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Improving Policy Model of Universal Health Coverage Policy : A Comparison Study between Indonesia and Thailand

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Thailand has been implementing UHC for almost fourteen years, and on the other hand, Indonesia entering the third year of UHC. 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 research seeks to provide policy model of UHC in these 3 important aspects particularly in financial model, improvement quality service and simplify referral service of current situation. The analytical approach of this study is derived from a qualitative research methods. In this research, the qualitative model used the interview guide and focus discussion group to explore the information. FGD is conducted both in Indonesia and Thailand with the certain respondents and and key informen. The research results shown in the evaluation of UHC in both countries are still facing state financial burden for the health care, lack of health-care service facilities particularly at primary health units and the procedure of referral system needs to be symplified.

Keywords: Policy Evaluation, Policy Model, Universal Health Coverage.

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I. Introduction

1.a. Background

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 hardship⁴. 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 program⁵.

⁶ A research conducted by National Team for the Acceleration of Poverty Reduction⁶, 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

⁴ Institutional analysis of Indonesia's proposed road map to universal health coverage, Amanda Simmonds and Krishna Hort, 2013.

⁵ Universal healthcare coverage in Indonesia One year on, The Economist Intelligence Unit Limited 2015.

⁶ The Road To National Health Insurance (JKN), 2015, National Team for the Acceleration of Poverty Reduction/TNP2K.

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 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)⁷.

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

⁷ *ibid*, page 14.

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 payment that pays providers based on the number of people under their responsibility (contracting unit)⁸. 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.

1.2. Research Objectives

This research generally is an evaluation study on UHC both Indonesia and Thailand. This research

⁸ Health Financing Reform in Thailand: Toward Universal Coverage under Fiscal Constraints, Piya Hanvoravongchai, The World Bank, Washington DC, January 2013.

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 research seeks to provide policy model of UHC in these 3 important aspects particularly financial model, improvement quality service and simplify referral service of current situation.

1.3. Significance of the Study

Both Indonesia and Thailand still facing a lot of problem in this UHC Policy. Study by Mutiarin, et al⁹. shown that Thailand has one of the most complex health care systems in Asia,

⁹ Evaluation of Universal Health Coverage Policy : A Comparison Study between Indonesia and Thailand, Dyah Mutiarin, et. al. ICONPO VI, Philippine, 2015.

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. Standard 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.

Over all, Universal Health Coverage (UHC) in ASEAN countries

1.4. Conceptual Framework

a. Universal Health Care Policy

WHO stated that Universal health coverage is the single most

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 health 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).

Thus, the significance of the study of this research is to understand that 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 (GDP), and become the burden for the National Budget allocated each year. this research seeks to provide policy model of UHC in these 3 important aspects particularly financial model, improvement quality service and simplify referral service of current situation.

2 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 al , 2012, 933). In his recent study Lagomarsino et al (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 al, 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 1. National Level Schemes of UHC

Year of reform	Revenue generation (sources of revenue ordered by proportion of contribution)	Risk pooling				Service delivery	
		Single	Multiple	Primarily public	Mixed	Primarily private	
Intermediate-stage reform countries							
Ghana (NHS) ^a	2003	Value-added tax, investment income, formal-sector payroll contributions, household premiums	x			x	
Indonesia ^a (BPJS) ^b	2004	General government revenues, formal-sector payroll contributions		x			x
Philippines (PhilHealth) ^c	1995	General government revenues, formal-sector payroll contributions, household premiums	x				x
Rwanda (Mutuelles) ^d	2000	Donor funding, general government revenues, household premiums, formal-sector payroll contributions		x	x		
Vietnam (VSS) ^e	2002	General government revenues, formal-sector payroll contributions	x			x	
Early-stage reform countries							
India ^a (RSBY) ^f	2008	General government revenues		x			x
Kenya ^a (NHIF) ^g	2002	Formal-sector payroll contributions, household premiums		x			x
Mali ^a (Mutuelles) ^h	2009	General government revenues, household premiums	x		x		
Nigeria ^a (NHS) ⁱ	2009	Formal-sector payroll contributions, general government revenues, household premiums, donor funding	x				x

For purposes of this table, we focus on the main national-level schemes. NHS=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 al, 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 al, 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 Delivery¹¹, 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. Health Care Policy Evaluation

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.

Study that had done by World Bank¹⁰ 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.

Mutiarin, et.al., found that with the official estimates indicate that

⁸ 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.

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 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 year¹¹.

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).

Study by Simmonds and Hort (2013), state that there were potential inequalities in implementing universal health coverage in Indonesia. Indonesia experience Poor quality and unequal distribution of government health facilities have been issues in implementing UHC. While in Thailand, the UHC has been implemented since

¹¹ Evaluation of Universal Health Coverage Policy : A Comparison Study between Indonesia and Thailand, Dyah Mutiarin, et. al. ICONPO V, Philippine, 2015.

2002. UHC in Thailand known as Universal Coverage (UC) Thai government passed the National Health Security Act in 2002. UHC become one of the most important social tools for health systems reform in Thailand. The new Universal Coverage Scheme (UCS), combined the already existing Medical Welfare Scheme and the Voluntary Health Card Scheme. (Jurjus, 2013).

1.6. Methodology

This evaluation is based on the policy evaluation of health insurance in the selected areas. Most of the data in this study will be qualitative in nature. Rossman and Wilson 1991 in Driscoll, et.al. 2007). In qualitative research, 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. Intense discussions among the UHC implementer and the health care units will be conducted within small groups, e.g. 5 to 20 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.

Data using in this research will be primary data and secondary data. Primary data will be collected through FGD. There are considerable constraints to obtain data from the primary sources, and in this way, secondary data sources are particularly important. Secondary data

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.

consist of all evidence in the forms of documents and records.

II. Findings and Results

2.1. Profiles of UHC Financial in Indonesia and Thailand.

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 2. 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; include 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

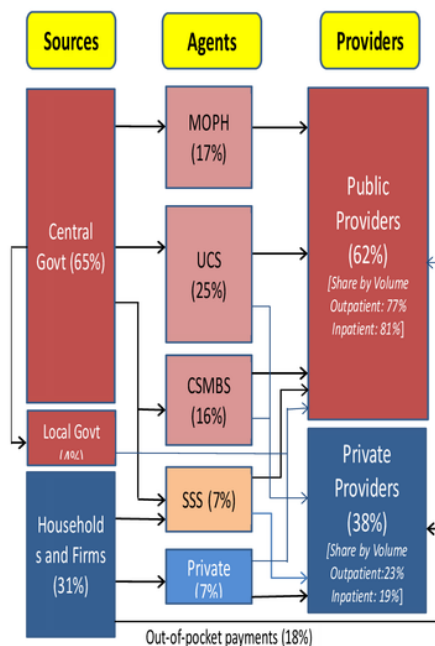
(Thammatach - aree, 2011).

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:



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 services 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 cap 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 (National 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).

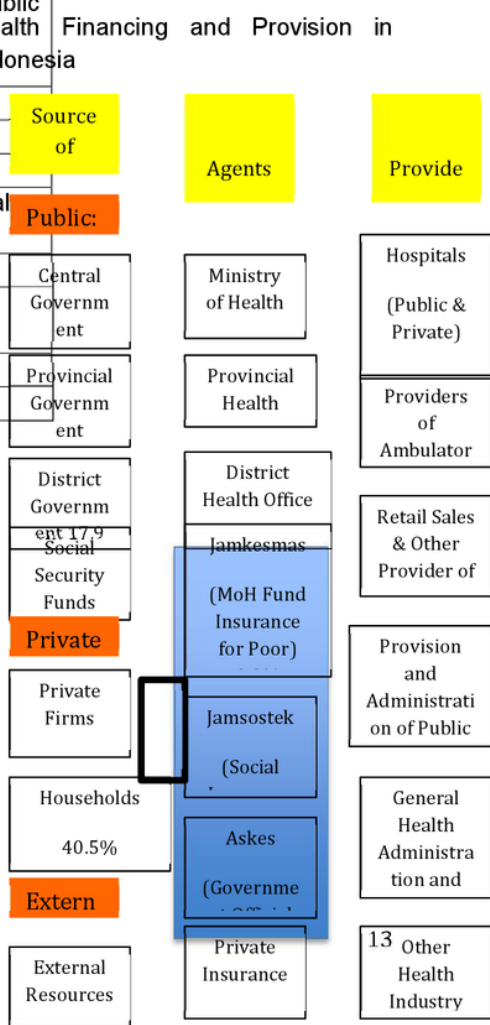
providing for excess or additional coverage of services not included in JKN.

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).

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



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

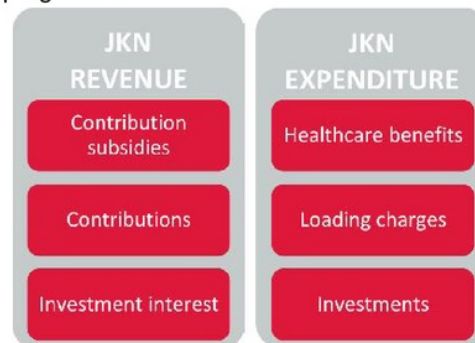
Figure above shows the general institutional arrangement for health financing and service delivery in Indonesia. Since 2014, the BPJS is aimed at integrating Jamkesmas, Jamsostek, Askes, and Jamkesda (which actually means insurance schemes managed by provincial and district governments). However, it 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.

Financial sustainability of the JKN programme



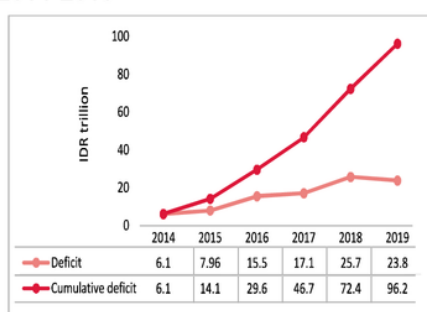
Source: Hidayat (2015).

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

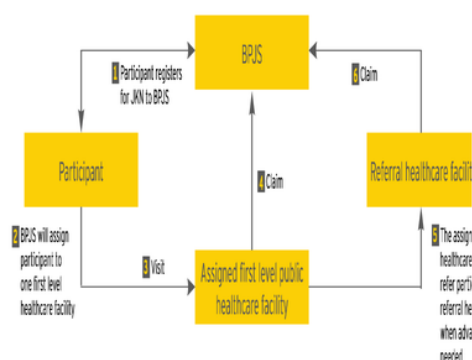
predicated on rising salary levels in the formal sector, a higher share of members from the informal sector, an increase of PBI subsidies and an assumedly better collection rate (Hidayat,2015).

Financial state of JKN (IDR trillion) 2014-2015



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, facing the challenge for insurance coverage budget which is 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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