance Health Services : A Comparison Study Between Indonesia And Thailand	Article for International Publication. Article for International Seminar. Reference Book.

In relation with the research roadmap of Universitas Muhammadiyah Yogyakarta and also from Thammasat University, and to response the implementation of both UHC schemes in Indonesia and Thailand, this research is an important contribution for the issues related of UHC in Indonesia as well as in Thailand.

With this background, in order to achieve the goal of this study, the policy model is utilized. Thus, by considering the Universal Health Coverage (UHC) Policy is an important health policy issue among ASEAN Countries, including Indonesia and Thailand, this second year proposal seeks to provide policy model of UHC in these 3 important aspects particulary financial model, improvement quality service and simplify referral service of current situation. To understand and cope with issues of UHC in Indonesia and Thailand, both teams are counterparts to each other and put each counterpart as host research location.

CHAPTER 2. LITERATURE REVIEW

a. Universal Health Care

In line with decentralization in health sector, the role of state has shifted from being an implementer of health service delivery, to a regulator creating enabling environment. Health service supply -including National Health Insurance- is shaped in part by government policies and actions, specifically the resources that a country has available and how a government prioritizes the health sector within its development program (Shah, 2005). Further Shah also stated, governments have choices about how to best allocate their resources within the health sector—between different types of health services, between different modes of financing and delivery, and between different levels of care—all of which have implications for improving the health of the poor.

WHO stated that Universal health coverage is the single most powerful concept that public health has to offer, attests to the increasing worldwide attention given to universal coverage—even for less affluent countries—as a way to reduce financial impoverishment caused by health spending and increase access to key health services (Lagomarsino et all , 2012, 933). In his recent study Lagomarsino et all (2012) observed nine low-income and lower-middle-income countries in Africa and Asia that have implemented national health insurance reforms designed to move towards universal health coverage.

In past decades, high-income countries pursuing universal health coverage have relied on various approaches. On the other hand, lower-income countries wishing to pursue coverage reforms have to make key decisions about how to generate resources, pool risk, and provide services (Lagomarsino et all, 2012, 933). In their recent study, some developing countries are attempting to move towards universal coverage. The nine countries are five at intermediate stages of reform (Ghana, Indonesia, the Philippines, Rwanda, and Vietnam) and four at earlier stages (India, Kenya, Mali, and Nigeria). These nine countries has launched ambitious national health insurance initiatives designed to move towards universal coverage, or have implemented incremental improvements to existing national insurance programs. The nine developing countries are creating hybrid systems, which is shown on below table.

Figure 2.1 Main National Level Schemes of UHC

	Year of reform	Revenue generation (sources of revenue ordered by proportion of contribtuion)	Risk pooling		Service delivery		
			Single	Multiple	Primarily public	Mixed	Primarily private
Intermediate-stage reform countries							
Ghana (NHIS)[25]	2003	Value-added tax, investment income, formal-sector payroll contributions, household premiums	×			×	
Indonesia* (BPJS)[26]	2004	General government revenues, formal-sector payroll contributions		×		×	
Philippines (PhilHealth)[27]	1995	General government revenues, formal-sector payroll contributions, household premiums	×			×	
Rwanda (Mutuelles)[28]	2000	Donor funding, general government revenues, household premiums, formal-sector payroll contributions		×	×		
Vietnam (VSS)[29]	2002	General government revenues, formal-sector payroll contributions	×		×		
Early-stage reform countries							
India* (RSBY)[30]	2008	General government revenues		×			×
Kenya* (NHIF)[31]	2002	Formal-sector payroll contributions, household premiums		×		×	
Mali* (Mutuelles)[32]	2009	General government revenues, household premiums		×	×		
Nigeria* (NHIS)[33]	2009	Formal-sector payroll contributions, general government revenues, household premiums, donor funding		×		×	

For purposes of this table, we focus on the main national-level schemes. NHIS=National Health Insurance Scheme. BPJS=*Badan Penyelenggara Jaminan Sosial* (social security administrative body). PhilHealth=Philippine Health Insurance Corporation scheme. Mutuelles=community-based health-insurance schemes. VSS=Vietnam Social Security. RSBY=*Rashtriya Swasthya Bima Yojna* (national health insurance programme). NHIF=National Hospital Insurance Fund. *Countries that are working to expand existing pools to include new populations, or are merging existing pools to create one pool.

Table 1: **Structure of health financing reforms in nine developing countries**

Source : Lagomarsino et all, 2012.

This study found that each of the nine countries has had strongly rising incomes, with per-head income increasing by between 15% and 82% between 2000 and 2010 (data from World Bank world development indicators database), which the evidence suggests ought to lead to demands for improved access to care and reductions in household out-of-pocket health-care costs (Lagomarsino et all, 2012, 935).

Regarding the health policy, at least there are three demands that must be satisfactorily answered by the stakeholders, namely: 1.) good understanding about the politic process that affects the policy, 2.) the necessity to create a participative policy formulation system, 3.) that the result of the policy formulation must be able to answer the real problem in the society.

Further, the decentralization policy in health sector has been fueled by new efforts at democratization through promoting accountability and introducing competition and cost consciousness in the health sector. The state's new role has shifted from being an implementer of health service delivery, to a regulator creating enabling environment (World Bank on Social Accountability: Strengthening the Demand Side of Governance and Service Delivery"!, 2006) . World Bank in 2004 developed framework modified to illustrate the accountability mechanisms in a decentralized setting. This conceptual differentiation is important as it captures the re-positioning of actors, mandates and authorities in the decentralized service delivery system. The so-

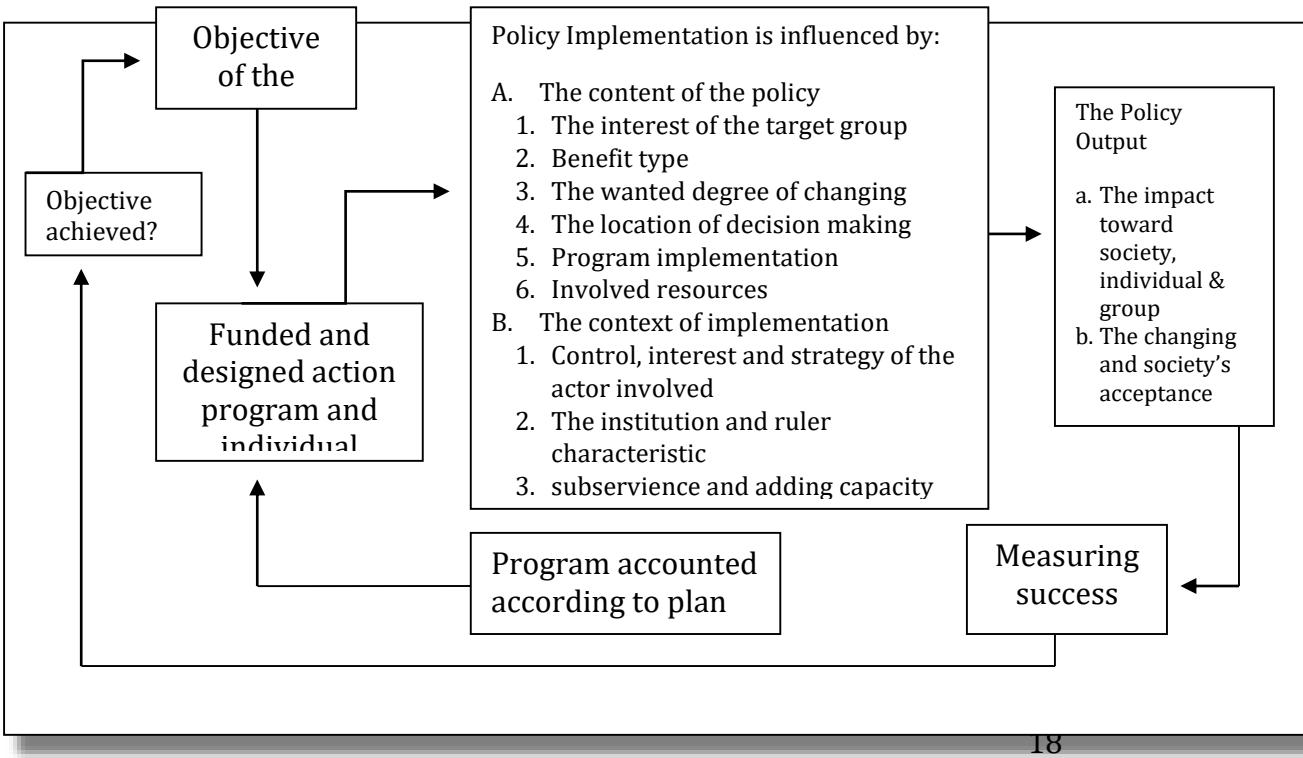
called *intermediate route of accountability* refers to client *voice* and the *compact* mechanisms relating clients to public officials and service institutions at the sub-national government level.

b. Evaluation of Health Policy

Public policy particularly in health sector does not only deal with individual or segmented interests, but it deals more with common objectives, public interests, or citizens at large. The proposed course of action that constitutes policy is then implemented through subsequent decisions and actions.

Reviewing health sector policy could not be separated from the nature of public policy itself. Grindle (1980 p. 11) says that the activities of implementation is strongly influenced by a number of factors (a) the content of policy (b) the context of policy implementation. Factors of policy content (content of policy) covers; (1) affected interests 2) type of benefit, (3) the desired extent changes, (4) location of decision making, (5) implementer programs and (6) affiliated resources. Whereas in the context of implementation the factors that influence are: (1) power, interests and strategies of the actors involved, (2) character-institutional characteristics in the regime, and (3) compliance and responsiveness.

Picture: 1. Policy Framework (Grindle, 1980)



The output from the inputs conversion is on the priority scale and furthermore chosen based on the urgency to become a public policy that has to be solved by the government into output that one of it is policy which implementation's aim is to solve previous issues to achieve the goal and target that has been set before.

More than that, because public policy is a series of evaluation, a more comprehensive understanding framework is needed to explain how they set up an evaluation and make improvement.

Evaluations are undertaken for a variety of reasons:

1. To judge the worth of on going programs and to estimate the usefulness of attempts to improve them: to identify planning and policy purposes, to test innovative ideas on how to deal with human and community problems.
2. To increase the effectiveness of program management and administration: to assess the appropriateness of program changes, to identify ways to improve the delivery of interventions ,
3. To meet various accountability requirements : impact accountability, efficiency accountability, coverage accountability, service delivery accountability, fiscal accountability, legal accountability

Palmier, divides policy evaluation into four categories:

1. Planning and need Evolutions.
   Includes assessment of the target population, the need now and in the future as well as existing resources.
2. Process evaluations
   Evaluation of the implementation of the action, executing media programs and information systems.
3. Impact evaluations
   Evaluate impact of policies, whether expected or not, and the expansion of the program.
4. Efficiency evaluations
   Evaluation of efficiency policies, which can be seen from the comparison with the cost advantage (Leslie, 1987: 52)

With the aim to provide an assessment of the implementation program, in this assessment did not evaluate the overall phase of the policy but only one stage of its

implementation (implementation evaluation).

Evaluation of the implementation according to Ripley is including the following:

1. Evaluation is reviewed to evaluate their processes
2. Implemented by adding questions to be answered in the perspective of what happened other than in compliance perspective.
3. Done with the evaluating aspects of the policy impacts that occur in the short term. (RJ Heru, 1997: 35)

Evaluation of the program performance consist of:

1. The relevance and the strategy of the program at large.
   The focus will be on assessing to which extent the program is adressing the major problematic situation.
2. The effectiveness of the program.
   It focus to which extent the program has been able to achieve its expected outputs and targets
3. The efficiency of the program.
   It analyse to which extent the program has used its resources in an optimal way.
4. The impact of the program.
   Impacts are changes at a higher level that are beyond the direct control of the program. It focus on changes in behavior within the groups and individuals with which the program had direct interaction.
5. The sustainability of the program.
   It is to understand to which extent the program has already produced some impacts or is expected to do so in the future, given the constraining environment and influencing factors.

To know the results of a health sector policy on national social insurance, evaluations are undertaken to measure :

1. The existing policy framework and strategic plans for the UHC.
2. National health insurance budget distribution
3. Identify implementation systems and priorities, targets and standards of UHC .
4. The equity impacts of national social insurance policy.

CHAPTER 3. METHODOLOGY OF THE STUDY

In order to achieve through the goal of this study, the policy model is utilized. To serve this goal, the scope of this research project has 5 phases of study:

Phase 1:

The 1st phase of the study will provide a comparative analysis of the similarities and differences in the UHC of Indonesia and Thailand.

Phase 2:

The second phase will explore the extent and policy related regarding gaps and problems of UHC by utilizing the result of first phase.

Phase 3:

The third phase will evaluate policy in order to fill these gaps by decreasing or eliminating obstacles to the UHC system of Indonesia and Thailand.

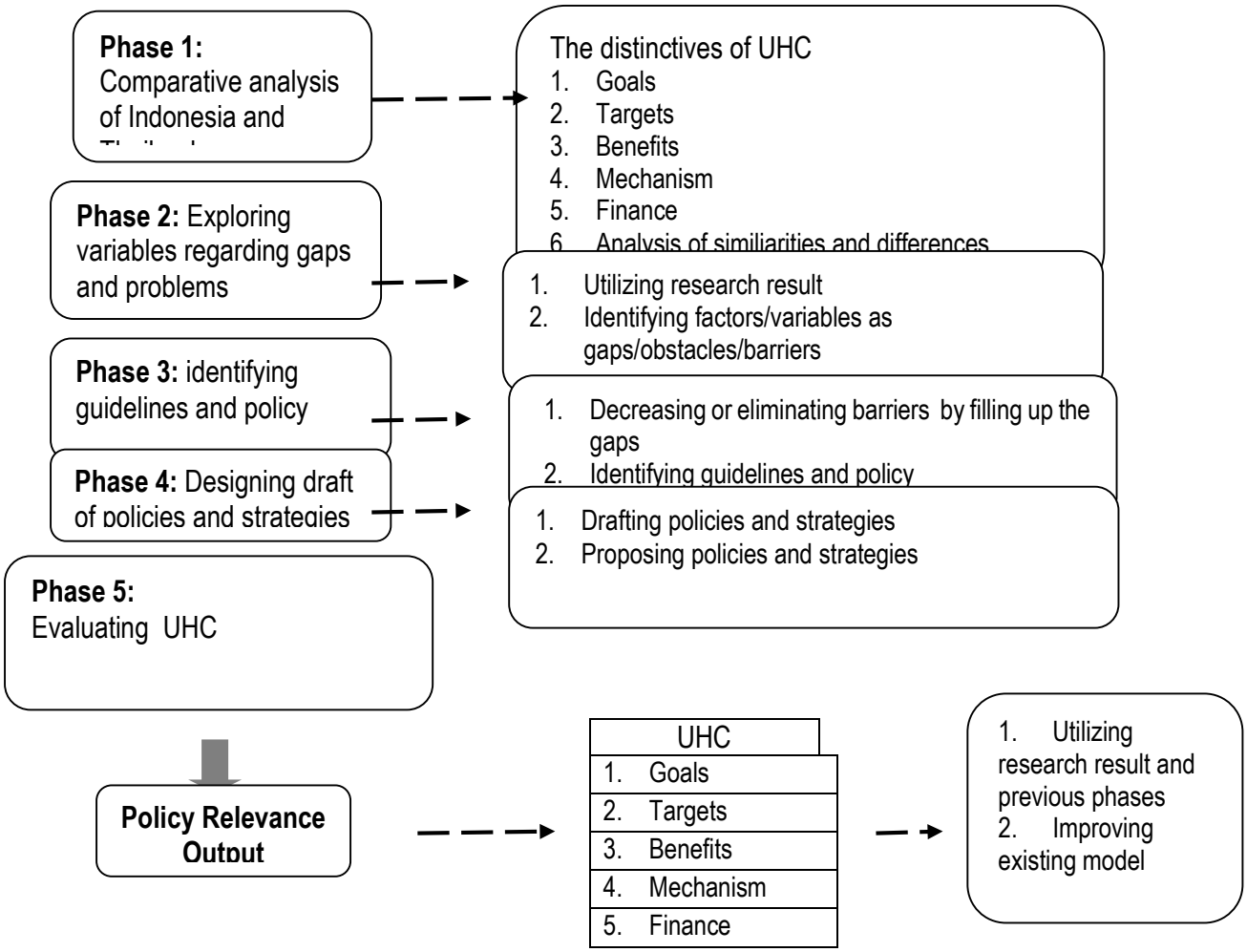
Phase 4:

The fourth phase will design draft of policies and strategy for improvement of UHC system regarding each urgent issue and over all in Indonesia and Thailand.

Phase 5:

The fifth phase will result improving of implementation model of UHC policy regarding as comparative analysis of policy in Indonesia and Thailand.

Figure 3.1 Conceptual and Evaluation Framework



This evaluation is based on the policy evaluation of health insurance in the selected areas. The followings are the steps that are taken in this study:

1. Most of the data in this study will be qualitative in nature. In qualitative, literature on methodology suggest that in qualitative research tradition, *confidence* or credibility is acquired by performing the procedures of triangulation (Denzin, 1970). Triangulation has also come to mean convergence among researchers (agreement between field notes of one investigator and observations of another) and convergence among theories. The instruments for qualitative approach will use interview guide and Focus Discussion Group.
2. Data using in this research will be primary data and secondary data. Primary data will be collected through depth interview and FGD both in Thailand and Indonesia. There are considerable constraints to obtain data from the primary sources, and in this way, secondary data sources are particularly important. Secondary data consist of all evidence in the forms of documents and records.

Table 3.1 List of Secondary Data

Data	Source	
	Indonesia	Thailand
Report of UHC	BPJS	NHSO
Statistics of UHC	General Hospitals	General Hospitals
Financial Report of UHC	BPJS, Ministry of Finance	NHSO, Ministry of Finance
Health Indices	Ministry of Health	Ministry of Health

3. Literature Review. This study will be undertaken by comparing relevant literature and research. There have been many studies, reports and journals on UHC, and there are still some other ongoing studies in UHC as health insurance in Indonesia and Thailand. Aside from the necessity that such studies will be important references, they can be a good materials for enhancing the quality of this study.

4. Observation of the practices of UHC, of recipient groups when recieve the programmes as form of the health insurance system. Given the time limit for report, observation was carried out by taking samples from the selected areas.

Tabel 3.2 List of observations

Name of object	Location	
	Indonesia	Thailand
Process of participants UHC Registration	BPJS	NHSO
Process of UHC Service delivery	General Hospitals	General Hospitals
Process of complain handling in UHC	BPJS, General Hospitals	NHSO, General Hospitals

5. Indepth interviews to the key informants from government health agencies. These are carried out along with the observation.

Table 3.3 List of Interviewed

Indonesia	Numbers	Thailand	Numbers
Management of BPJS	3	Management of NHSO	3
Management of General Hospital	4	Management of General Hospital	4
Management of Ministry of Health	1	Management of Ministry of Health	1
Management of Ministry of Finance	1	Management of Ministry of Finance	1
JKN Participants	5	UC Participants	5
Management of Private Hospitals	2	Management of Private Hospitals	2
Management of Provincial Health Office	2	Management of Provincial Health Office	2
Management of NGO of Health Sector Watch	2	Management of NGO of Health Sector Watch	2
Total	20	Total	20

6. Information gathering through the Focused Group Discussions (FGD) of government agencies who provide UHC that are monitoring and that involve to set up policy insurance mechanism particularly in health sector.

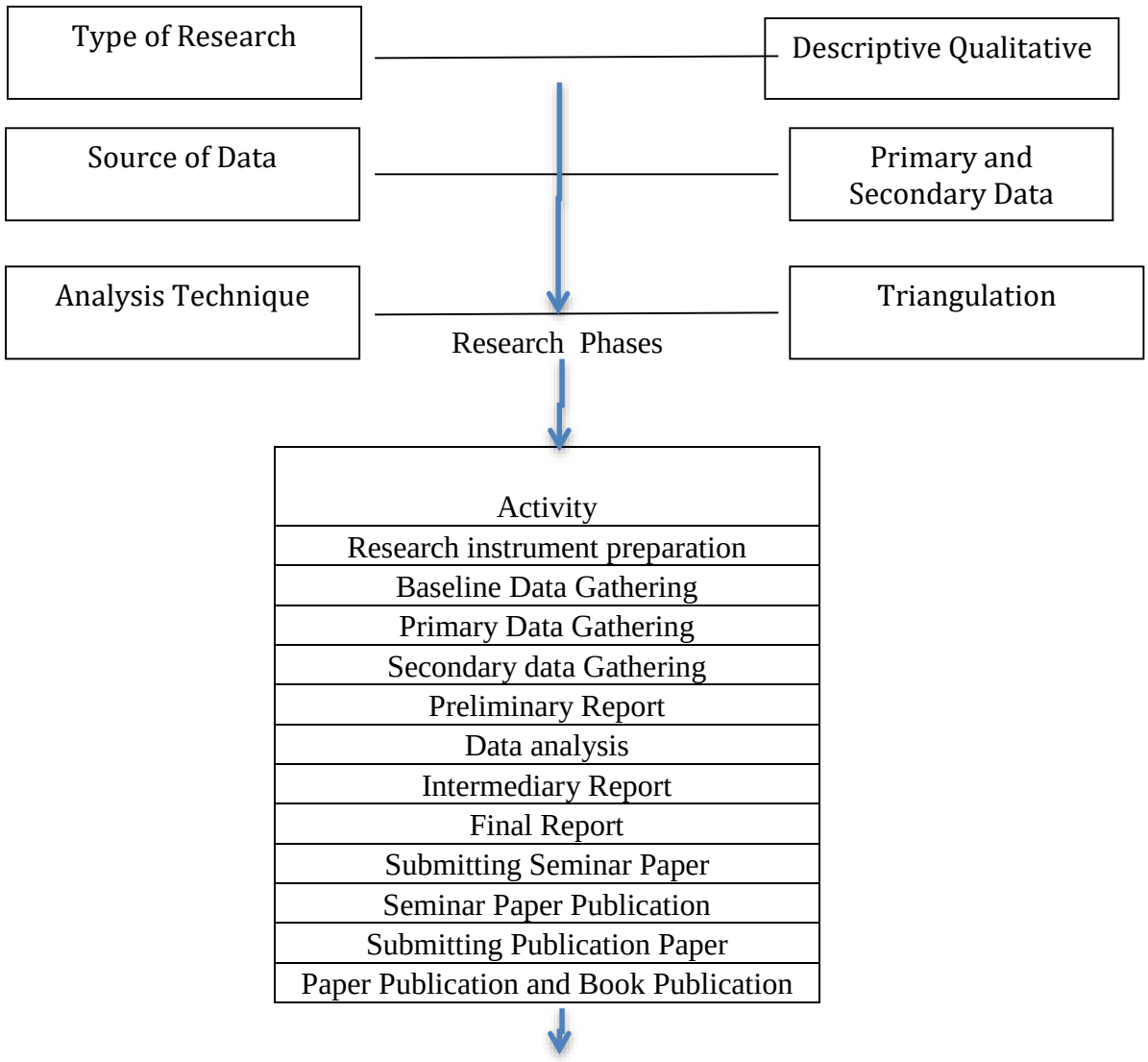
Table 3.4 List of FGD participants

Indonesia	Numbers	Thailand	Numbers
Management of BPJS	3	Management of NHSO	3
Management of General Hospital	4	Management of General Hospital	4
Management of Ministry of Health	1	Management of Ministry of Health	1

Management of Ministry of Finance	1	Management of Ministry of Finance	1
Management of Private Hospitals	2	Management of Private Hospitals	2
Management of Provincial Health Office	2	Management of Provincial Health Office	2
Management of NGO of Health Sector Watch	2	Management of NGO of Health Sector Watch	2
Total	15	Total	15

Intense discussions among the UHC implementer and the health care units will be conducted within small groups, e.g. 5 to 15 participants, with pre-determined topics or issues. The size of the groups is kept small to ensure that all of its members actively participate in the discussions.

Figure 3.2 Research Frame Work



Research Output :

- International Call paper,
-International journal,
- Reference Book of Policy Implementation,
- Intelectual Property Rights

CHAPTER IV

UHC PROFILES IN INDONESIA AND THAILAND

4.1 UHC Profile in Indonesia

UHC in Indonesia well known as Jaminan Kesehatan Nasional (JKN) organized by National Board of Health Insurance (Badan Penyelenggara Jaminan Sosial Kesehatan-BPJS-Kesehatan). It was under the Law No. 40/2014 of the National Social Security System, on October 19, 2004. The legalization of the Law on National Social Security was also triggered by the Constitution of 1945 and its amendment in 2002 on Article 5 Verse (1), Article 20, Article 28H Verse (1), Verse (2), and Verse (3), along with Article 34 Verse (1) and Verse (2) which mandate to develop the National Social Security System. Until it was legalized and legislated, the Law on National Social Security System had been through a long process, from 2000 to October 19, 2004.

Legal Foundation of BPJS Kesehatan:

1. The Constitution of 1945
2. Law No. 40/2004 on National Social Security
3. Law No. 24/2011 on Social Security Provider

In managing the BPJS Kesehatan, the management is guided by:

1. General Guidelines of Good Governance of the BPJS Kesehatan
2. Board Manual of the BPJS Kesehatan
3. Ethics Code of the BPJS Kesehatan

Based on Presidential Decree No. 24 / P Year of 2016 on the Appointment of the Board of Trustees and the Board of BPJS Kesehatan Term Year 2016-2021, the Board of Directors BPJS are as follows:

Table 4.1 The Board of Directors BPJS

No.	Board Position
1.	Director of planning and development
2.	Director of Legal, Communications and HAL
3.	Director of Human Resources and General
4.	Managing Director
5.	Director of Services

6.	Director of Membership and Marketing
7.	Director of Financial
8.	Director of Technology and Information

Based on Presidential Decree No. 24 / P Year of 2016 on the Appointment of the Board of Trustees and the Board of BPJS Kesehatan Term Year 2016-2021, consist of 7 members.

According to BPJS Kesehatan, members of BPJS Kesehatan is everyone, including foreigners who work for a minimum of 6 (six) months in Indonesia, which has been paying dues, including:

1. Recipient Contribution Health Insurance (PBI): the poor and people are not able to, with the determination of the participants in accordance with the law and regulation.
2. Not Receiving Aid Health Insurance Fee (Non-PBI), consisting of:
    - Recipients Wage Workers and members of their families
        a) Civil Servants;
        b) Members of the military;
        c) Members of the National Police;
        d) State officials;
        e) Non Government Employees Civil Service;
        f) Private Employees; and
        g) Workers who do not include the letters a to f are receiving wages. Including foreigners working in Indonesia for a minimum of 6 (six) months.
    - Not Receiving Wage Workers and members of their families
        a) workers outside the employment relationship or an independent worker;
        b) Workers who did not include a letter that is not the recipient Wages. Including foreigners working in Indonesia for a minimum of 6 (six) months.
    - Non-workers and family members
        a) Investors;
        b) Employer;
        c) Pension Recipients, consisting of:

- Civil Servants who stopped the pension rights;
- Members of TNI and Police officers stopped the pension right
- State officials who stopped the pension rights;
- The widow, widower or orphan pension recipients who receives pension rights;
- Recipient other retirement; and
- Widows, widowers, orphans or from other pension recipients who receive pension rights.

d) Veterans;

e) Pioneer Independence;

f) The widow, widower, or orphans of veterans or Pioneer Independence;

g) Not Workers who do not include the letters a to e are unable to pay dues.

Family members that remains :

1 Receiver Wage Workers:

- The nuclear family, including wife / husband and children are legitimate (biological children, stepchildren and / or adopted children), a maximum of 5 (five) people.
- Children biological, stepchild of a legal marriage, and adopted children are legitimate, with criteria:
    a. Not or have never been married or do not have their own income;
    b. Not the age of 21 (twenty one) years old or has not been aged 25 (twenty five) years of formal education is still continuing.

2 Not Receiving Wage Workers and Non-Workers: Participants can include family members who want (unlimited).

3 Participants can include additional family members, including children 4 and so on, father mother and in-laws.

4 Participants can include additional family members, which include other relatives such as siblings / in-laws, household assistant, etc..

CONTRIBUTIONS

1. For the Health Security Premium Support Beneficiary (PBI), the premium of the Health Security is paid by the goverment.
2. The premium of the Salary Beneficiary Workers members, working in State Institutions including Civil Servants, members of Indonesian National Army and Indonesian Police, State Officers, Non-Civil Servant State Officers is about 5% of the monthly salary with the provision: 3% is paid by the employer party and 2% by the members.
3. The premium of the Salary Beneficiary Workers members, working at State-owned Enterprises, Regional-owned Enterprises, and private sectors is about 5% from the monthly salary with the provision: 4% is paid by the employer party and 1% by the members.
4. The premium for the additional family members of the Salary Beneficiary Workers consisting of the fourth child and so on, parents, and parents-in-law, is about 1% from the monthly salary perperson, paid by the Salary Beneficiary Workers.
5. The premium for other relatives of the Salary Beneficiary Workers (such as biological/siblings-in-law, domestic assistant, etc); Non- Salary Beneficiary Workers and Non-workers members is:
   a. Rp.25.500,- (twenty five thousand and five hundred rupiah) per-person per-month with the benefit of Class II treatment service.
   b. Rp.51.000.- (fifty one two thousand hundred rupiah) per-person per-month with the benefit of Class II treatment service.
   c. Rp.80.000,- (eighty thousand rupiah) per-person per-month with the benefit of Class I treatment service.
6. The premium of Health Security for Veteran, Freedom Fighthers, and widow, widower, or orphan of Veteran or Freedom Fighters is about 5% from 45% of the monthly Civil Servant Rank III/a Salary with 14 (fourteen) length of service, paid by the government.
7. The premium payment is paid at most on the 10^{th} date of the month.
   No penalty for late payment of dues commencing in July 1, 2016 fines imposed if within 45 (forty five) days from the membership status reactivated, the participants concerned to obtain medical care hospitalization, it imposed a fine of 2.5% of the service charge health for each month in arrears, with the following provisions:

1. The number of months in arrears at most twelve (12) months.
2. Great highest fines Rp.30.000.000, - (thirty million rupiah).

Table 4.2 JKN Members

Types	*Numbers*
PBI APBN	*91.173.965*
PBI APBD	*13.942.123*
PPU PNS	*13.039.890*
PPU TNI	*1.550.824*
PPU POLRI	*1.210.256*
PPU BUMN	*1.247.091*
PPU BUMD	*153.203*
PPU SWASTA	*22.995.734*
PBPU PEKERJA MANDIRI	*18.134.825*
BUKAN PEKERJA	*5.064.326*
TOTAL	*168.512.237*

Table 4. 3 Health Facilities

Sub District Primary Unit Care	9813
Military Clinic	711
Police Clinic	569
Primary Clinic	3549
BPJS Doctors	4485
BPJS Dentist	1164
Hospital Type D	13
Hospital	1807
Privat Clinic	116
Pharmacy	1966

Optic	939

UC Profile in Thailand

The National Health Security Office or NHSO is set up according to the 2002 National Health Security Act, with two governing national Boards, namely the National Health Security Board and the Health Service Standard and Quality Control Board. The National Health Security Board is responsible for policy setting and system development. In principle, the development of benefit packages, health care service standard, criteria for fund management and no-fault compensation as well as regulation frameworks for contracting providers are decided. As stipulated under Section 13 of the 2002 National Health Security Act, the National Health Security Board is chaired by the Minister of Public Health and consists of members from various public and private organizations. The Board members include the permanent-secretary of related ministries, namely Ministry of Defense, Ministry of Finance, Ministry of Commerce, Ministry of Interior, Ministry of Labor, Ministry of Public Health and Ministry of Education as well as the director of the Bureau of the Budget. Representatives from health professional bodies, municipalities, local administration organizations and non-profit organizations working on children, youth, women, elderly and other vulnerable groups are also included as the Committee members. In addition, experts in health insurance, medical sciences and public health, Thai traditional medicine, alternative medicine, finance, law and social sciences are appointed board members by the Cabinet. NHSO secretary-general is designated as the board secretary. The Health Service Standard and Quality Control Board is responsible for controlling, monitoring and supporting standard and quality of health care providers. The Board also provides comments on standard fees for treatments, regulate no-fault liability payment, support public access to UC information and give response to consumer complaints. The Board members include the heads of many health care institutes such as the Department of Medical Services, the Food and Drug Administration Office, the Hospital Development Accreditation Institute and the Medical Registration Division. Representatives from

professional bodies, private hospitals, health care professionals, Royal Colleges as well as municipalities and local administration organizations are also included as board members. Representatives from non-profit organizations working on children, youth, women, elderly and other vulnerable groups are elected as members. Six qualified experts in tropical family medicine, mental health and Thai traditional medicine are appointed as committee members by the Minister of Public Health. NHSO secretary-general is also designated as the Board secretary.

With regard to good governance, an audit sub-committee appointed by National Health Security Board will function as internal auditors. The audit sub-committee is to closely inspect into the system whether internal operation, especially financial management, complies with the laws and regulations. Regular reports are submitted to the National Health Security Board on a quarterly and annual basis.

NHSO is an autonomous organization acting as a secretariat office for both national boards to manage and ensure the attainment of universal coverage for all. The internal operation in NHSO is divided into two main sections, the head quarter and regional offices. The head quarter office consists of 15 bureaus responsible for policy and planning, system support as well as monitoring and evaluation. 13 regional NHS Offices take responsibility for administering and monitoring the fund management at the regional level. The regional offices will ensure that health security implementation is responding to the local health needs. In order to accomplish this goal, co-operation and participation of stakeholders in decision-making process and health-related activities are required. In each regional catchment's area, there is the number of population of 2.3 to 5 million.

Table 4.4 NHSO Structure

No.	*Position*
1	*Secretary General*
2	*Deputy Secretary General*
3	*Deputy Secretary General*
4	*Deputy Secretary General*
5	*Deputy Secretary General*
6	*Deputy Secretary General*
7	*Assistant Secretary General*
8	*Assistant Secretary General*

The National Health security Act. 2002. Section 13 Standard and Quality Control Board consisting of:

1. The Director General of Department of Medical Services, the Secretary General of the Food and Drug Administration, the President of the Hospital Development and Accreditation Institute, and the Director of Division of Medical Registration.
2. A representative of the Medical Council, a representative of the Thailand Nursing Council, a representative of the Pharmacy Council, and a representative of the Law Society of Thailand.
3. A representative of private hospitals who is a member of the Private Hospital Association.
4. A representative of the Municipality, a representative of the Provincial Administrative Organization, a representative of the Tambon Administrative Organization, and a representative of other local government organizations elected by executives of its organization.
5. A representative of professional nurses, a representative of midwives, a representative of dentists, and a representative of pharmacists.
6. representatives of the Royal College of Medical Specialty, each of which is from the field of obstetrics and gynaecology, surgery, internal medicine, and paediatrics.
7. Three representatives elected by, among, representatives of health care professionals, each of which is from the field of applied traditional medicine, physical therapy, medical technique, radiological technology, occupational therapy, cardio-thoracic therapy, and communicative disorders.
8. Five representatives of, elected by, representatives each of which is from a non-profit private organization implementing activities for the following groups.
    (A) Children and adolescents
    (B) Women
    (C) Elderly
    (D) Disabled or mental health patients
    (E) HIV or other chronic disease patients
    (F) Labor

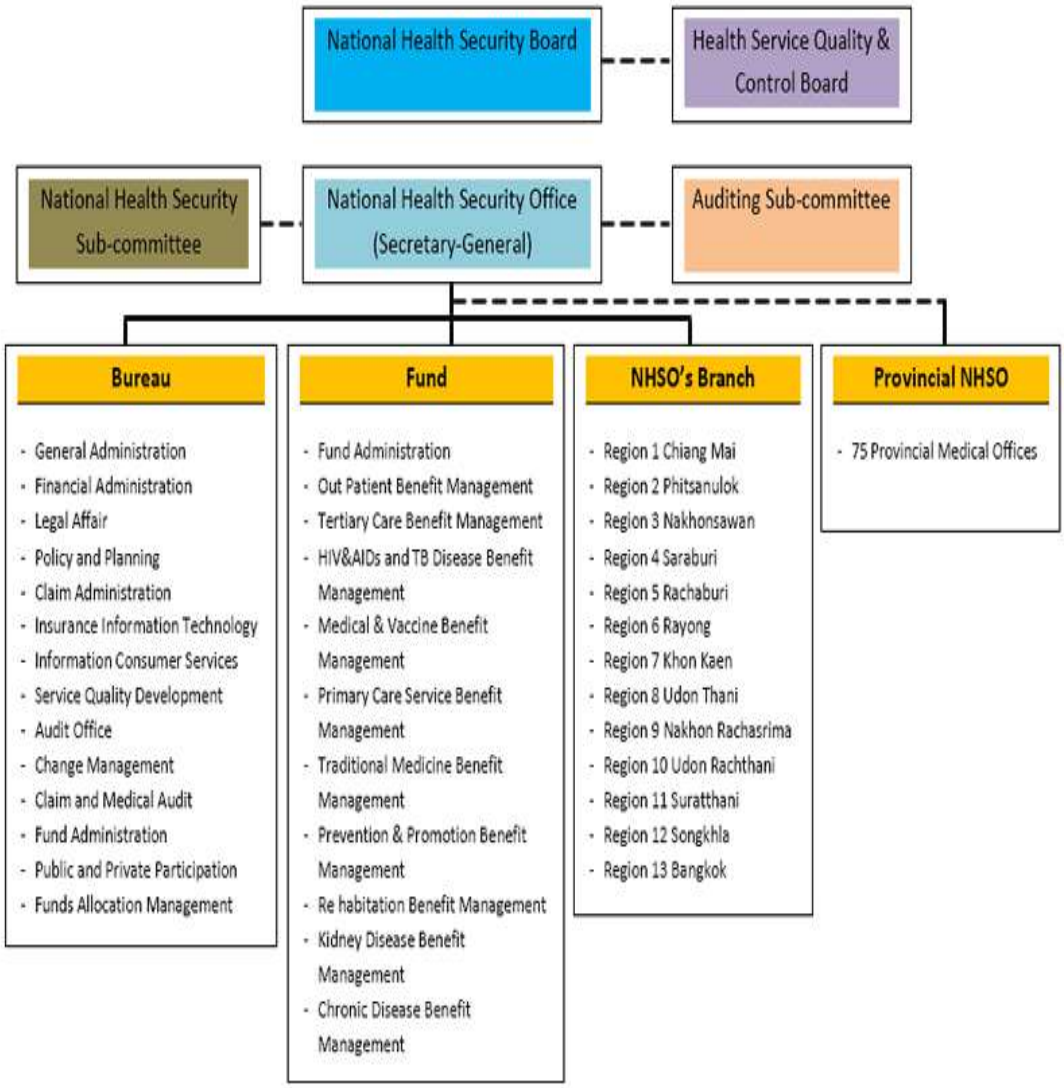
(G) Populous communities
(H) Agriculturists
(I) Minorities

9. Six qualified persons appointed by the Minister, each of which, at least, is a qualified person in tropical family medicine, a qualified person in mental health, and a qualified person in Thai traditional Medicine.
10. The Secretary General shall be the secretary of Standard and Quality Control Board

The Standard and Quality Control Board shall have powers and duties as follows.

1. To control the standard and quality of Health care units and Networks of health care units pursuant to Section 45.
2. To monitor the Health service provided by Health care units to meet the standard and quality in the case where such Health care units provide a level of services higher than the Health service pursuant to Section 5.
3. To prescribe the measurement, controlling, and encouraging of quality and standard of Health care units and Networks of health care units.
4. To submit standard prices of all diseases to the Board to set up regulations prescribing expenses of Health service to Health care units pursuant to Section 46.
5. To prescribe rules, procedures, and conditions for the complaint of a person if their right is violated due to the Health service, procedures for such complaint, and rules and procedures for assisting a person if their right is violated due to the Health service, as well as to determine a Complaint Unit to facilitate people in freely submitting complaints, irrespective of the person who is complaining.
6. To report the results of inspecting and controlling quality and standard of Health care units and Networks of health care units to the Board, and notify such result to Health care units or their authorizing agency in order to improve, modify, monitor, and evaluate the effect of quality and standard improvement.
7. To encourage people' participation in inspecting and controlling Health care units and Networks of health care units.

8. Provide payment of preliminary assistance to a beneficiary who is subject to damage or injury caused by any service provided by a Health care unit and the wrongdoer is non-apparent or the wrongdoer is apparent but such beneficiary can not be reimbursed within a period deemed appropriate pursuant to such regulations, procedures, and conditions as prescribed by the Board.
9. To encourage establishing of an information system for decision making of people to get health service.
10. To perform other duties for the execution of this Act and other laws or such duties as prescribed by the Board.



Head quarter & Branch

Branch	Region
Head quarter, Bangkok	Bangkok
Chiang Mai Branch	(Region 1)
Phitsanulok Branch	(Region 2)
Nakhonsawan Branch	(Region 3)
Saraburi Branch	(Region 4)
Ratchaburi Branch	(Region 5)
Rayong Branch	(Region 6)
Khon Kaen Branch	(Region 7)
Udon Thani Branch	(Region 8)
Nakhonratchasima Branch	(Region 9)
Ubonratchatani Branch	(Region 10)
Suratthani Branch	(Region 11)
Songkhla Branch	(Region 12)
Bangkok Branch	(Region 13)

Health services cover which provided by a health care unit under National Health Security Act (Section 3) as follows

1. Promotive and preventive cares.
2. Diagnosis.
3. Ante-natal care.
4. Curative care.

5. Medicine, medical supplies, organ substitutes, and medical equipments.
6. Delivery.
7. Boarding expense within health care unit.
8. newborn and child care.
9. Ambulance or transportation for patient.
10. transportation for disability person.
11. physical and mental rehabilitation.
12. other expenses necessary as prescribed by the Board.

Benefit Package

1. Comprehensive program.
2. Prevention: annual physical examination, immunization, family planning, ANC, Antiretroviral drug for pregnancy women and dental preventive services.
3. Medical service include ambulatory and inpatient service.
4. Basic dental services.

Curative Benefits

1. General examination, curative and rehabilitative services.
2. Medical examination, diagnosis, treatment and rehabilitation until the treatment ends, including alternative medical care as recognized by the Medical Registration Committee.
3. Childbirth delivery services, totaling for no more than 2 deliveries.
4. Meals and room charges for inpatients in common rooms.
5. Dental services: extraction, filling, scaling, plastic-based denture, milk-tooth nerve-cavity treatment, and placement of artificial palate in children with harelip and cleft palate.
6. Medicines and medical supplies according to the national essential drug list.Referrals for further treatment among health facilities.
7. High-cost medical services, including artificial organs and prostheses (both inside and outside the body), as per the payment criteria set by the NHSB.

8. Care for accident and emergency illnesses: any accident or emergency case can go for medical care at any health facility (participating in the scheme) located nearest to the scene.

Prevention Benefits

1. Having and using personal health record-books.
2. Examination and pre-natal care for pregnant women.
3. Services related to child health, child development and nutrition, including immunizations according to the national immunization program.

4. Annual physical checkups for the general public and high-risk groups.
5. Antiretroviral medications for the prevention of mother-to-child transmission of HIV.
6. Family planning services.
7. Home visits and home health care.
8. Provision of knowledge about health care for patients.
9. Counseling and support for people's participation in health promotion.
10. Oral health promotion and disease prevention.

NHSO report on 2014 stated that the ultimate goal of the Universal Health Coverage (UHC) implementation is to cover all population. In the past decade, the national UHC coverage of Thai citizens in Thailand has been increased dramatically from 71.00% in FY2001 to 92.47% in FY2002 when implementing the UHC policy, and to 99.84% in FY2014. This coverage was not included stateless group living in Thailand, Thai citizens living aboard, and other foreigners. The number of Thai citizens who are eligible to enroll to the universal coverage scheme (UCS) but have not enrolled in FY2014 is 105,184 people (0.16% of all population). However, the eligible non-registered group will be able to access to health services at any health facility registered to the

UCS when they need; and, they can register to the UCS and select their contracting unit near their home.

When classified into the main government health insurance schemes, i.e., the Civil Servant Medical Benefit Scheme (CSMBS), Social Security Scheme (SSS), and the

Universal Coverage Scheme (UCS), coverage of every scheme in the past decade has been increased as shown in table 3. A proportion of each government schemes in FY2014 is 73.80% of the UCS, 16.73% of the SSS, 7.11% of the CSMBS, and the rest are other small government schemes such as local administration offices and non-enrolled group.

Table 4.5 The number of Population in Thailand classified by health insurance status, FY2002 - 2014

(Unit: mil. people)

Status	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
UCS	45.35	45.97	47.10	47.34	47.54	46.67	46.95	47.56	47.73	48.12	48.62	48.61	48.31
SSS	7.12	8.09	8.34	8.74	9.20	9.58	9.84	9.62	9.90	10.17	10.33	10.77	11.07
CSMBS	4.05	4.02	4.27	4.15	4.06	5.13	5.00	4.96	4.92	4.96	4.97	4.98	4.84
Local Administration Office	-	-	-	-	-	-	-	-	-	-	-	0.10	0.58
Others[1]	-	-	-	0.22	0.23	0.24	0.24	0.23	0.52	0.64	0.61	0.49	0.56
Qualified non-registered UCS	4.60	4.37	2.83	2.36	1.36	0.78	0.52	0.33	0.41	0.03	0.06	0.08	0.11
Total coverage	61.12	62.45	62.54	62.81	62.39	62.41	62.55	62.70	63.47	63.92	64.59	65.04	65.46
Unknown citizen status[2]	-	-	-	0.00	0.45	0.90	1.16	1.44	1.35	1.20	0.79	0.62	0.21
Thais living abroad [3]	0.03	0.03	0.06	0.06	0.06	0.06	0.06	0.01	0.02	0.02	0.01	0.02	0.02
Foreigners	-	-	0.26	0.27	0.28	0.30	0.31	0.32	0.18	0.11	0.11	0.12	0.19
Total of others	0.03	0.03	0.32	0.34	0.80	1.25	1.52	1.78	1.54	1.32	0.91	0.77	0.42
Total population	61.15	62.48	62.86	63.15	63.19	63.66	64.07	64.47	65.01	65.24	65.50	65.80	65.88

Source: *Bureau of Registration Administration, NHSO*

Note: *1. Other government schemes for small group of beneficiaries, e.g., politicians, veterans, private school teachers,*

2. People who have problem on status such as duplicated ID number, wrong ID number, foreigners

3. The number from Bureau of Registration Administration (BORA), Ministry of Interior (MOI)

CHAPTER V. ANALYSIS

Based on the questionnaires collected in both countries there are shown that slightly more male (51.20 percent) than female respondents (48.30 percent) in Thailand. While in Indonesia, the samples shown more female (53.30 percent) than male respondents (46.70 percent). About half of the respondents accounted for married both in Indonesia and Thailand. Most of the respondents received six year of basic education and for high school. It is very interesting to find out that about 33.70% who come to receive UC services from Banpheo Hospital are unemployed or freelancers (18.50percent), business owners (16.60 percent), or homemakers/housewives (14.60 percent), respectively. And lastly, more than 50% have their monthly earnings more or less 10,000 Baht.[7] On the contrary, in Indonesia most of the respondents are non-PBI or participants who are catogorized as poor people and low income people.

Table 5.1 Geographical background of samplings

	THAILAND		INDONESIA	
Sampling properties	Frequency	Percentage	Frequency	Percentage
1. Gender				
Male	105	51.20	140	46.70
Female	99	48.30	160	53.30
N/A	1	0.50	0	0
2. Age				
60 - 65	46	22.40	114	38.00
66 - 70	58	28.30	90	30.00
71 - 75	53	25.90	51	17.00
76 - 80	32	15.60	45	15.00
81 - 85	13	6.30	0	0
86 - 90	2	1.00	0	0
91 - 95	0	0.00	0	0
95 +	0	0.00	0	0
N/A	1	0.50	0	0
3. Residency				
Bangkok (Thailand)	167	81.50		

[7] The conversion rate is about 33.00 baht per one US dollar.

	THAILAND		INDONESIA	
Sampling properties	Frequency	Percentage	Frequency	Percentage
Yogyakarta (Indonesia			225	75.00
Other provinces	22	10.70	75	25.00
N/A	16	7.80	0	0
4. Marital Status				
Single	27	13.20	33	11.00
Married	111	54.10	198	66.00
Divorce/widow/separated	66	32.20	69	23.00
N/A	1	0.50	0	0
5. Educational level				
Primary	74	36.10	119	39.70
High school	41	20.00	106	35.30
Vocational	21	10.20	22	7.30
Undergraduate	55	26.80	53	17.60
Graduate +	7	3.45	0	0
N/A	7	3.45	0	0
6. Occupation				
Civil servants/public enterprise	4	2.00	0	
Business owners	34	16.60	70	23.3
Employees	11	5.40	41	13.7
Farmers /agricultural	1	0.50	14	4.7
Retire officials	13	6.30	30	10
Homemakers/housewives	30	14.60	45	15
Freelance	38	18.50	0	0
Unemployed	69	33.70	0	0
Others	5	2.40	65	21,6
7. Income per month (Baht equivalent to Rupiah)				
Less than 2,000	48	23.40	98	32.7

	THAILAND		INDONESIA	
Sampling properties	Frequency	Percentage	Frequency	Percentage
2,000 – 5,000	24	11.70	82	27.3
5,000 – 10,000	46	22.45	75	25
10,000 -20,000	47	22.95	30	10
20,000-50,000	32	15.60	15	5
More than 50,000	5	2.40	0	0
N/A	3	1.50	0	0

The perception of respondents on implementation both UC anad JKN are varies. It has 5 parameters in the measuremenet such as: 1.Standart of Procedures of public hospital, 2. Communication between agencies of UHC Healthcare, 3. Medical human resources readiness, 4. Convenient Facilities and infrastructure, and 5. Medicinesufficiency. Overall, the perception of the respondents show better perception in Thailand rather than in Indonesia. In Indonesia the result in Standart of Procedures of public hospital parameter show 4.10 that is lower than Thailand with a remark of 4.68. In term of Communication between agencies of UHC Healthcare, it is found that Thailand is 4.56, while Indonesia only 3.77.

Another parameters of Medical human resources readiness, Convenient Facilities and infrastructure, and Medicine sufficiency also shown the higher result in Thailand.

Table 5.2 Parameters of implementation UHC

Implementation	Thailand	Opinion	Indonesia	opinion
1.Standart of Procedures of public hospital	4.68	Highly Satisfied	4.10	Very Satisfied
2. Communication between agencies of UHC Healthcare	4.56	Highly Satisfied	3.77	Very Satisfied
3. Medical human resources readiness	4.46	Highly Satisfied	4.18	Very Satisfied
4. Convenient Facilities and infrastructure	4.35	Highly Satisfied	4.20	Very Satisfied
5. Medicine sufficiency	4.46	Highly Satisfied	4.10	Very Satisfied

Source: Primary data

The higher result of Thailand in implementing UC can be understood that Thailand has been implemented UC for 13 years and has more health care units and

sufficient of health resources such as doctors, nurses, medicine, and administration staff to organize UC. It can be traced from the numbers of Primary Care Units (PCU) in Thailand, the services have been divided into 13 regional offices and one special group disperses to different parts of the country. There are about 1,167 main service units in total, mostly in Bangkok, Chiangmai, and Saraburi provinces, respectively. Within each area, there are a total number of 11,342PCU, mostly located in Chiangmai (1,264 units), Nakhornratchasima (1,064 units), and Ratchaburi (1,006 units), and etc. It is a tradition, norms, or belief that most Thai people would go straight to the General Hospital for minor sickness instead of going to visit "family doctors" in the PCU in their close vicinity or communities. This behavior has caused difficulties in capitation coverage financial management. Large facilities will not be able to handle overcrowded patients coming more than they received funding from the government based on the number of registered populations in the area; while small units will not have many registered patients.

Table 5.3 Numbers of Primary Care Unit in Thailand in year 2013 *

NHSO	Main Service Units		Total Primary Care Units (Places)	Proportion of Population to Primary Care Units (people)	Primary Care Unit <= 10,000 people	Primary Care Unit <10000 <= 30,000 people	Primary Care Unit > 30,000 <= 50,000 people	Primary Care Unit > 50,000 people
	Places	%						
Region 1 Chiangmai	116	9.94 %	1,264	3,205	1237	23	4	-
Region 2 Pitsanulok	54	4.63 %	709	3,688	685	24	-	-
Region 3 Nakhornsawan	52	4.46 %	649	3,475	635	14	-	-
Region 4 Saraburi	102	8.74 %	944	3,535	898	45	1	-
Region 5 Ratchaburi	76	6.51 %	1,006	3,888	970	33	2	1
Region 6 Rayong	84	7.20 %	886	4,360	819	62	3	2

Region 7 Khonkhaen	71	6.08 %	907	4,202	886	21	-	-
Region 8 Udonthani	88	7.54 %	971	4,479	939	31	1	-
Region 9 Nakhornratchasima	98	8.40 %	1,064	4,797	1017	47	-	-
Region 10 Ubonratchathani	77	6.60 %	928	3,658	916	12	-	-
Region 11 Suratthani	85	7.28 %	820	4,545	780	37	2	-
Region 12 Songkla	83	7.11 %	923	4,299	881	37	4	1
Region 13 Bangkok	179	15.34%	269	14,415	108	135	13	9
14. Special group	2	0.17 %	2	37,686	-	1	-	1
Total	1,167	100.00%	11,342	4286.73	10,771	522	30	14

Source: EIS-NHSO, Health insurance information service center, 2015, online

* There is no data in other previous years available on website.

The PCUs have different capacities in number of medical doctors, nurses, personnel, and medical equipments and facilities to handle patients ranging from less than 10,000 people, the smallest PCU, to the biggest PCU, able to handle more than 50,000 cases. In comparison, most of PCUs, accounted for 90 percent, can provide services to less than 10,000 people. Interestingly, Bangkok has the least number of small PCUs, but with more of larger size of PCUs and able to provide the most services to large proportion of population.

Quality of services

Thoroughly, the respondents' perception toward the quality of UHC service in Indonesia shows that about 79.67 percent of the respondents consider that there has been similarity and equality of JKN services for all participants. Only about 15.66 percent still thought that there has not been similarity and equality of BPJS services in giving the health services for BPJS patients. The empirical fact in field shows there are treatment differences between PBI BPJS participants and Non PBI participants. The

Non PBI BPJS patients were given priorities for services as served compared to PBI participants. Besides, the PBI patients will be delayed when they will arrange the room in hospital because they will be offered Second or First Class as the Third Class rooms are no longer available.

In contray, in Thailand, the informants' opinion concerning the quality of services in seven different aspects told different stories. It was found that in all they were highly satisfied with services at Banphaeo Hospital. This came to no surprise since this hospital, the Sukhumvit Branch of best practice hospital, was formerly a small and old private hospital equipped with small number of in-patients beds before Banphaeo Hospital took over. However, what is more important is the quality of medical treatment with respectable and responsible doctors, staff and personnel who are willing to give health care services without regard whether they are rich or poor, and especially with pride in their professions. The findings in this research have confirmed that Banphaeo Hospital is successful in its ability to maintain the standard and quality services to people from all walks of life to get access to at the costs that they can afford with no burden on their family and love ones. Considering the kind, eyes and kidney related disease, and numbers of medical attention or visits, every one or two months, they need from the hospital, it would costs them a fortune if they have to pay their own medical bills because most of them are retired. Their monthly income would not be enough to cover their cost of every day livings, not to mention the cost of regular heath care. The UC scheme is the only answer to their needs.

Table 5.4 Parameters on Quality Service of UHC

Service quality	Thailand	opinion	Indonesia	opinion
1. Equal treatment	4.62	Highly Satisfied	4.12	Very Satisfied
2.On-time services	**4.32**	Highly Satisfied	4.03	Very Satisfied
3. Sufficient services	4.15	Very satisfied	3.99	Very Satisfied
4. Continuous care services	4.67	Highly Satisfied	4.17	Very Satisfied
5. Service	4.17	Very satisfied	4.15	Very satisfied
6. Safety	4.27	Highly	3.99	Very Satisfied
7. Customers Care(medical	4.53	Highly Satisfied	4.12	Very Satisfied

Source: Primary Data

UHC Financial

In Indonesia, JKN is conceived to provide better health coverage for all Indonesians, by extending insurance to the entire population, including large swathes of the population not previously covered by any public insurance schemes (The Economist Intelligent Unit, 2015).

The tariff for a particular kind of health service over a fixed period is calculated by dividing the total number of claims for that service by the total usage of health services. As with usage, adjustments are also needed in calculating the tariff for the health-care service. It is also necessary to keep in mind that inflation in the health sector is usually higher than general inflation.

The Payment methods consist of:

1. Primary health care providers: capitation
2. Secondary and tertiary health care providers: Ina-CBG's (Indonesian - Case Based Groups)

A single payer model places great responsibility on the purchaser to develop a payment system that is precise and fair. Indonesia boldly implemented a new prospective case-based payment system for Jamkesmas a few years ago called INA CBGs (for Indonesia Case-Based Groups). Using the INA CBGs, payments made to advanced level facilities were reformed through Ministry of Health regulation No. 69 2013 on the standard tariff for health services (Kumorotomo, 2015).

Table 5.5 JKN Premium

MEMBER	PREMIUM	MONTHLY MEMBERSHIP FEE (IDR)	COVERAGE
SUBSIDIZED MEMBER	NOMINAL (per member)	19,225-	Class 3 IP care
CIVIL SERVANT/ARMY/POLICE/ RETIRED	5% (per household)	2% from employee 3% from employer	Class 1& 2 IP care
OTHER WORKERS WHO RECEIVE MONTHLY SALARY/WAGE	4.5 % (per household) And 5% (per household)	Until 30 June 2015: 0.5% from employee 4% from employer Start 1 July2015: 1% from employee 4% from employer	Class 1& 2 IP care
NON WAGE EARNERS/ INDEPENDENT MEMBERS (Informal Sector)	NOMINAL (per member)	1. 25,500,- 2. 42,500,- 3. 59,500,-	Class 3 IP care Class 2 IP care Class 1 IP care

Source: MOH, 2014

With the official estimates indicate that there are 76.4 million poor and near-poor beneficiaries of the 252.8 million total population in 2014, the BPJS is managing

formerly Jamkesmas to cover almost one third of the population. Based on the estimate that the government finance is targeted to cover 86.4 million with the PBI premium of Rp 19,225 per person per month, the central government's contribution to BPJS would equal to Rp 19.9 trillion. Since the government budget in 2014 was only Rp 44.9 trillion, it implies that almost half of the overall government health budget would be used to finance the BPJS. Then, the consequence is straightforward: the share for financing other areas of spending such as salaries and operating costs for centrally-financed hospitals, investments in improving supply and much-needed preventive and promotive interventions would have to be shrunk. The 2015 budget is allocating Rp 47.8 trillion. (Kumorotomo, 2015).

The central government outlays to finance the premiums of 86.4 million poor and near-poor in 2014 are expected to be IDR 19.9 trillion (~0.2% of GDP), up from 6 trillion allocated for financing Jamkesmas in 2011 (~0.1% of GDP). In addition to demand-side financing from the central government, additional supply-side financing from the central, provincial, and district governments will be needed to meet rising utilization rates as coverage expands. Indonesia's public spending on health was only around 0.9% of GDP in 2011, one of the lowest in the world (The Economist, Intelligent Unit, 2015).

In Thailand, with the government's attempt to help all Thai citizens to have health security coverage, the number of registered population for UC scheme will be increased every year and as a consequence the cost of health care using tax-based compulsory finance will rise respectively. The money allocated for UC scheme has increased from 56,091 million baht in 2003 to 154,258 million baht, about three times when it was first started. As previously elaborated, as more people (about 73 percent of population) joined the UC scheme, it is the government's obligation to provide health care benefits as it promised during the election campaign in 2002. Though, looking at financial of UC Scheme, it seems to be alarming, but this money is only accounted for 1.1 percent or 1.2 percent of the Annual National Gross Domestic Products (DGP), and only about 6percent of the National Budget allocated each year.

However, a closer look at the UC coverage from the data provided by NHSO, the amount of health coverage per person per year has increased more than 100 percent from year 2002 to 2014, from 1202.40 Baht to 2895.09 Baht, due to the expansion of the coverage and the benefits package to include minor care to chronic diseases. The

success story of Thailand should be given credits to all those behind the reform and a continuous developments of new ideas and the efficiency of funds management.

The master plan for implementing JKN has been laid out by the Ministry of Health in the Road-Map for National Health Insurance 2012-2019, a complicated and ambitious policy for a country that is targeting universal coverage for 252.8 million people. According to the plan, the transformation of five existing schemes (Jamkesmas, Askes, Asabri, Jamsostek, and parts of Jamkesda) into a single scheme under BPJS should be completed in 2014. Then, the BPJS will manage the health insurance scheme for all people who have paid the premium and all for whom it has been paid. As explained earlier, the BPJS system will cover both the premium payers as well as poor individuals whose premium is paid by the government under the Premium Payment Assistance (PBI). Monthly premium and membership fee (4.5% of salary) are made compulsory for all the workers, and the registration is to be completed in mid 2015. By 2017, all big and medium enterprises are expected to have the scheme. By 2018, the small enterprises are targeted to join. And by 2019 all Indonesian citizens and foreigners who work permanently in the country should be covered by the BPJS scheme.

The benefit packages to be covered by the BPJS include preventive and curative personal health care and rehabilitative services. Both medical and non-medical services such as ward accommodation and ambulance are also included. For the primary health care, the providers are Public Health Clinics, Private Clinics and general practitioners. And for the secondary and tertiary health care, the providers are both public and private hospitals. All the institutional arrangement has also been established under the master plan. Ministry of Health is responsible for setting regulations on health service delivery, tariff of services, medical prescriptions, and pharmaceuticals. Together with Ministry of Finance and the National Social Security Council, the ministry should also regulates monitors and evaluate the Universal Health Coverage (UHC) policy. The BPJS is responsible for registering health beneficiaries, administering membership, supervising health-care providers, and managing claims and complaints.

While in Thailand, according to Hanvoravongchai (2013), the National Health Security Office (NHSO), which serves as a state agency under the authority of the National Health Security Board (NHSB). According to the law, the board is authorized to prescribe the types and limits of Health service for (UCS) beneficiaries. The Board also appoints the NHSO secretary-general, who is in charge of NHSO operations.

Under the law, the NHSO is responsible for the registration of beneficiaries and service providers, and administers the fund and pays the claims according to the regulations set out by the NHSB.

Table 5.6 Characteristics of Thailand's three public health insurance schemes after achieving universal coverage in 2002

Scheme	Population coverage		Financing sources	Benefits package	Purchasing relation	Access to service	Per capita expenditure 2010
Social Security Scheme (SSS)	Private sector employees, excluding dependants	16%	Payroll tax financed, tri-partite contribution 1.5% of salary, equally by employer, employee and government	Comprehensive: outpatient, inpatient, accident and emergency, high-cost care, with very minimal exclusion list; excludes prevention and health promotion	Contract model: inclusive capitation for outpatient and inpatient services	Registered public and private competing contractors	US$ 71
Civil Servant Medical Benefit Scheme (CSMBS)	Government employees plus dependants (parents, spouse and up to two children age <20)	9%	General tax, non-contributory scheme	Comprehensive: slightly higher than SSS and UCS	Reimbursement model: fee for service, direct disbursement to public providers for outpatients; conventional DRG for inpatients	Free choice of public providers, no registration required	US$ 367
Universal Coverage Scheme (UCS)	The rest of population not covered by SSS and CSMBS	75%	General tax	Comprehensive: similar to SSS, including prevention and health promotion for the whole population	Contract model: capitation for outpatients and global budget plus DRG for inpatients	Registered contractor provider, notably within the district health system	US$ 79

Source: Health Insurance System Research Office, 2012

In other hand, the path ahead for universal health coverage in Thailand should remain focused on equity, evidence, efficiency and good governance (Health Insurance System Research Office/HISRO, 2012). The study by HISRO (2012) stated that for ambulatory care in health centres, district hospitals, and provincial hospitals were pro poor while university hospitals seem to pro rich. This result can be implied that district health centres, district hospitals, and provincial hospitals performed well in terms of pro poor utilization. However, the pro rich pattern of university and private hospital might be explained that main customers of these hospitals are CSMBS and SSS patients who are better off than UC scheme patients. This pattern was similar in hospitalization of inpatients (Thammatach - aree, 2011).

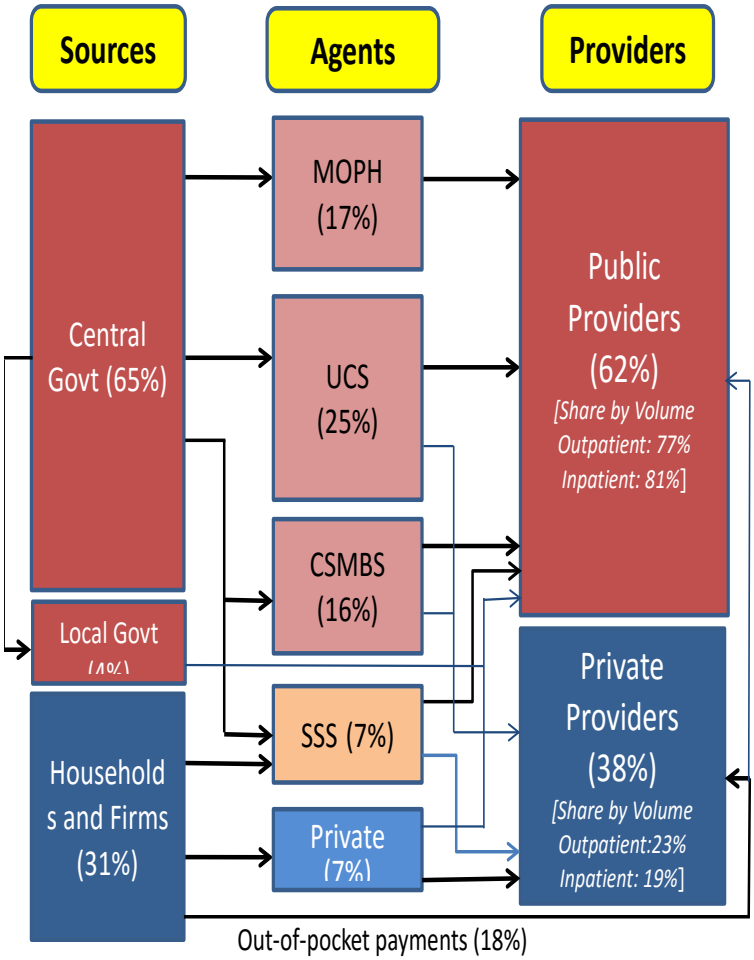
The NHSO receives a UCS budget from the government based on the number of beneficiaries it covers and the capitation rate per beneficiary. Each year, the NHSO

estimates the cost of service provision based on its unit cost studies and the number of beneficiaries it will cover. This cost per beneficiary (the capitation rate) is then submitted for approval by the government cabinet. The total budget based on the capitation rate is then submitted together with NHSO operating costs as part of the government budget to be approved by the parliament. Since its inception in 2002, the parliament has never revised the capitation rate approved by the Cabinet. However, the government could change the capitation figure requested by the NHSB, as happened in 2011, when the approved budget per capita is lower than the proposed capitation rate (Hanvoravongchai , 2013).

Further, the NHSO channels the funds to the contracted providers using several active purchasing mechanisms, with capitation and diagnosis-related groups (DRGs) the main payment methods. Payment for outpatient services is allocated based on the number of beneficiaries registered with a provider network (Contracting Unit for Primary Care, CUP). The capitation rate is adjusted by age composition, and the money is channeled directly to the CUP at the beginning of each budget year. For MOPH facilities, the amount transferred may be deducted for specific expenses, such as staff salary, at the central or provincial level depending on prior agreement between the NHSO and MOPH. Payment for inpatient services was allocated using case-based payment (following DRGs) under a global budget ceiling cap.

According to Hanvoravongchai , 2013, the main Actors and Fund Flows in the Thai Health System are described as below:

Figure 5.1 : Thai Health System



Sources: Data on fund flows are from National Health Accounts 2010 by the International Health Policy Program (IHPP)- Thailand. The diagram are non-MOPH public sector agents.

The Thai health financing system is financed mainly by general government revenue (tax-based financing). Wakatabe's et al (2016), showed that NHSO faces more difficult to convince the government in order to secure the capitation for preventive services due to less robust evidence than curative services. Therefore, the proportion of UC-PP has been marginalised from 15 to 10% of the UC budget by a higher increase in curative care. In 2013, 470 million US$ (7.20 US$ per capita) was allocated from government general taxes to these ser- vices for the entire population (65.4 million) (NHSO, 2013b). Under the prevention and promotion express- based payment (PPE) system, 248 million US$ (3.8 US$ per capita) was used for contracting units for primary care (CUPs) and primary care units (PCUs) provide service-based prevention (Evans et al., 2012). In 2013, NHSO also introduced performance-based financing (PBF) for 18

services (NHSO, 2013b). Seventy-five per cent of PPE is paid prospectively through age risk-adjusted capitation, while the remaining 25% is paid retrospectively if providers have achieved annual performance-based targets set by NHSO in consultation with MOPH.

According to Srithamrongsawat et al. (2010 cited by Hanvoravongchai, 2013) there were several UCS Impacts on the Health System and Health Outcomes. Based on an evaluation of the UCS in 2011 by a group of independent international experts (HISRO 2012, 120), the introduction and implementation of the UCS has resulted in at least the following six areas of impact on other components of health systems:

1. The approach of strategic purchasing adopted by the NHSO and the knowledge and know-how generated for its implementation indirectly influenced other major health insurance schemes to be more active in their purchasing. For example, the CSMBS and SSS have considered the use of the DRG system for inpatient care payments. The UCS decision to cover renal replacement therapy and antiretroviral treatment also influenced the SSS to expand its benefits package for their beneficiaries.
2. The UCS led to increased investment in the primary care system through improving the technical quality of, and coordination across, providers at the district level.
3. The UCS contributed significantly to the development of the information system in the health sector. The need to expand coverage to the population not already covered by other schemes led the NHSO to work with the Bureau of Registration Administration to improve the Ministry of Interior's vital registration system and birth registry to better capture the Thai population.
4. The increase in financial autonomy at the hospital level from the UCS payment system relative to the previous budgetary system allowed many health care providers to better respond to the increase in health care utilization by hiring more temporary staff or by providing additional compensation for higher workloads of their staff.
5. The UCS contributed significantly to strengthening the health technology assessment capacity in response to its demand for evidence for benefits package decisions. The UCS also supported the introduction and implementation of the Hospital Accreditation system.

6. The initial phase of the UCS saw higher staff workloads that demanded rapid adjustment from the health care providers to satisfy the increase in health service needs. The UCS focus on curative care also means public health functions, especially the areas that do not receive UCS funding, were adversely affected by a relatively lower level of funding for P&P.

While in Indonesia the scheme, Jaminan Kesehatan nasional (Natonal Health Insurance/JKN) was implemented by the newly-formed social security agency Badan Penyelenggara Jaminan Sosial Kesehatan (BPJS). It sought to improve the situation for citizens stuck in the middle of healthcare provision. Universal health coverage is defined as ensuring that all people have access to needed promotion, preventive, curative and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services. Universal health coverage has therefore become a major goal for health reform in many countries and a priority objective of WHO. JKN member consist of 126 Millons members has been achieved by August 2014, with 18.355 contracted health facilities, consisting of 16804 primary care facilities and 1551 hospitals.

According to SEARO (2014), there are four main JKN issues raised in 2014 include:

1. Availability and equitable distribution of health services in outer islands to serve JKN members and overall quality of healthcare services (Supply Site Readiness, WB 2014)
2. Provider payment: issues with long time laps for government primary care facilities in receiving capitation payment due to regulation on decentralization; and low tariff set in INA-CBG prospective payment.
3. Lack of JKN socialization activities for the people at large and coverage issues of people in the informal sectors.
4. Assurance of sustainable financing towards UHC.

In Indonesia, payments made to advanced level facilities were reformed through Ministry of Health regulation No. 69/2013 on the standard tariff for health services. These reforms were applied to level I and advanced level health-care service facilities under regulation No. 71 2013 on JKN health services. When Jamkesmas was first launched (2009–2010), payment of claims was based on the Indonesian Diagnoses-

related Group (INA-DRG) but this was developed into the Indonesian case-based groups (hereafter referred to as INA-CBG) and has been used since 2011. As of 2014, it is not only used for patients who are PBIs but also for non-beneficiaries.

The INA-CBG payment model is the amount of the claim that BPJS Kesehatan pays advanced health-care facilities for their services, according to the diagnosed illnesses. The tariffs are determined and issued by a team known as the National Case-mix Centre (NCC), under the Ministry of Health. Every year the team meets and processes data from hospitals and Jamkesmas to determine the tariffs and improve the methods used for calculating them. It allows greater transparency in managing and financing hospitals; • It provides an incentive for greater efficiency and better quality of service in hospitals, Also, case-based groups payments do not distinguish between high and low risk cases although the cost to the hospital is greater in high risk situations. This means that the case-based groups approach creates financial incentives for hospitals to avoid high-risk patients and this threatens the equity of access to health services (TNP2K, 2015).

The most important challenge for creating prospective payments, which in effect reducing out-of-pocket transactions, is to establish and continuously maintain the database on health service. Table below describes the database of health service tariff in Indonesia that has been evolving recently in the national effort to attain universal coverage (Kumorotomo,2014).

Table 5.7 Health service tariff in Indonesia

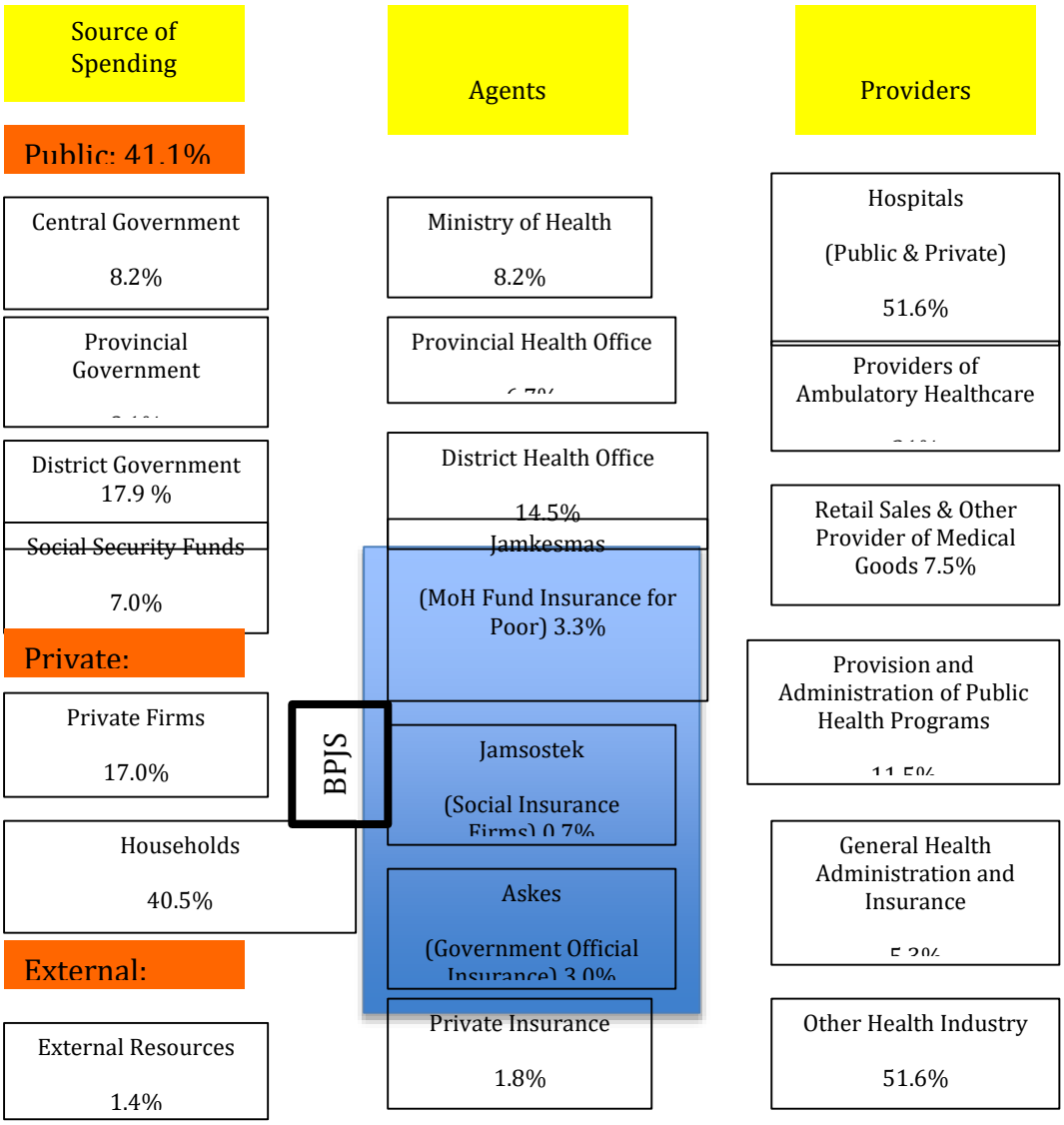
No.	Elements	INA-CBG (JKN, 2014)
1	Data coding	6,000,000 records
2	Costing benchmark	137 hospitals
3	Contributors	All classes in public and private hospitals
4	Case distribution	Normal
5	Trimming method	IQR
6	Tariff reference	Mean
7	Number of case-base group	1077 + 6 Special CMG
8	Tariff grouping	6

9	Proportion of implemented tariff	100%
10	Clustering	5 scales
11	Medical care class	3, 2, 1

Source: Wibowo, 2014 and Kumorotomo, 2015.

Under JKN, all citizens are now able to access a wide range of health services provided by public facilities, as well as services from a few private organisations that have opted to join the scheme as providers. JKN care aims to be comprehensive, covering treatment for everyday concerns such as flu through to open-heart surgery, dialysis and chemotherapy. Private insurance continues to play a role by providing for excess or additional coverage of services not included in JKN.

Figure 5.2 Health Financing and Provision in Indonesia



Source: Adapted from Soewondo et al, 2011; BPJS, 2014.

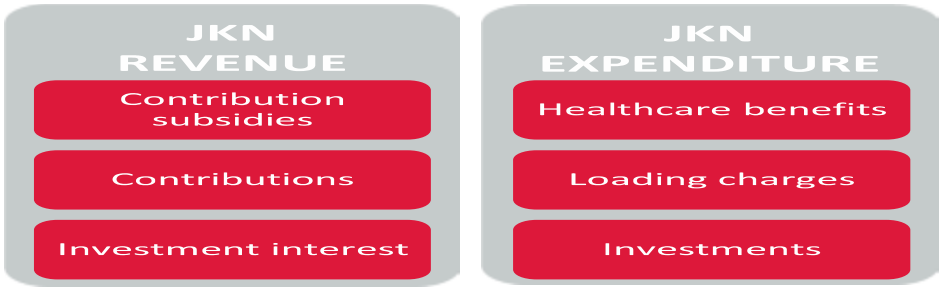
Figure above shows the general institutional arrangement for health financing and service delivery in Indonesia. Since 2014, the BPJS is aimed at integrating Jamkesmas, Jamsostek, Askes, and Jamkesda (which actually means insurance schemes managed by provincial and district governments). However, it turned out that most of Jamkesda schemes are currently managed by the provincial and district governments. There have been resistance from some of the provincial governors and district heads to fully integrate to the BPJS systems on the grounds that most beneficiaries at the local levels are in favor of the Jamkesda and they have been registered by the Jamkesda. As a

compromise, the BPJS is applying the so-called "bridging" program for registration and for reimbursement of health services provided by public as well as private hospitals. Therefore, in many provinces and districts the Jamkesmas is complemented and even substituted by the Jamkesda (Kumorotomo, 2015).

Health financing for BPJS is set based on premiums from employers, employees and the government general revenues as outlined below. Payment of the individual contributions is an essential component in the design and management of the overall Social Health Insurance system, with estimates developed to be actuarially correct. Funding for the scheme is made up as follows:

1. Pooling of funds from contributions of individual members;
2. Subsidized contribution for those below the poverty line (PBI) from central and/or local government;
3. A structuring the contribution of individual members currently outside the insurance system.

Figure 5.3 Financial sustainability of the JKN programme

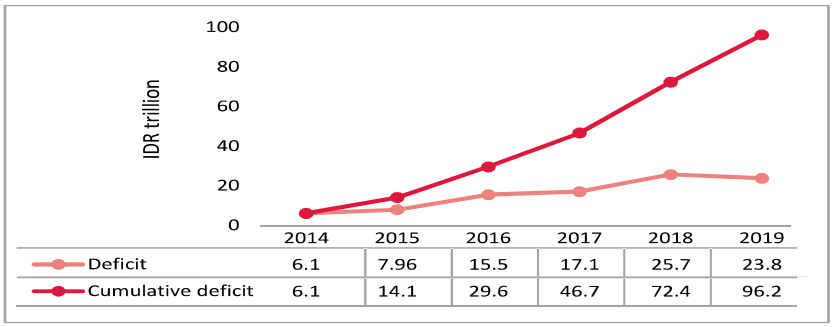


Source: Hidayat (2015).

The contributions for the poor and near-poor are paid by the government. In 2014, 86.4 million people were eligible for contribution assistance (known as PBI) and the GOI spent IDR 19.9 trillion (equivalent to US$ 1.43 billion) financing PBI. In 2014 the JKN scheme exhibited a rather large financial deficit with a medical claim ratio of 115%. This policy brief presents an assessment of the medium-term financial sustainability of JKN over the next five years. In 2014, the estimated costs PMPM were IDR 31,812, while the average contribution amounted to just to IDR 27,696. Dividing the costs by the contribution results in a claim ratio of 114.9%. It is obvious that JKN contribution levels are inadequate to cover the health care services, resulting in a deficit of about 15% or IDR 4,116 PMPM. In future, the average JKN contribution could rise

from IDR 27,696 PMPM to IDR 34,020 PMPM in 2019, an average increase of 4.6% a year. This projected rise is predicated on rising salary levels in the formal sector, a higher share of members from the informal sector, an increase of PBI subsidies and an assumedly better collection rate (Hidayat,2015).

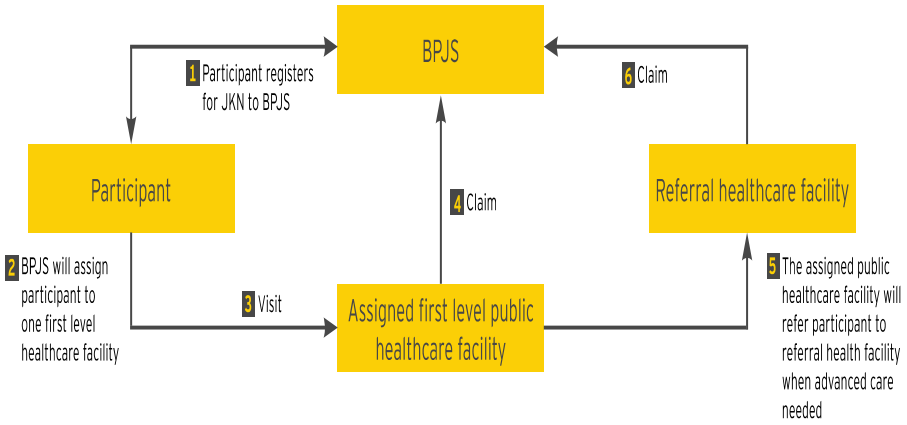
Figure 5.4 Financial state of JKN (IDR trillion) 2014-2015



	2014	2015	2016	2017	2018	2019
Deficit	6.1	7.96	15.5	17.1	25.7	23.8
Cumulative deficit	6.1	14.1	29.6	46.7	72.4	96.2

Source: Hidayat, 2015.

JKN operates on cashless referral model - refer to the diagram below for an illustration of claim procedures.



Source: Ernst and Young Indonesia, 2015

BPJS Kesehatan has been suffering from a deficit of claims it has paid against premiums it has received since late 2014. In 2014, the deficit stood at Rp 1.54 trillion, with Rp 42.6 trillion paid out in claims and Rp 41.06 trillion received in premiums. The country's total expenditure on health (TEH) has three-fold increase in the period 2005-2012, from IDR 28.4 trillion in 2005 to IDR 252.4 trillion in 2012; or from IDR 357.800 in 2005 to IDR 1.055.100 in 2012 in terms of percapita per year. As % of GDP, TEH has increased from 2.8% in 2005 to 3.1% in 2012. Further analysis found that the

general government expenditure on health has increased around 10% share from 28.4% TEH in 2005 to 39.2% TEH in 2012. Therefore, by percentage of TEH, the private expenditure has experienced 10% share reduction from 71.6% TEH in 2005 to 60.8% TEH in 2012 (Soewondo, 2014).

Conclusion

Based on the Indonesian's JKN in Indonesia and UC implementation in Thailand, both of them experienced :

1. Thailand has one of the most complex health care systems in Asia. Prior to reform, there were about six different health benefits schemes, targeting different groups of people with different benefit packages, compare to Indonesia which has started UHC Policy in 2014, and it only has one scheme of UHC Policy with two different category of participants.
2. The Evaluation of UHC in Indonesia and Thailand results in varies remarks, but most of the results have higher remarks in Thailand.
3. The perception of respondents on implementation both UC and JKN are varies. It has 5 parameters in the measurement such as: 1.Standart of Procedures of public hospital, 2. Communication between agencies of UHC Healthcare, 3. Medical human resources readiness, 4. Convenient Facilities and infrastructure, and 5. Medicine sufficiency. In Thailand, the result shown that the most higher remark is in parameter Standard of Procedures of public hospital 4.68, while the lowest remark is in parameter Convenient Facilities and infrastructure is 4.35. In Indonesia the highest remark is in parameter Convenient Facilities and infrastructure 4.20, while the lowest is parameter Communication between agencies of UHC Healthcare 3.77 only.
4. The quality of service in Thailand shows the better result compare to Indonesia. Continuous care services in Thailand has the highest result of 4.67, while the highest result of Indonesia in the same parameter has the result for 4.17.
5. For insurance coverage budget both are significantly increasing as well as its deficits. The governments of both countries need to address the constraints in providing benefits packages and payment mechanisms. The governments should building a strong pooled-fund for universal health coverage requires institutional arrangements that are responsive to financial efficiency, benefit equity, and continuous commitment giving services and high quality of health services to the poor. Finally, there is a need to balance between supply-side and demand side for services.

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