PUBLIC POLICY IN THEORY AND PRACTICE

Dyah Mutiarin
Suranto
Awang Darumurti
Amporn Tamronglak

Editor : Hazel D Jovita

Published by:
JKSG UMY
IP UMY and MIP UMY
2017
Acknowledgments

This book is a product of a Joint International Research Collaboration between the Department of Government Affairs and Administration Program - Faculty of Social and Political Science of Universitas Muhammadiyah Yogyakarta and the Department of Public Administration- Faculty of Political Science, Thammasat University. This book entitled as "Evaluation of Universal Health Coverage Policy: A Comparative Study between Indonesia and Thailand" is funded by the Ministry of Higher Education and Technology of Indonesia from 2015 to 2016.

We would like to express our sincere gratitude to the Rector of Universitas Muhammadiyah Yogyakarta, Dr. Ir. Gunawan Budiyanto MP., and Prof. Dr. Amporn Tamronglak of Thammasat University, who have made the publication of this book possible. We also thank all the writers for their hard work in finishing this book.

This book is divided into 2 themes: Theoretical Perspective and Public Policy Practices. Thus, the book explores the theories and practices of the role of public policy particularly in health sectors. We hope this book will benefit the readers, academicians, lecturers, scholars in examining in terms of public policy and its practices in health sector.

FOREWORD

Of the many social problems that every community face today, perhaps you have been asking what the governments are doing and why it is not working. With these questions, you might also have thought of answers that could be entirely true or probably not. As a student and facilitator
in the study of politics, society and government, I believe that the dynamic nature of public policy reveals the level of commitment among State actors.

This book lays down different theories of public policy and public policy implementation with emphasis on the basic concepts and peculiarity of each theories. Every page of this book reveals the vast experience and knowledge of the authors both in terms of public administration theories and practices. As distinguished academicians, the authors are able to immerse themselves in various social concerns such as health services. This book explains how health care services are carried out in Thailand and Indonesia, the challenges that each country faced in the course of implementation and the factors that led to its success. The analysis on each country’s health care systems provides a simplified, clear and good understanding of how the theories of public policy implementation explain social conditions particularly the health care services in Thailand and Indonesia.

I have come across of several academic outputs on public administration and this is one of the most liberal at the same time remedial books that I have ever read. While each view towards the state of social services in the country might be guided by empirical findings or first-hand experiences, however, there is value in understanding the nature of public policies in place in order to objectively determine the level and factors influencing the commitment of State actors. And that is the heart of this book.

I consider this work as a gift to students, teachers and practitioners of public administration. Among all the interesting and liberating academic outputs today, “The Evaluation of Universal Health Coverage Policy: A Comparative Study between Indonesia and Thailand” is definitely one of those.

TABLE OF CONTENTS
CHAPTER I.
THEORETICAL PERSPECTIVE
1. Introduction 1
2. The Definition of Public Policy 1
3. The Public Policy Cycle 5
4. Policy Making Processes 8

CHAPTER II.
PUBLIC POLICY IMPLEMENTATION AND EVALUATION 13
1. The Definition of Policy Implementation and Policy Evaluation 16
2. Factors Influencing Policy Implementation 16
3. Policy Instrument 30
4. Policy Implementation Actor 33
5. Characteristics of policy makers 37

CHAPTER III. PUBLIC POLICY PRACTICES 40
1. Background 46
2. Implementation of Health Policy 46
3. Health Care Policy Evaluation 50
4. UHC in Indonesia 62
5. UHC in Thailand 74
6. Indonesia’s JKN Finance 90
7. UHC Financial in Thailand 97

PUBLIC POLICY IN THEORY AND PRACTICE
CHAPTER 1. THEORETICAL PERSPECTIVE

1. Introduction
In line with the ongoing democratization process in Indonesia, at least there are three demands that must be satisfactorily answered by the stakeholders, namely: 1) good understanding about the political process that affects the policy; 2) the necessity to create a participative policy formulation system; and 3) that the result of the policy formulation must be able to answer the real problem in the society. These three challenges surely need an understanding about comprehensive process of policy formulation, policy agenda formulation, legitimacy, budgeting up to implementation and evaluation toward formulated policy. The policy formulation cycle should be understood not only on the theoretical level but also in terms of its relevance with respect to public policy processes.

2. The Definition of Public Policy
The common definition of public policy is “a proposed course of action of a person, group, or government within a given environment providing obstacles and opportunities which the policy was proposed to utilize and overcome in an effort to reach a goal or realize an objective or a purpose”.

Public policy 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. Lester (Wibowo dan Tangkilisan, 2004:45) suggests a definition for public policy: “the process or series of decision or government’s activity designed to handle public issues, whether it is real or still planned (imagined).”

Public policy has certain characteristics where the policy will be formulated, implemented and evaluated by an authority who are either a member of legislative, executive, or judicial department. Public policy is also defined comprehensively as the sum of government activities, whether acting directly or through agents, as those actions have an influence on the lives of citizens. Such a definition would include what is called policy implementation.

Robert Eyestone (Winarno, 1989: 2) states that public policy is the relation between a unit of

---


government with its surroundings. While according to Anderson (Winarno, 1989: 16), public policy: “policy is action that has a stated aim by the actor or a number of actors in settling down a matter or problem”. The understanding of public policy according to Easton (Winarno, 1989: 15) is “the connection between a unit of government with its surrounding.” Public policy basically is an effort based on rational thinking to achieve an ideal goal, such as justice, efficiency, security, freedom, and many goals from the community itself (Stone, 1997:37).

A simple definition proposed by Peters (1996:4), that public policy is the sum of the activities of governments, whether acting directly or through agents, as it has an influence on the lives of citizens. There are three stages of policy according to its influence to the society these are: policy choices, when the decisions are made by the politician, public official or parties that have the authority to make public policy; policy outputs, when the decision is committed by the government with real action, the making of the law, expense allocation, the formation of team work; and policy impacts, that is the real impact of policy selection that has been brought out to the target community and to the society as a whole.

Another definition according to Friedrich (1967), is that public policy is “a proposed course of action of a person, group, or government within a given environment providing obstacles and opportunities which the policy was proposed to utilize and overcome in an effort to reach a goal or realize an objective or a purpose.” It is then obvious that public policy is not supposed to only concern with individual interest or narrow interest of a group, but it also concerns with common objectives, public interests and the whole citizen in general.

From the several concepts of public policy stated, it can be concluded that public policy is understood as a process or series of government’s action (whether it is to perform or not to perform something) which located to the whole society that has certain goals, and that series of action is meant to settle down a matter and meet the need/interest of the public, for example efficiency in public services, attainment of justice, security and freedom.

3. The Public Policy Cycle

The common approach of understanding how a policy is made is to identify a certain sequence of steps such as inquiry of problem, identification of goals, design and evaluation of alternatives and the choice of decision. This way of looking at policy making is useful for imposing initial order or structure on a complex process. But it risks viewing policy making as though it were mechanistic and controlled by one governing mind, which is clearly not the case in real life. It does not adequately capture the complexity of the policy process and the different ways in which policies emerge. As Lindblom has stated, sometimes policies spring from new opportunities, not

---

from problems. Sometimes policies are not decided upon but nevertheless happen. In other words, deciding not to act is also a policy decision. This is in line with a straightforward definition that “public policy is whatever governments choose to do or not to do.”

It is obvious that there is a close relationship between politics and policy. Politics can be defined simply as the activity by which an issue of public concern is agitated or settled at various levels of government. Policy is thus the outcome of the political process. People engage in political activity – voting, electioneering, communicating with public officials, holding office – because they hope to affect public policy in some way. Public policy does not only emphasize on what is proposed by the government, but also emphasize on what actions and conducted by the government to solve public problems with the allocation of resources and authority that binds to the community. Public policy: 1) its form is action that is done actively or not from the available alternative option to solve the problems; 2) the creator is a government of actors authorized to create it; 3) its process is a planned and systemized action that leads to the goal; and 4) the target is the society or general interest.

The discussion about public policy will always be about public policy as mechanism that comes from the process of political system. Public policy appears from a process of inputs conversion that started from the demand or support from the environment in the form of issues or problems growing in the society. The output from the inputs conversion is on the priority scale and furthermore chosen based on the urgency to become a public policy which aims to solve previous issues or to achieve the goal and target that has been set before.

One of the approaches to understand how the policy is made is by identifying public issues and problems that the society has to face. Thus, policy usually seen as something that has certain stages or steps, like determining issue, target identification, finding alternative solution and selection of certain decision. This approach often ignores special political aspects, policy complexity process and the fact that the appearance of a policy can be different from each other. As stated by Lindblom (1968:4), “sometimes policies spring from new opportunities, not from problems.” Since public policy is a series of decision that involves many actors whether it is individual or institutional, a more comprehensive understanding framework is needed to explain how they set up an agenda and make a consideration in a decision.

A more theoretical explanation is made by Allison (1968) through her extensive study toward government policy at a critical point. Basically, there are three models that can be used to understand the creation of public policy, they are:

1. Rational actor model
   This model sees government as a black box or an individual actor that acts rationally. Government’s action and decision are rational option that has the aim to achieve certain

---


purpose in limit option and the knowledge of consequence that can happen. Thus, government’s action is seen as realization that suits the purpose or the target.

2. Organization process model
The analysis toward government policy can also be done by viewing the policy as the output of the organization that means to achieve their purposes. Because the organization has a structure, coordinating system, and cooperating units, therefore the standard operating procedures (SOP) and organization’s program will be the most important reference to do the analysis. Organization’s options, incremental changing, long-term planning, and administrative expedience are some of the general concepts that are often used to understand public policy according to this model.

3. Bureaucratic political model
In this model, government’s action is understood as political product from bargaining process. Thus, the actor’s position, priorities, narrower perception, interest, position, game rule and political power are important elements to analyze. The statement that: *where you stand depends on where you sit*, is one of the most important factor to understand how a government’s decision is finally taken.

After a public issue formally stated in policy agenda, the next important stage is to formulate a plan to deal with the public issue. Basically, the policy formulation is connected with how to formulate these plans. According to Cochran and Malone (1999:46), policy formulation is connected with the question “what” in the effort to dig policy alternative that can be done. What plan that can be lined to solve policy issue? What are the purpose and the priority that want to be achieved? What option is available to reach the purpose? What are the costs and the profit related to that plans? Basically, the policy formulation involves not only policy purposes but also several alternatives (or program) to achieve the purpose. Inside that, it is important to understand that the form of issue formulation often decides what the policy alternative is that can be recommended.

Some contemporary modification toward rational theory is also relevant with how a policy option is established between several available alternatives. The other varieties from the rational option theory or also called the public choice theory, is that the study about collective decision made by an individual or a group through political process to maximized their interest. Getting strong influence from economic theory, public choice theory is based on the assumption that the decision maker individuals are actually rational and emphasize both political sector or economic sector (Buchanan, 1978). According to public choice theory, people act differently in political field because of the different institutional order and not because they do not have interest.

In policy formulation matter, basically there is no prescription about how a policy is taken and why an alternative policy is better than the others. Policy formulation is a complicated process; *“(it is) a difficult game to play because any number of people can and do play, and there are few rules”*, said Peters (1996:59). In most cases, almost all actors or policy doers with different background can involve in policy inquiry formula. However, it can’t be denied that there are several kinds of actors who are more important than the other actors in policy formulation. A classic model of policy formulation has been made since the beginning by Anderson (1996:53). He explains that public policy is the product of interaction between members of legislative,
executive, administrative institutions and judicial institution. In this role, these parties are influenced by external group, political parties and special interest group or public in general.

Speaking about public policy as state’s instrument, there is an important thing; target in public policy’s purpose attainment, because public policy basically is made with the purpose to achieve desirable affect or to get the result and better condition for the country and the people. That is why every public policy must be implemented so better result and condition can be achieved. But often in the implementation process, a policy cannot be easily done even sometimes fails because of many obstacles. Based on the target in the purpose attainment in public policy as stated before, it has to be knows the way to achieve the target in purpose attainment where we see the public policy as continuously process.

According to Jones (1984), the policy process includes: (1) perception / definition; (2) aggregation; (3) organization; (4) representation; (5) agenda setting; (6) formulation; (7) legitimating; (8) budgeting and (9) implementation. Furthermore, Ripley (1987) explained that the public policy stages are as follows: (1) agenda setting (2) formulation and legitimation of goals and programs (3) program implementation performance and impact, (4) decision about future of policy programs.

As described in Winarno (2002:28-29) that policy implementation is part of five policy cycle stages, they are:

1. Agenda setting. The stage when the official put the issues to the public agenda. Before the issues compete, they are put into policy agenda first. Eventually, some issues get into policy maker’s agenda.
2. Policy formulation. The stage where every issue that have been put into policy agenda are being discussed by the policy makers. Those issues are defined to come up with the best solution. The solution comes from the available alternatives.
3. Policy adoption. The stage when all the policy alternatives are offered by the policy makers, eventually one of the alternatives is adopted with the support from major legislatives, consensus between institute director and court decision.
4. Policy implementation. The stage when a policy program that has been taken as issue solution alternative is done by the administrative corporation that mobilized financial resources and human resources, it is also done by the lower level of government’s agents. In this stage, several interests will compete with each other where some policy implementation gets the support from the implementer.
5. Policy evaluation. The stage where the policy that has been done will be estimated or evaluated to see how far the policy that has been made can solve the issues.

4. Policy Making Processes

Another important element for understanding policy-making process is the circumstances in which policy elites make decisions. Grindle and Thomas\(^7\) identify two typical kinds of

circumstances, perceived crisis (macro-politics) that concerns on most prevalent under crisis situations mean that policy elites pay particular attention to a policy problem which affect the legitimacy of the regime they serve or the overall survival of the regime and politics-as-usual (micro-politics) that concerns on most relevant in the non-crisis ridden circumstances including concerns about the more parochial demands of specific interest groups, the use of policy resources to maintain clientelistic relationships, the parcelling out of policy resources to ensure political control, and the more short-term interests of political elites.

The distinction between macro-politics and micro-politics suggests that the definition of politics by policy elites shifts under different circumstances means that different sorts of politics predominate under different conditions and at different times. Public policy making explains that the policy process will never come to a final decision and that the “policy process is not one process but a series of sub-processes”.

Policy formulation is a difficult game to play because any number of people can and do play, and there are few rules. At one time or another, almost every kind of policy actor could be involved in formulating policy proposals.

A classic model of the policy formulation process is formulated by Anderson who states that public policies constitute the product of interactions among legislature, executive, administrative agencies and judiciary. The external groups of political parties and interest groups and the citizens at large are influencing the process of policy formulation process.

The model focuses on what Lindblom calls “the proximate policy makers”, which consists of the president, legislators, judges, interest groups and also includes many unofficial actors who might have significant influence.

Various parties (e.g. think tanks, shadow cabinets, technocrats, professionals, or policy analysts) with relevant expertise are able to influence policy formulation since expertise begins to play a large role, given that the success or failure of a policy will depend to some degree on its technical feasibility as well as its political acceptability.

The role of experts and professionals as well as interest groups and individual citizens has increased as a result of the intensification of social interactions. There are more actors with various values who come in and influence modern public policy and the tendency toward a policy ‘polyarchy’ is almost inevitable. The growing importance of pluralistic decision

---


9 Peters, American Public Policy, p. 59.

10 Anderson, Politics and the Economy, p. 53.


making systems and the more complicated relationships among parties, bureaucracy and interest groups in policy formulation have been found in many developed countries, such as Norway, Japan, Sweden, the Netherlands and Britain.\(^{14}\) What occurs in developed countries may not occur to the same extent in developing countries but pressure groups outside the government or the so-called extra-administrative institutions are also common in most developing countries.\(^{15}\) In Indonesia, it has been predicted even during the authoritarian New Order administration that greater social confidence will lead to a more pluralistic and organised sharing of power and communication among various levels of Indonesian society.\(^{16}\) Interest groups have played an increasing role in the public policy process, especially with the onset of reformasi (reformation) and greater openness following the economic crisis in 1998.\(^{17}\)

Most public policies also have multiple objectives. A major issue in policy decision-making is how much of one objective is to be achieved in relation to others.\(^{18}\) The government actors and those outside the government have to face the same problems of conflicting objectives. The problems of multiple objectives are faced by all actors in varying degrees (including non-government actors with their behaviour, their demands, and their actions). A key question to be answered in explaining policy development is: How do the policy actors choose a particular action or policy from a number of alternatives? Seeing things or understanding things from the actors’ viewpoint is required for explaining actions and behaviours. In other words, to understand actions is basically to understand how the actors “rationalize” their choice of action and can be started from the perspective of each actor, his goals and understanding of the situation facing him. Classic work by Herbert Simon\(^ {19}\) states that rationality pertains to the selection of preferred behaviour alternatives in terms of some system of values. Along with the concept that it is rational if the actor sees it as correct behaviour for maximizing given values in a given situation, Parsons\(^ {20}\) uses the means-end relationship, accepting the end as given without inquiry as to its rationality or ‘reasonableness’. Because the individual’s information is limited, individual rationality is also limited, therefore, in evaluating and choosing among action alternatives, individuals are in effect characterised by ‘bounded

---

14 Richardson & Jordan (eds.), *Governing Under Pressure*, p. 169.


17 Arief Budiman et al., *Reformasi: Crisis and Change in Indonesia* (Clayton: Monash Asia Institute, 1999).


rationality’.  Thus, what needs to be explained is the individuals’ “subjective” or “bounded” rationality.

Policy formulation is concerned with such specific plans for attacking the problem, once a formal public problem is on the agenda. According to Cochran and Malone, policy formulation relates to the ‘what’ questions associated with generating alternatives. What is the plan for dealing with the problem? What options are available to achieve goals? What are the costs and benefits of each of the options? The formulation of a policy proposal ordinarily includes not only a statement of the goals of the policy, but also various alternatives (or programs) for achieving the goals. It is also important to note that interactions among actors are influenced by various factors (values, political party affiliation, constituency interests, public opinion, and decision rules). Policy actors are also determined by contextual setting (culture, history, administrative system, etc.) and there will be a difference between actors from developed countries and developing countries. However, the real issue is whether we can formulate the various factors in general or conceptual terms so that the framework can be used to guide research across various countries. For example, Thomas and Grindle explained experience from twelve cases in developing countries and showed that decision-making elites filtered policy options basically through four lenses, namely: the technical advice they received, the impact of their choices on bureaucratic interactions, the effect of potential changes on political stability and political support, and their concern about relationships with international actors.

The study on how policy makers interact to make decisions should not be confined only to legal-formal arrangements by which things are ‘supposed’ to be done. Banfield has argued in the context of urban politics in the United States, because of inequalities of wealth and status and corresponding inequalities of influence, many believe that what is called democracy is mostly sham. The big decisions are made by private persons, especially the very rich who use their influence to enforce the decisions they have secretly made. Anyone who resists the decisions of the ‘power elite’ is ignored or crushed, if necessary by coercive means. Influence in this context means the ability to get others to act, think, or feel as one intends. To concert activity for any purpose or to decide a particular policy, a more or less elaborate system of influence can be observed: the appropriate people are persuaded, deceived, coerced, inveigled, or otherwise induced to do what is required by the power holders.

---


Aside from party loyalty and deference, Banfield and Wilson\textsuperscript{26} pointed out some mechanisms for the centralisation of influence to prominent actors, namely:

1) Indifference and apathy (when some actors in effect give over their authority to others by failing to exercise it because they do not care what happens).

2) Inducement (when a promise of reward (or threat of punishment) induces the possessor of authority to exercise it in the way someone else demands, thus in effect turning the authority over to that someone else).

3) Salesmanship (the possessor of authority may be induced by rhetoric or by the exercise of charm or charisma to put it at the service of another).

Nevertheless, it should be noted that public values constitute the boundary for public policy. Common values and beliefs inform, guide, and limit the behaviour of political decision makers.\textsuperscript{27} The basis for verbal formulation is served by these values and beliefs. In addition, time spent discovering and evaluating the probable consequences of a proposal is not necessarily wasted. Policy makers or the government must somehow also legitimise each policy choice. Policy analysts, in their pursuit of elegant solutions and innovative policies, frequently forget a mundane point that no matter how correct a policy choice may be, it is of little practical value if it cannot be legitimised, but their forgetfulness can present a real barrier to their success.\textsuperscript{28} Therefore, policy makers must understand the process of legislation.

In more democratic systems, public policy making might become more complicated as it has to accommodate various actors even though many argue that the quality of policies is better in democratic systems.\textsuperscript{29} In this respect, the role of executives, legislatures, judiciary, and other policy actions are equally important to improve the quality of public policies.\textsuperscript{30} To sum up, there are four theoretical elements that serve as important guide in public policy: actors, goals, actions, and interactions. The policy actors include those in formal government positions as well as those outside the government who have particular stakes or interests. The goals of each actors are often multiple and not always consistent, and those of various actors often conflict in various degrees. To balance these objectives, an action or selected policy alternatives will be taken. Interactions involve actors using the resources they have to influence others in various ways in order to pursue their desired goals according to formal and informal procedures. All of those point mentioned above have to be understood in terms of how they

\begin{itemize}
\item Anderson, \textit{Politics and the Economy}, p. 34.
\item Aaron Wildavsky, \textit{Speaking Truth to Power} (Boston: Little-Brown, 1979); Peters, \textit{American Public Policy: Promise and Performance}, p. 80.
\item For a good explanation about a complication in reforming fiscal policy under democratic system, see Jos Mooij (ed.), \textit{The Politics of Economic Reforms in India} (New Delhi: Sage Publications, 2005).
\item Mezey, for example, argued that the more legislative institutions were involved the more likely that policy formulation was to meet democratic criteria, the more executive institutions were involved the more likely it was to meet managerial criteria. Michael L. Mezey, \textit{Congress, the President and Public Policy} (Boulder, Westview Press, 1989), p. 189.
\end{itemize}
are subjectively seen by the actors involved, even if their subjective understanding is or turn out to be mistaken or “objectively” wrong.

The interactions of policy actors result in decisions called policy outputs that may take various forms and they consist of general policy in the forms of law and also the subsequent decisions that elaborate or specify the general outputs – in the course of implementation. Finally, policy development is a continual process of how policy actors perceive the policy outputs. Policies are seldom settled or determined once for all and policies that are “terminated” are often succeeded or replaced by subsequent policies. To speak of policy termination in such situations, Hogwood and Peters explained,\textsuperscript{31} is just “talking about the death of the caterpillar without noting the birth of the butterfly.” Most policy making in contemporary governance constitutes policy succession or policy maintenance and the majority of policy making in modern societies is the replacement of existing policies by new attempts at ‘solving’ the same problems.\textsuperscript{32} This is the case with policy making on fiscal decentralisation in Indonesia. Frequently, public policy may constitute no more than unplanned decision-making, just like what has been described as ‘humdrum’ by Hayward that means that policy making has no explicit or long term objectives\textsuperscript{33} on the British system of policy making.

\textbf{CHAPTER 2. PUBLIC POLICY IMPLEMENTATION AND EVALUATION}


\textsuperscript{32} Hogwood & Peters, \textit{Policy Dynamics}, p. 104 and p. 221.

\textsuperscript{33} Jack E.S. Hayward, “National Aptitudes for Planning in Britain, France and Italy” in Richardson & Jordan (eds.), \textit{Governing Under Pressure}, p. 40.
The recommended policy to be selected by the policy makers do not guarantee that the policy will succeed in the implementation. There are many variables that influence the success of the policy implementation both individually and institutionally. Implementation of a program includes the efforts by the policy makers to influence the behavior of the bureaucrat implementer to be willing to give the service and manage the behavior of target group. In many politic systems, public policy is implemented by government corporations. These corporations implement government’s works from time to time to give impact to their citizen. In classic state administration literature, politic and administration are separated. According to Frank Goodnow who wrote it in 1900, politics is related to the policy determination that will be implemented by the state. This is also related to justice value and what determination should be implemented or not to be implemented by the state. While administration, on the other hand, is related to what policy that will be implemented by the state, administration is related to fact declaration not what it should be. The consequence of the opinion above is the administration focuses looking at the efficient way, one best way to implement public policy (Anderson, 1979; Henry 1988:34).

However, often government institutions’ practices have to face works under macro or ambiguous law mandate; it forces them to make discretion, to decide what should be and what should not be done. Implementation involves the effort of the policy makers to influence what Lipsky calls as “street level bureaucrats” to give service or to arrange the behavior of the target group. For simple policy, implementation only involves one institute that will function as implementer, for example, the school committee’s policy to change the teachers’ method of teaching in class. On the contrary, for macro policy, an example is the poverty reduction policy in the village which involves many institutions in the implementation efforts in the district, subdistrict and village. Regarding the involvements of many actors in implementation, Randall B. Ripley and Grace A. Franklin, write as follow:

Implementation process involve many important actors holding diffuse and competing goals and expectations who work within a contexts of an increasingly large and complex mix of government programs that require participation from numerous layers and units of government and who are affected by powerful factors beyond their control (Ripley and Franklin, 1986:11).

1. The Definition of Policy Implementation

According to Ripley (1986, 4-5), policy implementation is “what happens after laws are passed authorizing a program, a policy, a benefit, or some kind of tangible output.” The definition shows series of activities that follow the statement about the purposes of the program and the sought results by the government’s official. Implementation includes actions and non-action that are being done by variety of actors, especially the bureaucrats who design the program implementation up to the effect occurrence.

On another occasion Ripley says that the implementation includes some type of action. Government agencies that have been stipulated in their laws of accountability for managing the program must obtain the needed resources. These resources include personnel, equipment and money. Secondly, government agencies should be included in the interpretation and planning. They should develop the language of law into concrete directions, rules and plans and program
designs. Finally, government agents must be able to increase profits or limitations to their clients or target groups. Implementation is a part of the policy process.

Daniel A. Mazmanian and Paul Sabatier (1979) explain the meaning of this implementation by saying that: Understanding what happens after officially stated or formulated is the focus of attention of policy implementation, namely the policies and activities that arise after the legalization of state policy guidelines, which include both administration efforts and to generate real effects on society or events.

Furthermore, Mazmanian and Sabatier formulate the process of state policy implementation with the following details: Implementation is the execution of basic policy decisions are usually in the form of legislation, but can also be made by the commands or decisions of an important executive or judicial decision. Normally, the decision identifies the problems that are going to be solved, mentioning the goals / targets that want to be achieved expressly and various ways of structuring / regulating the implementation process. This process takes place after going through a certain stage, usually in the form of implementation of policy decisions by the agency / implementing agencies, the willingness of those decisions implemented by the target groups. (Solichin, 1981: 54).

Furthermore, the implementation process is often referred to as a black box that is often not transparent, but certainly become a variable that determines the success of the transparency process from the target and policy purpose towards the achievement of policy outcomes. The policy implementation began after a policy is approved by the legislature and it begins with the preparation stage of the program, taking into account the following matters:

a. Identify the problem to be interfered;
b. Affirming the goals to be achieved; and
c. Designing the structure of the implementation process, to develop a clear program, or specify the program into the project activities.

Even Ujodi (1981: 32) explicitly states: The execution of politics is important if not more important than policy making policies will remain dreams or blue point in file jackets unless they are implemented.

From the explanation above, it can be seen that the implementation is a basic problem in development whether it is in the form of programs or projects. Policy implementation is the implementation of public policies that have been decided upon, implementation also means to break down a policy into operational policies set forth in the target scene. Therefore, policy implementation is a series of activities that consist of operational stages of policy implementation as follows:
All the implementation elements depend on the programs and certain actors each have its own interests in the program and each is trying to accomplish by making demands in allocation procedures. Therefore, the implementation becomes more dispersed, both geographically and organizationally; the task to implement a particular program becomes very difficult, especially with the increasing involvement of decision-making units. It is worthy to note that the decisions made during the policy formulation should be able to show who's given the task to do various program and those decisions should also give effect to how the policy is being achieved. For example, the differences in the capacity of various bureaucracy agents to manage the program properly. Most of them are active, skilled and dedicated as an employee, while others feel there is tremendous pressure from political elites and has great access to resources, and some just accommodate the demands made to them.

According to Casey and Kumar the steps in implementing the policy are as follows:

a. Identification of problems which include:
   1. Limiting problem to be solved;
   2. Separating problem from the supporting symptoms; and
3. Formulating hypotheses.
   b. Determine the factors that make the existence of these problems, through qualitative and quantitative data gathering.
   c. Review the barriers in decision making, including:
      1. Analyze the political situations and organizations that previously influence the policy
      2. Consider the many variables that can affect the composition of staff, political pressures, staff morale and skills, cultural sensitivity, the willingness of the population, and the effectiveness of management.
   d. Develop alternative solutions
   e. Approximate possible solutions. Approximate viable solutions. Define clear criteria and that can be applied to test the strengths and weaknesses of each alternative.
   f. Continue to monitor feedback from any action undertaken in order to determine the next necessary action.

Policy Implementation Activities consist of:
   a. Procurement of resources, both natural resources, technology, human, financial resources;
   b. Implementation toward policy decisions, and the prerogatives of the goals of macro policy;
   c. Planning (compiling action designs to implement policy decision), specifies the interpretation of macro policy into operational designs activity;
   d. Organizing (efficient use of public organizations, involvement of other agencies, other coordination, etc.); and
   e. Provision of services.

2. Factors Influencing Policy Implementation

The complexity of implementation is not only showed by the number of actors or organization units involved but also by its implementation process with its complex individual and organizational variables where each influencing variable also interact to each other, as described in the next part of this book.

The success of policy implementation will be determined by many variables or factors, and each variable is connected. To enrich our understanding about various variable involved in the
implementation, therefore this chapter will elaborate some implementation theories from George C. Edwards III (1980), Merilee S. Grindle (1980), and Daniel A. Mazmanian and Paul A. Sabatier (1983), Van Meter and Van Horn (1975), and Cheema and Rondinelli (1983), and David L. Weimer and Aidan R. Vining (1999).

In Edward III’s opinion, policy implementation is influenced by four variables: (1) communication; (2) resources; (3) disposition; and (4) bureaucratic structure.

The important thing to note is that not all factors that influence policy implementation affect the policy itself. Each policy program has certain influence factors. The factors listed above does not only directly affect the implementation, but also indirectly affect other factors or programs that will be implemented.

These four variables are also connected to each other (Picture 6.1).

(1) Communication
The success of policy implementation put the implementer under the condition to know what to do. What becomes the objective and the target of the policy must be transmitted to the target group in order to reduce the implementation distortion. If the objective and the target of the policy are not clear or even unknown by the target group, therefore, there is a possibility that the resistance of the target group can happen. The success of the Family Planning (Keluarga Berencana) in Indonesia, for example, is because the Badan Koordinasi Keluarga Berencana Nasional (BKKBN) intensively socializes the objective and purpose of the Family Planning to couples of childbearing age through various media.
(2) Resources

Even though the content of the policy has been communicated clearly and consistently, but if the implementer is lack of resources to implement, the implementation will not effectively work. The resources can be in form of human resources; implementer competency, and financial resources. Resources are important factor to implement the policy effectively. Without resources, the policy will be in paper only.

(3) Disposition

Disposition is the nature and characteristic possessed by the implementer, like commitment, honesty and democracy. If the implementer has good disposition, he will be able to implement the policy like what the policy makers want. When the implementer has different attitude or perspective from the policy makers, the process of implementation will not be effective.

Some experiences in developing in the Third World countries show that the level of commitment and honesty of the implementer is very low. Many corruption cases that show up in Third World countries, like Indonesia, are
concrete examples of how low the commitment and the honesty of the implementer in implementing development programs.

(4) Bureaucratic Structure

The organization’s structure has significant influence towards policy implementation. One of the most important aspects in every organization is Standard Operating Procedures (SOP). SOP has become the manual to every implementer in taking steps. Organization structure that is too long will weaken the supervision and cause red-tape. The complicated and complex bureaucratic procedure caused the activity of the organization to become inflexible.

1.2. The Theory of Merilee S. Grindle (1980)

The success of the implementation according to Merilee S. Grindle (1980) is influenced by two main variables, namely, the content of the policy and context of implementation. As seen in Picture 6.2, the policy includes the following variables:

(1) how far the interest of the target groups contained in the content of the policy;
(2) the type of function achieved by the target group, for example, the inhabitants in slum areas prefer to accept clean water program of electricity program than to accept motorcycle credit cut; (3) how far the changes wanted from a policy - a program aimed to change the attitude and behavior of a target group is relatively difficult to implement compared to program that gives credit helps or provide free rice to the poor; (4) whether the location of the program is right, for example, when BKKBN has the program of improvement of the family welfare by giving money fund to pre-prosperous, may people ask whether the location of the program is correctly in BKKBN; (5) whether the policy mentioned its implementer in detail; and (6) whether a program is supported by adequate resources.

While the context of implementation variable involves: (1) how big the control, interest and strategy owned by the actors who involved in the policy implementation; (2) characteristic of the institution and the ruling regime; (3) and the subservience level and the responsivity of the target group.

Implementation as described or defined above, includes some of the activities when a policy is
formulated up to the realization to the program impact or policy. In the course of implementation, there is a dividing factor between the target objective and policy outcomes, and between the gaps, there are a number of factors that influence the outcome.

<table>
<thead>
<tr>
<th>Policy objectives</th>
<th>Policy outcome (results)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factor gap (what is its cause?)</td>
<td></td>
</tr>
</tbody>
</table>

Grindle (1980 p. 11) says that the activities related to implementation are strongly influenced by (a) the content of policy and (b) the context of policy implementation. The policy content (content of policy) refers to: (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 the context of implementation is influenced by the following factors: (1) power, interests and strategies of the actors involved; (2) character-institutional characteristics in the regime; and (3) compliance and responsiveness.

In other words, Grindle (1980), goes on to say that the implementation problems are as follows:

a. Government agents have a variety of ambiguous purposes and cannot be measured so it is very difficult to develop technically rational solutions to the implementation issues.

b. If political pressure is making it impossible to perform an action, therefore government agents will use political criteria to set priorities and organize their actions.

c. The agents who implement the various programs are made vulnerable because of their inability to reach all goals.

d. Leadership politicization shows operation in normal process to feedback and learning.

Grindle’s opinions about policy implementation models are as follows:

a. Policy implementation is determined by the policy content and surrounding context.

b. Policy implementation is done after the policy transformed into action program and the funds provided.

c. Smoothness level of program implementation is affected by the conditions of implementation of the policy itself. The implementability level of a policy can be seen from the policy side and the context of policy.

d. The policy contains the:
   1. interests affected by policy;
   2. benefits that will be generated;
   3. desired degree of change;
4. position of policy making;
5. information on who is managing the program; and
6. resources mobilized.

e. Environmental context of the policy includes:
   1. The interests, power and strategies of actors involved;
   2. The characteristics of institutions and authorities; and
   3. The compliance and understanding of power.

f. The result of the policy implementation can be seen on its impact on society, group and individual. Results were also measured from the level of changes that occur in society, or the level of community acceptance of a change in conditions made by that policy.

Figure 2.3. Policy Implementation Framework. Source: Grindle, Merilee S, 1980: 11.

1.3. Theory by Daniel A. Mazmanian and Paul A. Sabatier (1983)

According to Mazmanian and Sabatier (1983), there are three variable groups that influence the success of the implementation as seen in Picture 6.3, namely: (1)
tractability of a problem; (2) ability of statute to structure implementation; and (3) non-statutory variables affecting implementation.

Figure 2.4. Variables that Affect Implementation process. Source: Mazmanian, Daniel A. and Sabatier, Paul A, 1983: 22.
Problem Characterization:

(1) The level of technical difficulty is a relevant problem. In one side, there are some social issues that technically easy to solve, like the shortage of drinking water supplies for the people or the sudden increase of prices. On the other hand, there are some social issues that are hard to solve, like poverty, unemployment, corruption, etc. That is why, the issue’s nature itself determine whether it is easy to be resolved or not.

(2) The diversity level of the target group. This means that a program will be relatively easy to implement if the target group is homogenous. On contrary, if the target group is heterogeneous, the program implementation will be relatively difficult because the level of understanding of every member of the group toward the program will be different.

(3) The proportion of target group against the total population. A program will be relatively hard to implement if the target is the entire population. On the contrary, a program is relatively easy to implement if the number of the target group is not too big.

(4) The scope or intent of changing towards desired behavior. A program aimed to give knowledge will be easy to implement rather than program aimed to change attitude and behavior of society. For example, the implementation of regulation No. 14 (1992) about traffic and road transport is hard to implement because it involves the attitude changing of a society in traffic.

The Policy Characteristics:

(1) The clarity of the policy contents. This means that if the content of the policy is clearer and more detailed, the implementer will easily understand and translate it into real action. On the contrary, if the content of policy is unclear, it can result in a distortion in policy implementation.

(2) How strong is the theoretical background/support of the policy? Policies that have basic theoretical ground have a firmer status because it has been tested, even though in certain cases and social conditions, it may require some modifications.

(3) The allocation of financial resources to the policy. Financial resources are crucial factor to every social program. Every program need staff support to do the technical
and administrative works, along with monitoring the program which entails significant costs.

(4) The magnitude of the support joined among various implementing agencies. The failure of the program is often caused by lack of vertical coordination and inter-agency horizontal hat involve in program implementation.

(5) The clarity and consistency of rules in the implementer agency.

(6) Level of commitment of the authorities towards the policy objectives. The corruption cases in the Third World, especially in Indonesia, is caused by the poor commitment of the authority to carry out their task, job or programs.

(7) The extent of outside groups’ access to participate in policy implementation. A program that gives big chance to the community to get involved will get support than program that does not involve the community. The community will feel isolated or alienated if they only become the audience of a program in their area.

Policy scope:

(1) The condition of social economy and the level of technology progress of the community. More open and educated community will be relatively more receptive to modernity programs than closed and traditional community. Similarly, technological progress will help in the process of the success of program implementation, because these programs can be socialized and implemented with the help of modern technology.

(2) Public support toward the policy. Policy that gives incentive is usually easy to get public support. In contrary, policy that is dis-incentive, like the rise of petrol price or the tax raise will be less supported.

(3) The attitude of the constituency groups. The constituency groups in the community can influence policy implementation through many ways, namely: (1) the constituency groups can intervene to the decision made by implementing agents to change some comment with the purpose to change the decision; and (2) the constituency groups can have the ability to indirectly influence implementing agents through published critic about the performance of the implementing agencies and make statement aimed at the legislative institute.
(4) The commitment level and skill of the agent and implementer. Eventually, the commitment of the implementer agent to objectify the objective that has been stated in the policy is the most crucial variable. The Implementer agent has to have skill in making objective priority and followed by objectifying the objective priority.

1.4. Theory by Donald S. Van Meter and Carl E. Van Horn (1975)

According to Mater and Horn, there are five variables that influence the implementation performance, namely: (1) standard and policy target; (2) resources; (3) inter-organizational communication and activity strengthening; (4) implementer agent characteristic; and (5) social, economy and politic condition (Picture 6.4)

(1) Standard and policy target. Standard and policy target must be clear and measured so they can be objectified. If the standard and policy target escape, then there will be multi-interpretation and conflict between the implementer agents.

(2) Resources. Policy implementer need to be backed by resources both human resources and non-human resources. In many government program cases, like Social Safety Net (Jaring Pengaman Sosial – JPS) for poor community in village is not that successful because of the lack of implementer agent’s quality.

(3) The relationship between organizations. In many programs, program’s implementation need to be supported and coordinated with another agency. Therefore, coordination and cooperation between agencies are needed for the success of a program.
Figure 2.5. Policy Implementation Model by van Meter and van Horn

(4) The characteristic of implementing agent. The characteristic of implementing agent refers to the bureaucrat structure, norms, and relationship patterns that happen in the bureaucracy, all of them will influence the implementation of a program.

(5) The social, politic and economic condition. This variable also covers the environmental economic resources that can support the success of policy implementation; how far the interest groups give their support to the policy implementation; the participant’s characteristic, whether they support or reject; how the public opinion’s nature in the environment; and whether public elite support the policy implementation or not.

(6) Implementer disposition. This implementer disposition covers three important things, namely: (a) implementer’s responses to the policy, which affect his desire to implement the policy; (b) cognition, his understanding about the policy; and (c) intensity of the implementer’s disposition, that is the value preference owned by the implementer.
1.5. Theory by Shabbir Cheema and Dennis A. Rondinelli (1983)

The following Picture 6.5 describes the conceptual framework that can be used to analyze government’s implementation programs with the decentralized nature. There are four variables that can influence the performance and impact of a program, namely: (1) surrounding condition; (2) relationship between each organization; (3) organization resources to implement program; (4) the characteristic and the ability of the implementer agent.
Figure 2.6. Program Implementation Process according to Cheema and Rondinelli

Environment Condition:
1. The type of political system
2. Policy Implementer Structure
3. Local political structure characteristic
4. Resources obstacle
5. Social cultural
6. The degree of involvement of the program receiver
7. The availability of the sufficient physical infrastructure

Corp. between organizations:
1. Clarity and consistency of the target program
2. Function distribution between proper institutes
3. Planning procedure standardization, budget, implementation & evaluation
4. Accuracy, consistency & community quality between institutions.
5. Net effectiveness to support the program

Organization Resources:
1. Resources control.
2. Balance between the distribution of budget & program activity
3. The accuracy of the budget allocation
4. Enough income for the expenditure
5. Center political ruler support
6. Local political ruler support
7. Bureaucrat commitment

Characteristic and capability of Implementer Institution:
1. Technical skill, managerial, & political official.
2. Ability to coordinate, control & to integrate decision
3. Support & institute politic resources
4. Internal communication attitude
5. Good relationship between institution and target group
6. Good relationship between institution and outsider of government and NGO
7. The quality of the related institution leader
8. Official commitment to the program
9. Institution position in the hierarchy of the administrative system

Source: Rondinelli and Cheema, 1983.
1.6. Theory by David L. Weimer and Aidan R. Vining (1999)

In Weimer and Vining’s (1999) opinion, there are three variable groups that can influence the success of the implementation of a program, namely: (1) policy logic; (2) environment where the policy is operated; (3) the ability of the policy implementer.

Logic of a policy. This means that the policy stated must be reasonable and get the theoretical support. We can think that the logic of a policy is similar to the logical relationship of hypothesis. For example: Policy or program by the district government to improve the quality of science lessons in Senior High School by giving funding assistance. This policy will work with the following hypotheses: firstly, there is a Senior High School that have several achievement in the district and they want to propose to use the fund for that program; Secondly, there is a selection process to choose the High School that is also made as the program’s target; Thirdly, the fund given is really used for settled objective; Fourthly, the result achieved can be proven or verified; and Fifthly, education officials in district can acquaint that this success experience can be used in other Senior High Schools. This means that the content of a policy or a program must cover some aspects that make it possible for the policy or the program to be implemented orderly in practice.

The environment where the policy is being operated will influence the success of the implementation of a policy. What is meant by this environment includes social environment, politic, economic, defense and security and geography. A policy can be successfully implemented in a certain area but it can also fail to be implemented in another area because of the difference of the environmental condition. For example, for now not all Junior High School and Senior High School can implement the program “Competency Based Curriculum” as made by the National Education Department due to the variety of conditions among schools.

Implementer ability. The success of a policy can be influenced by the competency level and skill of the policy implementer. For the case of
competency based curriculum in Junior High School and Senior High School, thus the quality, commitment and the equal number of teacher give a significant contribution for the success of the program because they are the implementer of the program.

3. Policy Instrument
After the research from many policy implementer studies written by the policy experts, Howlett and Ramesh (1995) conclude that there are ten types of policy instruments (Picture 6.6) and will be discussed as follow.

![Spectrum of Policy Instruments](image)

Figure 2.7. Spectrum of Policy Instruments. Source: Howlett and Ramesh, 1995:82.

1. Voluntary Instruments
The characteristic of voluntary instruments is that it is very small or there is almost no intervention from the government. The government often intentionally does nothing or does not make a policy concerning a public issue, because the government believes that it can be done themselves by the family and the community, voluntary organization and the private market. Voluntary instruments are important tool to implement social and economy policy. The use of this instrument will get better position when the government does the privatization process. There are some reasons why these instruments are used, namely: cost efficient which fit the community norms and they get the support from family and
community. The implementations of the removal of household garbage in a house complex organized by the chairman of the neighborhood association and neighborhood security watch system by certain community to watch over the safety of the neighborhood are concrete examples. These voluntary instruments consist of: family and community, voluntary organizations and private markets.

3.1.1. Family and Community

The first instrument of voluntary instruments in order to implement a policy is family and community. In society, friends and neighbors often give some services and goods, this can be seen as the expansion of the service that should be given by the government. For example: Neighborhood security watch by a certain community in order to implement the security policy.

3.1.2. Voluntary organizations

Voluntary organizations are efficient tool to give economy, social, health and education service to the society. They are sometimes faster and responsive in helping natural disaster victims. For example, many social organization and foundation build hospitals, schools, and shelter for the orphanages and the elderly.

3.1.3. Market

Market is the most needed instrument in certain neighborhood. It is a very effective and efficient tool to provide private goods needed by the society. Market will also guarantee the existence of competition in supplying service and goods then the society can choose the cheapest service and goods.

2. Compulsory Instruments

Compulsory Instruments are also referred as instruction instrument or direct act to the target both individual and company. The government has the authority to give instruction to the citizen to do a certain act, and watch over the company to obey the law and supply the service and goods needed by the society. These
compulsory instruments consist of regulation, public enterprises and direct provision.

i. Regulation
This regulation means to constrain the behavior of individual, society and company both private and public company. Whoever disobeys the regulation will be sanctioned by the government. Police and court system are needed to implement this regulation. This regulation can be in the sectors of economic, social, security, etc. Regulation in economic sector, for example, the regulation of paddy’s basic price, the tariff cost of land transport and the volume of import goods. The regulation can also in form of standard determination, license procedure, and prohibition of certain act.

ii. Public enterprises
Public enterprises are also known as State Owned Enterprises or Badan Usaha Milik Negara (BUMN). Basically, public enterprises have assets for about 51% up to 100% owned by the government, and the management under the control of government, also produce goods and public service. Public enterprises as policy instrument offer profit at one side, like supplying goods and service that do not produced by private sector or market, but in the other side, the government sometimes find it hard to control public enterprises management.

iii. Direct Provision
The government sometimes directly gives the service and goods funded and managed by central government, like Bantuan Presiden untuk Desa-Desa di Indonesia, Presiden untuk Desa Tertinggal (IDT), Program Jaring Pengaman Sosial (JPS), etc.

3. Mixed Instruments
Mixed instruments consist of information, subsidy, property right arrangement, and tax.

iv. Information
Information distributed to individual and company is expected to change their behavior. Information is usually general; this is intended to increase society’s knowledge so they will have enough information
before they make decision. For example, information about tourism, information about government’s programs, and information related to social and economy statistic need to be informed to the society by the government, so the society can respond to it.

v. Subsidy
What is meant by subsidy is all government’s financial help to individual, company and organization. The objective is to give expense help to many activities.

vi. Property right’s arrangement
Property right’s arrangement is objectify to control all kinds of activity that can harm the society, such as water pollution, factory waste, and numbers of vehicles in the city. Through that control, the public interest can be protected.

vii. Tax
Tax is the compulsory payment from individual and company to the government that functions as government income to finance government’s expense. However, tax can also be used to manage society’s behavior. For example, high tariff tax can be taxed to alcoholic liquor while tariff for export tax for handcraft product can be reduced with the intention to increase the volume of the handicraft product export and to develop home industry.

4. Policy Implementation Actor
According to Fadillah (2005:57): "policy actors are people or institutions that affect a particular policy, this actor can be the makers, implementers, picker or even a victim of one of certain policies."

Randall B. Ripley and Grace A. Franklin (1986) in Subarsono (2005: 89) write as follows: "Implementation process involve many important actors holding diffuse and competing goals and expectations who work within a contexts of an increasingly large and complex mix of government programs that require participation from numerous layers and units of government and who are affected by powerful factors beyond their control”.

The complexity of implementation not only shown by the number of actors or organizational units that are involved, but also the implementation process is influenced
by a variety of complex variables, both individual variables and organizational variables, and each of these influential variables also interact with each other.

In discussing the policy implementation it is important to see who the actors involved in implementation, because the success of policy implementation cannot be separated from the role of each policy actor. Policy actor is the policy maker as policy makers, the bureaucracy as an implementer and target groups as a policy target groups. But beyond that there are many actors involved in international, national and local level that might have been in form of formal organizations, governmental and non-governmental organizations (Wibawa, 2004). While macro policy will involve several institutions, such as bureaucratic district, subdistrict and village government. The involvement of various actors in the implementation, as Ripley and Franklin (1986:12) explained, consists of several levels namely national, provincial and district/city, which each consist of groups of officials, individuals and organizations with their own appropriate scope levels of government. Policy actors can also be classified on the executive, legislature and judiciary on the one side, while the people, political parties, interest groups and mass media on the other side.

According to Jones there are four classes or types of actors (actors) involved, namely: a rational class, grade technicians, incremental class and reformist faction. Each group of actors has a different behavior in the policy process that will be described in the following description:

1. Rationalist faction. The main characteristics of most actors here is that the rationalist in making a selection of alternative policies and methods they always take the following steps:
   1) Identify the problems;
   2) Formulate goals and put them in a certain level;
   3) Identify all the policy alternatives;
   4) Forecasting or predicting the consequences of each alternative;
   5) Compare these effects by always referring to the goal;
   6) And choose the best alternative.

   Based on these characteristics, the behavior of rationalist actor’s faction is synonymous with the role played by planners and policy analysts who are highly trained professionals in the use of rational methods when dealing with problems of public.

1. Technicians group. A technician is basically nothing more rationalist, because he is a man who because of their expertise or specialty is involved
in several stages of the policy process. Group of technicians in performing their duties may have freedom, but freedom is limited to the scope of work and expertise.

2. Incremental Group. This group of incremental can be identified with the politician. The politicians, as we know, tend to have a critical attitude, but often impatient to the work force of planners and engineers, although they are actually very dependent on what is done by planners and technicians.

3. Reformist faction (reformer). Like the incremental class, basically actor of reformist faction also admitted to the limited information and knowledge required in the policy process, though they are different in the way of taking conclusions (Abdul Wahab, 2004: 29-31).

From the description above, the author tries to conclude that the actors involved in the policy include planners (policy makers), politicians, and technicians (could come from the bureaucracy) and the target group. This is similar to Anderson which states, implementing a policy not only limited to the ranks of the bureaucracy, but also involves actors outside the government bureaucracy, such as community organizations and even individuals also include implementing the policy. This means that there are linkages between the several actors in the implementation of a policy, namely public policies that have been set by the government and gain legitimacy from the legislature has made it possible for bureaucrats to act in implementing the policy.

In understanding and interpreting the intent and purpose of a policy it cannot be forgotten about the understanding or perception of their respective stakeholders. The understanding or perception of a policy-by-policy actor will determine the action in producing a more operational derivatives policy. The actors who involved in the implementation of a program or policy’s understanding will determine the success of the implementation of the program or policy itself. One of the reasons of the failure of a policy is because the actor does not understand correctly the policy. It is not surprising that a policy can be confused and not in accordance with normative expectations that have been outlined and failed to achieve its objectives because of different perceptions and levels of understanding of the actors involved in implementation.

While Leslie A. Palmier, divides policy evaluation into four categories:

1. Planning and need evaluations
   Includes an 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 (Pa Leslie, 1987: 52)

With the aim to provide an assessment of the implementation program, this assessment did not evaluate the overall phase of the policy but only one stage of its implementation (implementation evaluation). Implementation is an important aspect of the overall stage of the policy as expressed in the book Ujodi Solichin (1990: 45).

Evaluation of the implementation according to Ripley includes 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)

5. Characteristics of policy makers

1. Not only information, policy and institutions making are often based on previous patterns.
2. The decision taken the elite way because subordinates does not have enough means of communication. The subordinates are not able to utilize existing communication infrastructures so decisions are usually made without involving their opinion.
3. Centralized nature of decision-makers is caused by inherited colonial system.

Similarly, there are obstacles that affect the success of policy implementation, such as:
1. Obstacles to measure the gravity level of issue changes after intervention by a policy.
   a. Behavior patterns’ changes of the target groups.
   b. Technology development
   c. Institutional change
2. The diversity of the regulated behavior.
3. Percentage of population that needs to change its behavior.
4. Coverage or diversities of the change of behavior patterns demanded by a particular policy.

In line with the above constraints, the nature of the policy itself can adversely affect the implementation easily.

1. Validation of a causal theory of a policy. Does a policy have apparent link between the emergence of a policy with a goal or desired change or expected result.
2. The ability of a policy to determine the scope of the specified target group and the foresight of the target groups.
3. Availability of financial resources from institutions that implement these policies.
4. Cohesiveness among the responsible institutions for implementing those policies.
5. Assessment appointing agency or officers responsible for implementing those policies.
6. Supporting other rules of the implementing agencies (which implement the policy) the achievement of objectives.
7. Support and participation of other external actors who support the achievement of objectives.

The implementation success is determined by the nature and content of the policy itself. This means that the nature of the policy will determine the form of its implementation and further influence the success rate. Besides it is also influenced by factors that determine the hardness and easiness of an implemented policy that is as follows:

a. Affected interest
   That is how far the changes demanded by the course of wisdom would threaten certain interests in society that is being opposition either covertly or openly.
For that the executor must approach the parties who feel disadvantaged, so that their attitudes can be transformed.

b. The Type of benefits enjoyed by the target groups
   If a program promises a clear benefit for the target group but they do not understand the benefits, it will be difficult to get support.

c. The extent of expected changes
   The more extensive the changes that are expected by the target group of the program, it will be increasingly difficult to obtain support from the program target group. If there are two policy options with roughly the same results, then the choice should be given to alternatives that require the smallest changes in the target group. But if the policy choice requires inevitable fundamental changes in the target group, so that implementers need to implement the policy gradually so that the possibility of resistance is reduced.

d. Scope of decision making
   The more extensive the scope of a policy decision, the more difficult it is to implement as compared to the policies with smaller scope.

e. Sources involved
   Most of the decisions of the policy formulation process is who or which agencies would be charged as executor. In order for effective implementation, the implementing authorities should have sufficient capability and supported by adequate resources.

f. Atmosphere of (context) policy implementation
   Public policy is made and executed in an environment that can be supportive to the implementation process and can facilitate the execution of the policy.
CHAPTER III. PUBLIC POLICY PRACTICES

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

1. Background

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 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, both experience the challenges in the implementation of the UHC. The problems of inequality and poor quality remain 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).

Indonesia initiated UHC in January 2014 and committed to achieve universal coverage by 2019. UHC in Indonesia known as National Health Coverage/ Jaminan Kesehatan Nasional (JKN). The policy framework is based on Law No. 40/2004 on the National Social Security System, and Law No.24/2011 on the Social Security Agency (BPJS). These two laws follows the Road Map toward National Health Insurance—Universal Coverage 2012-2019 (Peta Jalan Jaminan Kesehatan Nasional 2012-2019). Base on this road map, the health insurance for the poor (Jamkesmas) has been expanded to reach 76.4 million people (32 per cent of the population). The table below shows the numbers of people and type of insurance in Indonesia by 2012.
Table 3.1 Number of people and type of health insurance in Indonesia by 2012

<table>
<thead>
<tr>
<th>Type of Health Insurance</th>
<th>People</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants of Health Insurance for Civil Servants / (Askes PNS)</td>
<td>17,274,520</td>
</tr>
<tr>
<td>Military and Police/ TNI/Polri</td>
<td>2,200,000</td>
</tr>
<tr>
<td>Jamkesmas Participants (Ministry of Health)HealthInsurance for the Poor</td>
<td>76,400,000</td>
</tr>
<tr>
<td>JPK Jamsostek Participants /Peserta JPK Jamsostek (WorkforceSocialSecurity) - Private employees and employers</td>
<td>5,600,000</td>
</tr>
<tr>
<td>Jamkesda/PJKMU Participants - regional health insurance for the poor/ PesertaJamkesda (yang dijaminPemda)</td>
<td>31,866,390</td>
</tr>
<tr>
<td>Corporate Insurance (Self-Insured)/Jaminan Perusahaan</td>
<td>15,351,532</td>
</tr>
<tr>
<td>Commercial Health Insurance Participants/ Peserta Askes Komersial</td>
<td>2,856,539</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>151,548,981</td>
</tr>
</tbody>
</table>


As shown at Table 1.1, the biggest number of participants is from Participants of Health Insurance for Civil Servants (Askes PNS) and the smallest is from military and police/ TNI/Polri. The scheme is funded by the central government from general tax revenue. Beneficiaries particularly the poor are not responsible for premium payments nor are they charged a copayment at the time of visit, but for the formal workers and informal workers are subject to pay the premium in certain amount. This financial health system will burden the state budget at large.

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. On the other hand, the Thai government passed the National Health Security Act in 2002 and implemented the UHC or also known as the Universal Coverage (UC). 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).

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.

Table 3.2 Characteristics Of Thailand’s Three Public Health Insurance Schemes After Achieving Universal Coverage In 2002

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

Source: Health Insurance System Research Office, 2012

On the 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 the ambulatory care in health center, district hospitals, and provincial hospitals were pro poor while in the university hospitals were pro rich. This result can be implied that district health center, 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 many customers of these hospitals are CSMBS and SSS patients who are better off than UC scheme patients. This pattern was similar in the hospitalization of inpatients (Thammatach - aree, 2011).

**Universal Health Coverage**

In line with the 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 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 the table below.

**Table 3.3. Main National Level Schemes of UHC**

<table>
<thead>
<tr>
<th>Country</th>
<th>Year of reform</th>
<th>Revenue generation (sources of revenue ordered by proportion of contribution)</th>
<th>Risk pooling</th>
<th>Service delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intermediate-stage reform countries</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ghana (NHIS)²</td>
<td>2003</td>
<td>Value-added tax, investment income, formal-sector payroll contributions, household premiums</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Indonesia* (BPJS)³</td>
<td>2004</td>
<td>General government revenues, formal-sector payroll contributions</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Philippines (Philhealth)²</td>
<td>1995</td>
<td>General government revenues, formal-sector payroll contributions, household premiums</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Rwanda (Mutuelles)³</td>
<td>2000</td>
<td>Donor funding, general government revenues, household premiums, formal-sector payroll contributions</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Vietnam (VSS)³</td>
<td>2002</td>
<td>General government revenues, formal-sector payroll contributions</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Early-stage reform countries</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>India* (RSBY)²</td>
<td>2008</td>
<td>General government revenues</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Kenya* (NHIF)²</td>
<td>2002</td>
<td>Formal-sector payroll contributions, household premiums</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Mali* (Mutuelles)³</td>
<td>2009</td>
<td>General government revenues, household premiums</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Nigeria* (NHIS)³</td>
<td>2009</td>
<td>Formal-sector payroll contributions, general government revenues, household premiums, donor funding</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>

For purposes of this table, we focus on the main national-level schemes: NHIS=National Health Insurance Scheme. BPJS=Baden Penyelenggaran 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 Yojana (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 all, 2012, 935).

The idea of universal coverage is to protect people, at all income levels, from financial risks associated with ill health. One should note, however, that the concept of universal coverage is not based on subjective judgment of the policy makers. Many politicians say that they have launched a social health protection and are committed to implement health finance for all. Yet political statements and program launching is not enough. The conceptual fault here is that universal coverage sometimes can be used to justify practically any health financing reform (Kutzin, 2013) while the objective coverage is not entirely attained. The objective of universal coverage is efficiency and equity in health resource distribution so that objectivity, transparency and accountability have to be assured (Kumorotomo, 2015).

The ineffective free-market mechanism to provide health services for the poor is the main reason for many countries to embrace universal coverage. Therefore, it is encouraging that the USA and China, the two major economic powers that previously relied on private insurance for health care, are currently moving back to universal coverage policy. Countries in Africa, such as Ghana, Moldova and Rwanda are adopting the new health systems to cover all the citizens. In Asia, similar policies have been implemented in Kyrgyzstan, Malaysia, Thailand and Indonesia (Kumorotomo, 2015).

Regarding the health policy, at least there are three demands that must be satisfactorily answered by the stakeholders, namely: 1) good understanding about the political 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 a 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.

2. Implementation 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 such as (a) the content of policy and (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 the factors that influence the context of implementation are: (1) power, interests and strategies of the actors involved; (2) character-institutional characteristics in the regime; and (3) compliance and responsiveness.

Financial Sustainability of Universal Health Care Policy

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\(^\text{34}\) (Lagomarsino et all , 2012, 933). Furthermore, Physicians for a National Health Program\(^\text{35}\) (2010) stated there are four models of Health Finance Models:

1. Beveridge: provided by government-financed health facilities, managed by government agencies. Examples: UK, Spain, Scandinavians, Cuba, New Zealand, Hongkong. The UK’s (Beveridge) National Health Service model relies on general taxes, one national risk pool, and publicly provided services available to all.

2. Bismarck: Germany’s (Bismarck) social health insurance model relies on household premiums and payroll taxes, many risk pools, and services purchased largely from private providers available to those who enrolled. Provided by private institutions; financed by non-profit insurance system, the premium is paid by employees,


\(^{35}\) Physicians for a National Health Program, 2012 http://www.pnhp.org/single_payer_resources/health_care_systems_four_basic_models.php
corporates, and the government; managed and controlled by the government. Examples: Germany, France, Switzerland, Belgium, Japan.

3. National Health Insurance System: provided by private institutions, financed by the government from the levied taxes. Examples: Canada, Taiwan, South Korea.

4. Out-Of-Pocket (OOP): provided by private health facilities, financed by the patients through direct payments, no institutional management. Examples: most developing countries in Sub Saharan Africa, India, China (before 1990s), Latin American countries.

Figure 3.1: Health Finance System

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 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.

---

The findings of Lagomarsino’s at al, study shows that : Despite tax-collection challenges, six of the nine selected countries (India, Indonesia, Ghana, Nigeria, Vietnam, and the Philippines) rely increasingly on tax revenues to fund coverage expansion. These six countries offer subsidies to target populations such as poor people, pregnant women, and children. India, Indonesia, and Vietnam rely on general taxes to fund health coverage for poor people. The examination of the structure of these nine African and Asian national health insurance reforms shows substantial variety. They some common patterns, such as use of tax revenues to subsidize target populations, steps towards broader risk pools, and emphasis on the purchase of services through demand-side financing mechanisms. The

<table>
<thead>
<tr>
<th>Year of Revenue Generation (sources of revenue ordered by proportion of reform contribution)</th>
<th>Risk Pooling</th>
<th>Service Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intermediate-stage reform countries</td>
<td>Single</td>
<td>Multiple</td>
</tr>
<tr>
<td>Ghana(NHIS)</td>
<td>2003</td>
<td>Value-added tax, investment income, formal-sector payroll contributions, household premiums</td>
</tr>
<tr>
<td>Indonesia(BPJS)</td>
<td>2004</td>
<td>General government revenues, formal sector payroll contributions</td>
</tr>
<tr>
<td>Philippines (PhilHealth)</td>
<td>1995</td>
<td>General government revenues, formal sector payroll contributions, household premiums</td>
</tr>
<tr>
<td>Rwanda (Mutuelles)</td>
<td>2000</td>
<td>Donor funding, general government revenues, household premiums, formal-sector payroll contributions</td>
</tr>
<tr>
<td>Vietnam(VSS)</td>
<td>2002</td>
<td>General government revenues, Formal-sector payroll contributions</td>
</tr>
<tr>
<td>Early-stage reform countries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>India(RSBY)</td>
<td>2008</td>
<td>General government revenues</td>
</tr>
<tr>
<td>Kenya(NHIF)</td>
<td>2002</td>
<td>Formal-sector payroll contributions, household premiums</td>
</tr>
<tr>
<td>Mali(Mutuelles)</td>
<td>2009</td>
<td>General government revenues, household premiums</td>
</tr>
<tr>
<td>Nigeria(NHIS)</td>
<td>2009</td>
<td>Formal-sector payroll contributions, general government revenues, household premiums, donor funding</td>
</tr>
</tbody>
</table>

question on sustainability to cover the health insurance for all people in those nine countries remain a big question in covering the increasing demand of health access for their people.

Both Indonesia and Thailand still facing a lot of problem in this UHC Policy. Study by Mutiarin, et al\textsuperscript{37} shown 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 the implementation of both UC and JKN 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 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 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 implementation (Lagomarsino, 2012; Simmonds and Hort, 2013).

The problem faced by the government 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 a burden for the National Budget allocated each year. This research seeks to provide policy model of UHC finance model.

3. 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. Learning from reform experiences in different countries in Asia and Latin America, there is no “one best way” or “one size fits all.” It all depends on the economic, political and social status of each individual country.

Another aspect of financial management to be considered is to decide whether to have a single fund or multiple funds of the money collected from the people. Various countries in Asia have adopted the multiple funds approach to health care such as Japan, Korea, and Chile; while Taiwan use the single way to manage funds. The only issue arises from multiple funds is the inefficiency of administrative cost. A single taxed-based health system would be easier to manage and Korea has been trying to merge or combine different funds into a single fund system.

In Thailand, the money used to support the National Universal Health Care Coverage comes mostly from the government. Based on the pilot implementation of capitation contract model in Banpaeo Hospital in January 2001 and Social Health Insurance early on in April 1991, the research concluded that the capitation contract model would be more suitable for the increase of health care costs in the future in designing Universal Coverage Scheme. The general tax financed would be the best possible way for fund management in comparison to the fee for service reimbursement model of the CSMBS. Considering the upscale of UC scheme in the future, the copayment was contemplated to be politically and technically infeasible (Tangcharoensathien and others, n.d.). Section 38 of the 2002 Act has set up a “National Health Security Fund” (NHSF) under the National Health Security Office (NHSO) with main authorities in providing and supporting health care costs and public health services to service units. There are at least 8 different sources of funding to ensure that all citizens can get access to cheap and quality health care services at reasonable and affordable price as follows:

11 Government annual allocation
12 Local government administration
13 Fees from services as specified by the Act
14 Fine collected by the Act
15 Donations to the National Health Service Fund
16 Interests from the savings and asset of the Fund
17 Other income or asset derived from related activities of the Fund
18 Other sources as allowed by the law, e.g. Dental Fund, Subdistrict Administrative Organization Fund, Medicine Fund, Kidney Fund, etc.

The study conducted by World Bank\textsuperscript{38} 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.

Moreover, the World Bank\textsuperscript{39}, 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 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 is 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. Looking at financial aspect 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 (GDP), and only about 6 percent of the National Budget allocated each year\textsuperscript{40}.

The model of this research is shown below:

\textsuperscript{39} ibid
\textsuperscript{40} Evaluation of Universal Health Coverage Policy : A Comparison Study between Indonesia and Thailand, Dyah Mutiarin, et. al. ICONPO V, Philippine, 2015.
1.4. UHC Settings

Indonesia and Thailand (as members of ASEAN countries) have been implementing UHC as a commitment on Health Policy. It appeared that the Indonesian and Thailand government implementing UHC as a deal with a far-reaching health-care reform.

On January 1st 2014, the Government of Indonesia (GOI) has taken significant steps towards universal health coverage through the development of an integrated national health scheme. The program known as National Health Insurance /Jaminan Kesehatan Nasional /JKN. It is an attempt to unify the previous various social health insurance under a single social security agency. While in Thailand, the Universal Coverage (UC) started on 2002, based on the National Health Security Act 2002. As stipulated in the Section 5 of the National Health Security Act 2002, it is said that all Thai citizens shall be entitled to a Health service with such standards and efficiency. The Board shall have beneficiaries jointly pay cost sharing as prescribed by the Board to the Health care unit per visit, except such persons as prescribed by the Board who shall be entitled to Health service without joint payment.

Thus, it is important to the existing policy framework and strategic plans for the UHC, the National health insurance budget distribution, the constraints of UHC, and as well as the quality service of UHC.

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\textsuperscript{41}. Indonesia in 2014 marked a consecutive National Health Insurance as part of Universal Health Coverage (UHC) until now as its second year implementation. Despite the progress that the Indonesian government has made since the rollout of the National Health Insurance Program (JKN) at the beginning of 2014, various issues remain such as health care infrastructure, health chain supply, drugs supply, sufficient and proper funding of the program\textsuperscript{42}.

A research conducted by National Team for the Acceleration of Poverty Reduction\textsuperscript{43}, 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 centers 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)\textsuperscript{44}.

\textsuperscript{41}Institutional analysis of Indonesia’s proposed road map to universal health coverage, Amanda Simmonds and Krishna Hort, 2013.
\textsuperscript{42}Universal healthcare coverage in Indonesia One year on, The Economist Intelligence Unit Limited 2015.
\textsuperscript{43}The Road To National Health Insurance (JKN), 2015, National Team for the Acceleration of Poverty Reduction/TNP2K.
\textsuperscript{44}ibid, page 14.
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 payment that pays providers based on the number of people under their responsibility (contracting unit).

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.

Both Indonesia and Thailand still facing a lot of problem in this UHC Policy. In the study of Mutiarin, et al. shown 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 results of UHC in Indonesia and Thailand have varying remarks, but most of the results have higher remarks in Thailand. Mutiarin et al., found that the perception of respondents on implementation both UC and JKN vary. 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 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 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 which both appreciate the importance of healthcare and both experienced the challenges in the implementation of UHC. 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, what matters is to understand that both 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 from the Annual National Gross Domestic Products (GDP), and become a burden for the annual National Budget.
1.5. IMPLEMENTATION OF UHC

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.

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.

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 political process that affects the policy; 2) the necessity to create a participative policy formulation system; 3) 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.

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.

According to Susilawaty (2007), the purpose of health policy is to achieve national development in the health sector which is based on the initiative and aspirations by empowering, collecting, and optimizing potential areas for the benefit of local and national priorities.

Health policy in practice is not confined to the interests of individuals as the scope is very broad covering the public interest, general purpose and citizens in general. Thus, a health policy should be able to empower and improve community participation in health development. Thus, the health policy must seek the availability of health services which are equitable and evenly without differentiating between segments of society with each other including in ensuring the availability of health services for the poor and the nearly poor.

In general, policy implementation is a dynamic process, where the implementers perform an activity or activities that are likely to get a result that is consistent with the objectives or goals of the policy itself (Agustino, 2012: 139). While Nugroho (2012: 674) explains that the implementation of the policy in principle is a way for a policy to be able to achieve its objectives. Basically the policy implementation is an action/real program implemented based on the formulation of policies that have been developed previously to achieve specific goals.
Different from Nugroho, Suharno (2013: 169) argues that the implementation of policies that have gone through the stage of recommendation is a relatively complex procedure, so that there is not always a guarantee that the policy will work in practice. Meanwhile, Agustino (2012: 140) argues that policy implementation is a very important stage in the overall structure of a policy, because through this procedure the overall policy process can be influenced by the level of success or failure in achieving goals. This was confirmed by Udoji (1981) in Agustino (2012: 140) that implementation is a policy even more important than policy-making. These policies will only be a dream or a good plan neatly stored in the archive if not implemented."

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, such as (a) the content of policy and (b) the context of policy implementation. The factors affecting policy content (content of policy) are; (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 the factors that influence the context of implementation are: (1) power, interests and strategies of the actors involved; (2) character-institutional characteristics in the regime; and (3) compliance and responsiveness.

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 ongoing 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

The study conducted by the World Bank revealed 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 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 1.1 percent or 1.2 percent of the Annual National Gross Domestic Products (DGP), and only about 6 percent of the National Budget allocated each year.

On the 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 centers, district hospitals, and provincial hospitals were pro poor while university hospitals seem to pro rich. This result implied that district health centers, 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).

The study of Simmonds and Hort (2013), stated that there were potential inequalities in implementing universal health coverage in Indonesia. Indonesia experienced poor quality and unequal distribution of government health facilities in implementing UHC. While in Thailand, the UHC has been implemented since 2002. UHC in Thailand known as Universal Coverage (UC) which the 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).

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.
4. Profile of UHC in Indonesia and Thailand.

4.1. Profile of UHC in Indonesia

Legal Framework of National Health Insurance/JKN in Indonesia

On January 1st 2014, the Government of Indonesia (GOI) has taken significant steps towards universal health coverage through the development of an integrated national health care scheme. The program known as National Health Insurance /JaminanKesehatan Nasional /JKN. It is an attempt to unify the previous various social health insurance under a single social security agency. Report from Bappenas in 2014 (Bappenas, 2014) shows that JKN is the forerunner in the development of social assistance for health. Before JKN, the government had sought to pioneer some form of social assistance for health, such as social health insurance for civil servants (PNS), pensioners and veterans, as well as health insurance (JPK) safety net for employees of state-owned and private companies, as well as health insurance for military and police personnel.

JKN is in line with Law Number 40 of 2004 on National Social Security System (Sistem Jaminan Sosial Nasional/SJSN). Following Law No. 40/2004, the Government of Indonesia enacted Law No. 24/2011 on Social Security Administrative Body (Badan Penyelenggara Jaminan Sosial/BPJS). The establishment of Law on Social Security Administrative Body is an implementation of Law Number 40 Year 2004 on National Social Security System, in order to provide legal certainty for the establishment of BPJS to administer the Social Security programs throughout Indonesia. This Law is the implementation of Article 5 sub article (1) and Article 52 of Law Number 40 Year 2004 on National Social Security System which mandates the establishment of Social Security Administrative Bodies and institutional transformation of PT Askes (Persero), PT Jamsostek (Persero), PT TASPEN (Persero), and PT ASABRI (Persero) into Social Security Administrative Body. The transformation shall be followed by the transfer of participants, programs, assets and liabilities, employees, and the rights and obligations. With this Law two (2) BPJS are established, namely BPJS Health and BPJS Employment. BPJS Health shall administer a health program and BPJS Employment shall administer a work accident, old-age, pension and death programs.

Bappenas (2015) identified the operations of social health insurance-related legislations consist of: nine (9) Governmental Regulations and eight (8) Presidential
Regulations, as follows:

a. The Nine (9) Government Regulations (PP) include:

1) Government Regulation No.101/2012 on Recipients of Health Insurance Premium Assistance;
2) Government Regulation No. 82/2013 on the Initial Capital for BPJS;
3) Government Regulation No. 84/2013 on Revision in Regulation No. 14/1993 on Labor Social Security;
4) Government Regulation No. 85/2013 on Interagency Relation;
5) Government Regulation No. 86/2013 on Method of Administrative Penalty for Employers other than State Organizer;
6) Government Regulation No. 87/2013 on Management of Health Security Assets;
7) Government Regulation No. 88/2013 on Method of Administrative Penalty for Supervising Board and BPJS’ Board of Director,
8) Government Regulation No. 89/2013 on Revocation of Regulation No. 69/1991 on the Health of Civil Servants, Recipients of Pension Fund, Veterans, former Veterans and their families;
9) Government Regulation No. 90/2013 on Revocation of Regulation No. 28/2003 on Subsidy and Governmental Allocation in the Establishment of Health Insurance for Civil Servants and Recipients of Pension Funds.

b. The Eight (8) Presidential Regulation are as follows:

1) Presidential Regulation No. 12/2013 on Health Insurance;
2) Presidential Regulation No. 105/2013 on Health Service for Ministers and Certain State Officials;
3) Presidential Regulation No. 106/2013 on Health Insurance for Chairs of State Institutions,
4) Presidential Regulation No. 107/2013 on Special Health Service on the Operational Activity of Ministry Of Defense, Indonesian National Armed Forces and Indonesian National Police;
5) Presidential Regulation No. 108/2013 on Phasing Social Security Program Membership;
6) Presidential Regulation No. 109/2013 on the Form and Content of BPJS’ Financial Reporting and Statements;
7) Presidential Regulation No. 110/2013 on Salary or Wage and Other Additional Benefits and Incentives for Members of Supervisory Board and Members Board of Directors of Social Security Organizing Agency (BPJS);
8) Presidential Regulation No. 111/2013 on Revision of Presidential Regulation No.12/2013 on Health Insurance.

The Ministry of Health (MOH) also administered regulation related to social health insurance implementation. Related regulations to the health insurance program produced by the MOH include: two (2) Health Ministry Regulation (PeraturanMenteriKesehatan) and a (1) MOH Decree (KeputusanMenteriKesehatan) Number 328 on the Drug Formulary. The two MOH Regulations are: (1) MOH Regulation No. 71/2013 on “Healthcare Services in the Health Insurance Program” and (2) MOH Regulation No. 69/2013 on “Standard of Healthcare Tariff at Primary and Referral Healthcare Facilities in the Implementation of Health Insurance Program.”

5.1.1.2. JKN Objectives

National Health Insurance (JKN) is the government’s commitment to providing health insurance to all Indonesians. The National Health Insurance ensures that all participants receive health care as part of their basic needs (article 19 paragraph 2 in SJSN Law). The entire population needs to have access to health-care services that are proactive, preventive, curative and rehabilitative, as well as the necessary medication and medical supplies. In line with Article 19, the ideal benefits package would be comprehensive and would guarantee health services according to an individual’s medical needs for all forms of illness. The JKN aims to provide:

a. Personal health services;
b. Health promotion;
c. Preventive health;
d. Curative health;
e. Rehabilitative medicine services; and
f. Medical consumable materials in accordance with the necessary medical indications

5.1.1.3. JKN Principles

In accordance with Law Number 40 of 2004 on SJSN, the National Health Insurance is managed through the principles of:
1. Mutual cooperation ("Gotong royong"). With everyone paying their installments, the spirit of "gotong royong" supports the idea of the healthy helping the sick and the rich helping the poor.

2. Non-profit. BPJS is not permitted to make a profit. Public funds are collected in a trust to be used for the benefit of participants.

3. Openness, diligence-caution, accountability, efficiency and effectiveness. Management principles under the management of funds from participants and the results of developments.

4. Portability. This ensures that even if participants move house or change employment, as long as they remain in the Republic of Indonesia they maintain their rights as JKN participants.

5. Mandatory participation. All participants are protected. Applications adapt to the financial capabilities of people and the government, as well as the feasibility of program implementation.

6. Funding body. Payments by participants to the organizing body are entrusted in funds that are well managed and for the benefit of participants.

7. Funds managed by in social assistance funds are to be used entirely for program development and for the greater interests of participants.

5.1.1.4. Requirement to be a JKN’s Participant

According to the Republic of Indonesia Law Number 24 Year 2011, Article 14 on agencies implementing the Social Security, followed by the President of the Republic of Indonesia Regulation No. 12 Year 2013 concerning Health Care Benefits, the participants of the National Healthcare are:

a. PBI Health Care Benefits; and
b. Non PBI Health Care Benefits.

Participants of PBI Health Care Benefits include poor people and low income people while the participants of Non PBI Health Care Benefits are those who are not classified as poor and low income people and they consist of the:

a. Salaried Employee and their family members;
b. Non Salaried Employee and their family members;
c. Non Employee and their family members.
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.

1. Non 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.

   Non 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 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 rights;
- State officials who stopped the pension rights;
- The widow, widower or orphan pension recipients who receive 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; and
g) Not Workers who do not include the letters a to e are unable to pay dues.

2. Family members that remains:
Receiver Wage Workers:
  a) The nuclear family, including wife / husband and children are legitimate (biological children, stepchildren and / or adopted children), a maximum of 5 (five) people.
  b) Children biological, stepchild of a legal marriage, and adopted children are legitimate, with criteria:
     i. Not or have never been married or do not have their own income;
     ii. Not the age of 21 (twenty one) years old or has not been aged 25 (twenty five) years of formal education is still continuing.
  c) Non Receiving Wage Workers and Non-Workers: Participants can include family members who want (unlimited).
  d) Participants can include additional family members, including children 4 and so on, father, mother and in-laws.
  e) Participants can include additional family members, which include other relatives such as siblings / in-laws, household assistant, etc.

5.1.1.5. Targeted People

In the road map of JKN it was agreed that universal health coverage would be achieved by 2019 when all residents will have health insurance and receive the same medical benefits.
The targets are:

1. As of 1 January 2014, BPJS Kesehatan has managed almost 125 million health insurance participants as shown in the table above. These participants will come from the Social Health Insurance for Civil Servants scheme (hereafter referred to as Askes), the Jamkesmas scheme (public health insurance), the Social Security Programme for Employees (hereafter referred to as Jamsostek), the national armed forces, the national police and parts of the Regional Health Insurance scheme (hereafter referred to as Jamkesda).

2. All those under the Jamkesda scheme will become members of BPJS Kesehatan no later than the end of 2016.

3. Employers will register their workers and their families in stages over the 2014–2019 period.

4. Self-employed workers earning an income will register as members of BPJS over the 2014–2019 period.

5. By 2019, no workers will be left undocumented with BPJS Kesehatan.

6. 257.5 million (All Indonesian people) will be covered by BPJS Kesehatan. Universal health coverage will be achieved by the end of 2019 (TPN2K, 2015)
5.1.1.6. Benefits of JKN

National Health Care provides benefits in a form of healthcare protection given to every individual who has paid a premium or have the premium covered by the government.

Benefits of the National Health Insurance (JKN) Health Social Security Institution, which includes:

- Primary health care, non-specialist health services includes the following:
  1. Administration of service
  2. Promotive and preventive services
  3. Examination, treatment and medical consultation
  4. Non-specialist medical measures, both operative and non-operative
  5. Care drugs and consumable medical materials
  6. Blood transfusions as needed medical
  7. Investigations Laboratory diagnosis of first level
  8. Hospitalization first level as indicated
  9. Advanced level referral health services, the health services include:

- Outpatient, includes:
  1. Administration services
  2. Examination, treatment and specialist consultation by a specialist and sub-specialist doctor.
  3. Medical treatment in accordance with a medical specialist, medical indications
  4. Drugs and medical consumable materials
  5. Medical device implants
6. Advanced diagnostic support services in accordance with the medical indications
7. Medical Rehabilitation
8. Blood Services
9. Forensic medicine services
10. Service bodies in health facilities

- Inpatient, includes:
  1. Non-intensive inpatient treatment
  2. Inpatient care in intensive care
  3. Other health services specified by the Minister

The benefit package has been unified, creating greater equity, at least on paper. However, different people have different levels of hotel coverage with PBI having less quality hoteling than others. This should be phased out. Special privileges for civil servants are creeping back into the package, sometimes in secret.

The Benefits Package still requires expansion and integration on certain dimensions. One example is the Primary Health Care Services Package. The PHC package has been defined in law, including medical services, medicines, routine lab, investment, training, and certification. The BPJS covers maternal and neonatal health (absorbing Jampersal), vaccines provided by the government (no syringes, needles, etc.) and treatment of communicable diseases, medicines. Outside of capitation payment are drugs for Puskesmas and home visits, and the latter may be an issue for providers in remote areas, as well as some outpatient specialty services.
5.1.1.7. Organization of JKN under BPJS Health

There are many institution linked to JKN under BPJS Health such as:

1. The People's Representative Council (Dewan Perwakilan Rakyat - DPR)
2. The Presidential Advisory Council (Dewan Pertimbangan Presiden – Wantimpres)
3. The Audit Board (BadanPemeriksaKeuangan – BPK)
4. The National Team for Accelerating Poverty Reduction (Tim Nasional Percepatan Penanggulangan Kemiskinan – TNP2K)
5. The National Social Security Council (Dewan Jaminan Sosial Nasional – DJSN)
6. The Coordinating Ministry for People’s Welfare (Kementerian Koordinator Bidang Kesejahteraan Rakyat)
7. The Ministry of Defense (Kementerian Pertahanan)
8. The Ministry of Finance (Kementerian Keuangan)
9. The Ministry of State-Owned Enterprise (Kementerian BUMN)

Source: TNP2K (2010)
Note: JAMKESMAS = Public Health Insurance; JAMKESDA = Regional Health Insurance; ASKES = Social Health Insurance for Civil Servants and Military; JAMSOSTEK = Health Care Social Security Programme for Employees

Figure 3.6. Type of Benefits

<table>
<thead>
<tr>
<th>TYPE OF BENEFIT</th>
<th>JAMKESMAS</th>
<th>JAMKESDA</th>
<th>ASKES</th>
<th>JAMSOSTEK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Outpatient Services (RUTP)</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Advanced outpatient services (RUTL)</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Basic inpatient services (RITP)</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Advanced inpatient services (RITL)</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered max. 60 days p.a. per disability</td>
</tr>
<tr>
<td>Catastrophic benefits (hemodialysis, heart operations and similar)</td>
<td>Covered, except where access to equipment or experts is unavailable</td>
<td>Covered</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Special benefits</td>
<td>Spectacles, hearing aids, walking aids etc</td>
<td>Spectacles, hearing aids, walking aids etc</td>
<td>Spectacles, hearing aids, walking aids etc</td>
<td>Spectacles, hearing aids, walking aids etc</td>
</tr>
<tr>
<td>Exceptions</td>
<td>Services not delivered according to established procedure, infertility, cosmetic, natural disasters, social services, dental prosthetics</td>
<td>Services not delivered according to established procedure, infertility, cosmetic, natural disasters, social services, dental prosthetics</td>
<td>Services not delivered according to established procedure, infertility, cosmetic</td>
<td>Services not delivered according to established procedure, infertility, cosmetic, cancer therapy, hemodialysis etc</td>
</tr>
<tr>
<td>Thalassaemia benefit</td>
<td>Covered, including non-participants</td>
<td>Information unclear, not explicit, no information re. exceptions</td>
<td>Covered</td>
<td>Not covered as it comes under congenital abnormalities</td>
</tr>
</tbody>
</table>
10. The Ministry of Labour and Transmigration (Kementerian Tenaga Kerja dan Transmigrasi)

11. The Ministry of Health (Kementerian Kesehatan)

12. The Ministry of Social Affairs (Kementerian Sosial)

13. The Ministry of Interior Affairs (Kementerian DalamNegeri)

14. The Ministry for Planning and Development /The National Board for Planning and Development (Kementerian Negara Perencanaan Pembangunan /Bappenas)

15. The National Team for Health Insurance for the Poor (Tim Nasional Jaminan Kesehatan Nasional – Jamkesmas)

16. The Local Government (Pemerintah Daerah)

17. Employer Pension Fund (Dana Pensiun Pemberi Kerja – DPPK)

18. Financial Institution Pension Fund (Dana Pensiun Lembaga Keuangan – DPLK)

All the relations of organization can be seen in the figure below:
The Presidential Decree No. 160 / M Year 2013 dated December 31, 2013 was issued on the Appointment of Commissioners and Board of Directors of PT Askes (Persero) to the Board of Trustees and Directors of Health Social Security Institution and Decision of the Board of Directors of Health Social Security Institution Number 1. In 2014, the Board of Directors commencing Health BPJS dated January 1, 2014 are composed of the following:

1. Fachmi Idris (President Director)
2. Purnawarman Basundoro (Director of Legal, Communication and Inter-Institutional Relations)
3. TonoRustiano (Director of Planning, Development and Risk Management)
4. Fajriadinur (Director of Services)
5. UHC in Thailand

5.1 Legal Framework of UC in Thailand

In Thailand, UHC known as Universal Coverage (UC). Thailand’s National Health Care has long been struggling by an authoritative medical doctor, Sanguan Nitayarumphong, and his small number of team in drafting the bill in 1997 before it gained attention from the infamous rising and leading politician like Thaksin Shinawatra. Taking advantages of this new idea that would help him gain more votes from the people of Thailand, Thaksin Shinawatra grasped this opportunity to win the general election in 2001. Led by Think Tank team of Sanguan Nitayarumphong, Thai Rak Thai Party’s bill proposal was passed into law by both the lower house and the senate in 2002 (Nitayarumphong, 2006).

Based on the National Health Security Act 2002, there are 9 Chapters and Transitory Provision, 70 sections in all. The Act begins with the definitions of terms and continues with 9 chapters, including the Right to Health service (Section 5-12), National Health Security Board (Section 13-23), National Health Security Office (Section 24-37), National Health Security Fund (Section 38-43), Health Care Unit and Standard of Health service (Section 44-47), Standard and Quality Control Board (Section 48-53), Officials (Section 54-56), Health Care Unit Standard Control (Section 57-62), Penalties (Section 63-64), and Transitory Provision (Section 65-70).

Section 5 of the Act clearly states that the rights of all Thai citizens to be entitled to a health service with such standards and efficiency. In addition, the details of the rights to health service are laid in various sections in the bill, such as section 6, 7, 41, 47, and 59 as follows:

1) The right to select a personal health care unit or to change personal health care unit to the personal convenience and necessity (Section 6);

2) The right to receive health service at other health facility as prescribed by the Board in case of reasonableness, accident, or emergency illness (Section 7);
3) The right to complain and request for investigation of being overcharged fees for service exceeding the rate as prescribed by the Board, being charged fees for service by a health care unit without authority, or cannot be reimbursed for damage or injury caused by the health service provided by the health care unit within 32 hours - a period deemed appropriate (Section 59);
4) The right to request for reimbursement for any damage or injury caused by any service provided by the health care unit and the wrongdoer (Section 41); and
5) The right to participate in the development of the National Health Security System Policy and the Fund Management (Section 47).

5.1.2.2. UC’s Objectives

The Universal Coverage Services struggles to provide equal health services to every citizen strategically and aims to achieve the following objectives:

1) to focus on health promotion and prevention as well as curative care;
2) to emphasize the role of primary health care and the rational use of effective and efficient integrated services;
3) to foster proper referrals to hospitals; and
4) to ensure that subsidies on public health spending are pro-poor, at the same time ensuring that all citizens are protected against the financial risks of obtaining health care.

5.1.2.3. UC’s Principles

In order to achieve the goals specified above, the National Health Security Act 2002 was generated through a long process of research and development based on nine various principles, which are as follows:

1) Easy accessibility: people from all walk of life would be able to get access to health care and be part of the scheme, taking their responsibilities of their health, being the owner of the policy, monitoring the program, and partly responsible for the cost for the health care at reasonable price;
2) Entitled rights to health coverage and mechanism to the health coverage protection;
3) Standard and quality health service units;
4) Promoting the utilization of primary care units prior to be sent to the second tier health care unit;

5) Supporting and promoting cooperation among all primary care units in network operation;

6) Promoting long-term cost management of universal health care coverage to become independent from relying on unnecessary health care benefits;

7) Standardization of all core health care benefits, reduce health care redundant benefits from different funds;

8) Efficient health care management employing full stream information technology; and

9) One single health care fund.

5.1.2.4. Requirement to be UHC’s participant

As stipulated in the Section 5 of the National Health Security Act 2002, it is said that all Thai citizens shall be entitled to a health service with such standards and efficiency. The Board shall have beneficiaries jointly pay cost sharing as prescribed by the Board to the health care unit per visit, except such persons as prescribed by the Board who shall be entitled to health service without joint payment.

All the people have to do is to go to health care units as specified by their rights to choose the primary service unit at their convenience, which can be changed to the one nearby in case they have moved to different place to live as they see appropriate. In case where severe treatment is required as confirmed by the family doctor, the patients shall be transferred to nearby hospital where there are specialized doctors and medical facilities available. Also in case of emergency, the patients will be sent to other hospitals where all facilities and doctors are available. Medical expenses and costs will be charged and paid by different funds depending on their eligibilities. For instance, civil servants will be paid by the Civil Servants Health Service Fund; those in private sector will be covered by Social Security Fund, etc.

5.1.2.5. Targeted people

Thailand has one of the most complex health care systems in Asia. Prior to the Reform, there were about six different health benefits schemes targeting different groups of people with different benefit packages. The first one is the low income and public welfare schemes for free of charge at designated public facilities. The second
one is for those working for the government, called Civil Servant Medical Benefit Scheme (CSMBS). It provides health care benefits to both the government officers, their parents, and their dependents. The third one is the Social Security Scheme (SSS) for those working in the private sector with no copayment. It is a compulsory health insurance with limited choice of health care to a contractual public or private hospital. The fourth one is the Workmen’s Compensation Scheme (WCS). It is also a compulsory insurance scheme related to work with copayments when the total charge is higher than the set ceiling. Lastly, the voluntary Health Card (HC) scheme which is provided by the Ministry of Public Health (MPOH) exclusive for the MOPH facilities with referral networks and no copayment.

The National Health Service Reform had been officially initiated since 2001 under the “30 Baht Health Care Project.” It was first implemented as a pilot project in 6 provinces in April 2001, namely Pathumthani, Samutsakorn, Nakornsawan, Yasothorn, Payao, and Yala. About 1.39 million citizens (37.37% of populations in 6 provinces) were covered in this scheme. Two months later, it was expanded to cover 15 more provinces, accounted for 4.9 million or 35% of population in these provinces. Later, in October of 2001, the project had also been implemented in all other provinces in Thailand and 13 areas of Bangkok because Bangkok Administration was more complicated and it required more preparation for the project management. It was not very long that the 30 Baht project had fully covered every area of Thailand in April, 2002. So, it was a gradual and continuous process of policy implementation.

After the National Health Security Bill was passed in 2002, the government initiated the reform as promise during political election campaign. The National Health Security Office (NHSO) was setup to manage the Universal Health Care Coverage in Thailand as stipulated in the 2002 National Security Act. Two governing Boards, namely The National Health Security Board and the Health Service Standard and Quality Control Board, were also appointed to set the national health care policy and to monitor and control the quality of services up to the international standard accordingly. The details of the boards’ authorities will be elaborated later in this report.

As a result of the reform, at present the health care system in Thailand had been cut down to three major schemes, including Civil Servant Medical Benefit Scheme (CSMBS), Social Security Scheme (SSS), and the National Health Security Scheme (NHSS). The 30 Baht project had been transformed to be NHSS. Each scheme targets different groups of Thai populations with different benefit packages. The one in focus
of this study is the last one since it covers about 47 million 75% of population, while 8%, 15.8% are in the CSMBS and SSS respectively.

As stated above the National Health Security Coverage will target all Thai citizens who are not currently gaining benefits from any other health service funds. It is estimated approximately around 2.3 to 5 million people in Thailand.

5.1.2.6. Benefits

Section 3 of this Act also states that “Health service expenses” refers to any expenses born by a health service provided by a Health Care Unit (HCU). The Board has responsibilities to appoint subcommittee to develop benefits scheme, including public health services, types and scope of public health service. The benefits are as follows:

1) Prevention and promotion services including medical and public health service for supporting people living longer age and deceasing patient and disable rate;
2) Diagnosis and investigation services for checking mistakes which occur in medical service;
3) Ante-natal care including checking and supporting infant care services as the model of Department of health, Ministry of Public Health and/or World Health Organization (WHO);
4) Therapeutic items or services including medical treatment service until the end such as kidney treatment in particular;
5) Drugs, biological, supplies, appliances, and equipment including anti HIV virus was contained in national core medicine index;
6) Delivery of the first 2 children;
7) Bed and board services including food and general patient room;
8) newborn care;
9) ambulance or transportation for patient;
10) Transportation for a disabled person;
11) Physical and mental rehabilitation including efficiency of medical service until the end; and
12) Other expenses necessary for the health service as prescribed by the Board.
Table 3.5. Benefit Package And Financing Characteristics Of The Health Benefit Schemes

<table>
<thead>
<tr>
<th>Scheme characteristics</th>
<th>Low income and public welfare</th>
<th>CSMBS</th>
<th>SSS</th>
<th>WCS</th>
<th>Health Card</th>
<th>Private insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit package</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance services</td>
<td>Only designated public hospitals</td>
<td>Public only</td>
<td>Public and private</td>
<td>Public and private</td>
<td>Public (MOPH)</td>
<td>Public and private</td>
</tr>
<tr>
<td>Inpatient services</td>
<td>Public only</td>
<td>Public and private</td>
<td>Public and private</td>
<td>Public and private</td>
<td>Public (MOPH)</td>
<td>Public and private</td>
</tr>
<tr>
<td>Choice of provider</td>
<td>Referral line</td>
<td>Free</td>
<td>Contrafactual basis</td>
<td>Free</td>
<td>Referral line</td>
<td>Free</td>
</tr>
<tr>
<td>Cash benefits</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Usually no</td>
</tr>
<tr>
<td>Inclusive conditions</td>
<td>All</td>
<td>All</td>
<td>Non-work related illness, injuries, except 15 conditions</td>
<td>Work-related illness and injuries</td>
<td>All</td>
<td>As stated in the contracts</td>
</tr>
<tr>
<td>Maternity benefit</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Varies</td>
</tr>
<tr>
<td>Annual physical checkup</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Possible</td>
<td>Varies</td>
</tr>
<tr>
<td>Promotion &amp; prevention</td>
<td>Very limited</td>
<td>Yes</td>
<td>Health education and immunisation</td>
<td>No</td>
<td>Possible</td>
<td>Varies</td>
</tr>
<tr>
<td>Services not covered</td>
<td>Private bed, special nurse, eye glasses</td>
<td>Spediaql nurse</td>
<td>Private bed, special nurse</td>
<td>No</td>
<td>Private bed</td>
<td>Varies</td>
</tr>
<tr>
<td>Financing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Source of fund</td>
<td>General tax</td>
<td>General tax</td>
<td>Tripartite contributions, 1.5% of payroll</td>
<td>Employer, 0.2-2% of payroll with experience rating</td>
<td>Household purchase 500 baht plus tax subsidy 500 baht</td>
<td>Premium</td>
</tr>
<tr>
<td>Financing body</td>
<td>MOPH</td>
<td>Ministry of finance</td>
<td>Ministry of Labour</td>
<td>Ministry of Labour</td>
<td>MOPH</td>
<td>Competitive companies</td>
</tr>
<tr>
<td>Payment mechanism</td>
<td>Global budget</td>
<td>Fee-for-service reimburse</td>
<td>Prospective capitation</td>
<td>Fee-for-service reimburse</td>
<td>Limited fee-for-service</td>
<td>Fee-for-service reimburse</td>
</tr>
<tr>
<td>Copayment</td>
<td>No</td>
<td>Yes, for IP at private hospital</td>
<td>Maternity and emergency services</td>
<td>Yes, if exceed the ceiling of 30,000 baht</td>
<td>No</td>
<td>Almost none</td>
</tr>
</tbody>
</table>

5.1.2.7. Organizations

Based on the National Health Security Act 2002, Thailand’s National Health Scheme is organized and managed by two closed related Boards: the National Health Security Board and the Health Service Standard and Quality Control Board under the National Health Security Office (NHSO), an autonomous organization (see figure 1 below).

![Organization Chart of the National Health Security Office (NHSO)](http://www.nhso.go.th/eng/Site/ContentItems.aspx?type=Mg%3d%3d)

**Figure 3.8. Organization Chart of the National Health Security Office (NHSO)**


The NHSO is led by the Secretary-General, with the assistance of the National Health Sub-committee and the Auditing Sub-committee. The duties of the NHSO are to manage and ensure the attainment of universal coverage for all.

In this design, the policy making and system development is assigned to the National Health Security Board who will develop the national health policy framework on benefit packages, health care service standard, criteria and no-fault compensation and regulations frameworks for contracting providers. Under Section 13 of the 2002 Act, the Ministry of Public Health is appointed as the Chair of the National Health Security
Serving on the National Health Security Board also include a number of experts in medical sciences and public health, Thai traditional medicine, alternative medicine, finance, law and social sciences, administrators, high ranking government officials, 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. From public and private organizations, namely Ministry of Defense, Ministry of Finance, Ministry of Commerce, Ministry of Interior, Ministry of Labor, Ministry of Public Health and Ministry of Education, and the Director of the Bureau of the Budget. All board members are appointed by the Cabinet.

As the Health Service Standard and Quality Control Board, the 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; 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 appointed by the Minister of Public Health. The Board’s main responsibilities are to control, monitor, develop standard and quality of health care providers, and provide comments on standard fees for treatments, regulate no-fault liability payment, support public access to UC information and give response to consumer complaints.

To ensure the integrity and good governance of the policy and implementation, an audit sub-committee, acting as internal auditors, is appointed by the National Health Security Board. Its main task is to closely inspect the system whether internal operation, especially financial management, complies with the laws and regulations. The National Health Security Board will be regularly reported by the audit sub-committee on a quarterly and annual basis.

Taking a closer look at the inside operation of the NHSO, it is found that the NHSO is divided into the Headquarter Office and the Regional Offices. Located in Bangkok, the Central Unit has 15 bureaus, responsible for policy and planning, system support as well as monitoring and evaluation. The regional offices are located in different provinces around the country--3 in the North, 3 in the East, 4 in the
Northeastern, 2 in the South, and 1 in Bangkok-- responsible for administering and monitoring the fund management at the regional level to ensure that health security implementation is responding to the local health needs. There are also 75 medical offices in almost every province in Thailand in providing health services to the people.

2.2. The Implementation of UHC

Based on the questionnaires collected in both countries (table 3) 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 Banphee Hospital are unemployed or freelancers (18.50 percent), 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. On the contrary, in Indonesia most of the respondents are non-PBI or participants who are categorized as poor people and low income earning people.

Table 3.6. Geographical background of samplings

<table>
<thead>
<tr>
<th>Sampling properties</th>
<th>THAILAND</th>
<th></th>
<th>INDONESIA</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>1. Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>105</td>
<td>51.20</td>
<td>140</td>
<td>46.70</td>
</tr>
<tr>
<td>Female</td>
<td>99</td>
<td>48.30</td>
<td>160</td>
<td>53.30</td>
</tr>
<tr>
<td>N/A</td>
<td>1</td>
<td>0.50</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2. Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60 - 65</td>
<td>46</td>
<td>22.40</td>
<td>114</td>
<td>38.00</td>
</tr>
<tr>
<td>66 - 70</td>
<td>58</td>
<td>28.30</td>
<td>90</td>
<td>30.00</td>
</tr>
<tr>
<td>71 - 75</td>
<td>53</td>
<td>25.90</td>
<td>51</td>
<td>17.00</td>
</tr>
<tr>
<td>76 - 80</td>
<td>32</td>
<td>15.60</td>
<td>45</td>
<td>15.00</td>
</tr>
<tr>
<td>81 - 85</td>
<td>13</td>
<td>6.30</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>86 - 90</td>
<td>2</td>
<td>1.00</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>91 - 95</td>
<td>0</td>
<td>0.00</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>95 +</td>
<td>0</td>
<td>0.00</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>N/A</td>
<td>1</td>
<td>0.50</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>3. Residency</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bangkok (Thailand)</td>
<td>167</td>
<td>81.50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yogyakarta (Indonesia)</td>
<td>225</td>
<td>75.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other provinces</td>
<td>22</td>
<td>10.70</td>
<td>75</td>
<td>25.00</td>
</tr>
</tbody>
</table>

49 The conversion rate is about 33.00 baht per one US dollar.
<table>
<thead>
<tr>
<th>Sampling properties</th>
<th>THAILAND</th>
<th></th>
<th>INDONESIA</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>N/A</td>
<td>16</td>
<td>7.80</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>4. Marital Status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>27</td>
<td>13.20</td>
<td>33</td>
<td>11.00</td>
</tr>
<tr>
<td>Married</td>
<td>111</td>
<td>54.10</td>
<td>198</td>
<td>66.00</td>
</tr>
<tr>
<td>Divorce/widow/separated</td>
<td>66</td>
<td>32.20</td>
<td>69</td>
<td>23.00</td>
</tr>
<tr>
<td>N/A</td>
<td>1</td>
<td>0.50</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5. Educational level</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>74</td>
<td>36.10</td>
<td>119</td>
<td>39.70</td>
</tr>
<tr>
<td>High school</td>
<td>41</td>
<td>20.00</td>
<td>106</td>
<td>35.30</td>
</tr>
<tr>
<td>Vocational</td>
<td>21</td>
<td>10.20</td>
<td>22</td>
<td>7.30</td>
</tr>
<tr>
<td>Undergraduate</td>
<td>55</td>
<td>26.80</td>
<td>53</td>
<td>17.60</td>
</tr>
<tr>
<td>Graduate +</td>
<td>7</td>
<td>3.45</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>N/A</td>
<td>7</td>
<td>3.45</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>6. Occupation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Civil servants/public enterprise</td>
<td>4</td>
<td>2.00</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Business owners</td>
<td>34</td>
<td>16.60</td>
<td>70</td>
<td>23.3</td>
</tr>
<tr>
<td>Employees</td>
<td>11</td>
<td>5.40</td>
<td>41</td>
<td>13.7</td>
</tr>
<tr>
<td>Farmers /agricultural</td>
<td>1</td>
<td>0.50</td>
<td>14</td>
<td>4.7</td>
</tr>
<tr>
<td>Retire officials</td>
<td>13</td>
<td>6.30</td>
<td>30</td>
<td>10</td>
</tr>
<tr>
<td>Homemakers/housewives</td>
<td>30</td>
<td>14.60</td>
<td>45</td>
<td>15</td>
</tr>
<tr>
<td>Freelance</td>
<td>38</td>
<td>18.50</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Unemployed</td>
<td>69</td>
<td>33.70</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Others</td>
<td>5</td>
<td>2.40</td>
<td>65</td>
<td>21.6</td>
</tr>
<tr>
<td>7. Income per month</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Baht equivalent to Rupiah)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 2,000</td>
<td>48</td>
<td>23.40</td>
<td>98</td>
<td>32.7</td>
</tr>
<tr>
<td>2,000 – 5,000</td>
<td>24</td>
<td>11.70</td>
<td>82</td>
<td>27.3</td>
</tr>
<tr>
<td>5,000 – 10,000</td>
<td>46</td>
<td>22.45</td>
<td>75</td>
<td>25</td>
</tr>
<tr>
<td>10,000 -20,000</td>
<td>47</td>
<td>22.95</td>
<td>30</td>
<td>10</td>
</tr>
<tr>
<td>20,000-50,000</td>
<td>32</td>
<td>15.60</td>
<td>15</td>
<td>5</td>
</tr>
<tr>
<td>More than 50,000</td>
<td>5</td>
<td>2.40</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>N/A</td>
<td>3</td>
<td>1.50</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

The perception of respondents on the implementation of both UC and JKN varies. It has 5 parameters in the measurement: 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. Overall, the perception of the respondents show better perception in Thailand rather than in Indonesia. In Indonesia the result in Standard Procedures of public hospital parameter shows 4.10, which is lower than Thailand’s remark of 4.68.
In terms of communication between agencies of UHC Healthcare, it is found that Thailand has 4.56, while Indonesia has only 3.77.

Another parameters are the medical human resources readiness, convenient facilities and infrastructure, and medicine sufficiency which shows higher result in Thailand.

Table 3.7. Parameters of implementation UHC

<table>
<thead>
<tr>
<th>Implementation</th>
<th>Thailand</th>
<th>Opinion</th>
<th>Indonesia</th>
<th>opinion</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Communication between agencies of UHC Healthcare</td>
<td>4.56</td>
<td>Highly Satisfied</td>
<td>3.77</td>
<td>Very Satisfied</td>
</tr>
<tr>
<td>3. Medical human resources readiness</td>
<td>4.46</td>
<td>Highly Satisfied</td>
<td>4.18</td>
<td>Very Satisfied</td>
</tr>
<tr>
<td>4. Convenient Facilities and infrastructure</td>
<td>4.35</td>
<td>Highly Satisfied</td>
<td>4.20</td>
<td>Very Satisfied</td>
</tr>
<tr>
<td>5. Medicine sufficiency</td>
<td>4.46</td>
<td>Highly Satisfied</td>
<td>4.10</td>
<td>Very Satisfied</td>
</tr>
</tbody>
</table>

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 healthcare units and sufficient of health resources such as doctors, nurses, medicine, and administration staff to organize UC. It can be traced from the number 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, norm, 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 more patients which are more than the number of registered populations in the area which the government provided funding; while small unit facilities do not have many registered patients.
Table 3.8. Numbers of Primary Care Unit in Thailand in year 2013 *

<table>
<thead>
<tr>
<th>NHSO</th>
<th>Main Service Units</th>
<th>Total Primary Care Units (Places)</th>
<th>Proportion of Population to Primary Care Units (people)</th>
<th>Proportion of Primary Care Unit &lt;= 10,000 people</th>
<th>Proportion of Primary Care Unit &lt; 10,000 &lt;= 30,000 people</th>
<th>Proportion of Primary Care Unit &gt; 30,000 &lt;= 50,000 people</th>
<th>Proportion of Primary Care Unit &gt; 50,000 people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region 1</td>
<td>Chiangmai</td>
<td>116</td>
<td>1,264</td>
<td>3,205</td>
<td>1237</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>Region 2</td>
<td>Pitsanulok</td>
<td>54</td>
<td>709</td>
<td>3,688</td>
<td>685</td>
<td>24</td>
<td>-</td>
</tr>
<tr>
<td>Region 3</td>
<td>Nakhornawan</td>
<td>52</td>
<td>649</td>
<td>3,475</td>
<td>635</td>
<td>14</td>
<td>-</td>
</tr>
<tr>
<td>Region 4</td>
<td>Saraburi</td>
<td>102</td>
<td>944</td>
<td>3,535</td>
<td>898</td>
<td>45</td>
<td>1</td>
</tr>
<tr>
<td>Region 5</td>
<td>Ratchaburi</td>
<td>76</td>
<td>1,006</td>
<td>3,888</td>
<td>970</td>
<td>33</td>
<td>2</td>
</tr>
<tr>
<td>Region 6</td>
<td>Rayong</td>
<td>84</td>
<td>886</td>
<td>4,360</td>
<td>819</td>
<td>62</td>
<td>3</td>
</tr>
<tr>
<td>Region 7</td>
<td>Khonkaen</td>
<td>71</td>
<td>907</td>
<td>4,202</td>
<td>886</td>
<td>21</td>
<td>-</td>
</tr>
<tr>
<td>Region 8</td>
<td>Udonthani</td>
<td>88</td>
<td>971</td>
<td>4,479</td>
<td>939</td>
<td>31</td>
<td>1</td>
</tr>
<tr>
<td>Region 9</td>
<td>Nakhornratchasima</td>
<td>98</td>
<td>1,064</td>
<td>4,797</td>
<td>1017</td>
<td>47</td>
<td>-</td>
</tr>
<tr>
<td>Region 10</td>
<td>Ubonratc hathani</td>
<td>77</td>
<td>928</td>
<td>3,658</td>
<td>916</td>
<td>12</td>
<td>-</td>
</tr>
<tr>
<td>Region 11</td>
<td>Suratthani</td>
<td>85</td>
<td>820</td>
<td>4,545</td>
<td>780</td>
<td>37</td>
<td>2</td>
</tr>
<tr>
<td>Region 12</td>
<td>Songkla</td>
<td>83</td>
<td>923</td>
<td>4,299</td>
<td>881</td>
<td>37</td>
<td>4</td>
</tr>
<tr>
<td>Region 13</td>
<td>Bangkok</td>
<td>179</td>
<td>269</td>
<td>14,415</td>
<td>108</td>
<td>135</td>
<td>13</td>
</tr>
<tr>
<td>14. Special group</td>
<td>2</td>
<td>0.17%</td>
<td>2</td>
<td>37,686</td>
<td>-</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>1,167</td>
<td>11,342</td>
<td>4286.73</td>
<td>10,771</td>
<td>522</td>
<td>30</td>
</tr>
</tbody>
</table>

NHSO: National Health Services Organization
The PCUs have different capacities in terms of the number of medical doctors, nurses, personnel, and medical equipment and facilities to handle patients ranging from less than 10,000 people for the smallest PCU, to the biggest PCU which is 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 has more large PCUs and able to provide the most services to large proportion of population.

2.3. 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. Empirical fact shows that 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.

On the contrary, in Thailand, the informants’ opinion concerning the quality of services in seven different aspects told different stories. It was found that all were highly satisfied with services at Banphaeo Hospital. This came to no surprise since this hospital, the Sukhumvit Branch, 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 that the common illnesses are eyes and kidney
related diseases which require number of medical visits to the hospitals every one or two months, it would cost the patients 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 the cost of everyday living, not to mention the cost of regular health care. The UC scheme is the only answer to their needs.

<table>
<thead>
<tr>
<th>Service quality</th>
<th>Thailand</th>
<th>Opinion</th>
<th>Indonesia</th>
<th>opinion</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. On-time services</td>
<td><strong>4.32</strong></td>
<td>Highly Satisfied</td>
<td>4.03</td>
<td>Very Satisfied</td>
</tr>
<tr>
<td>3. Sufficient services</td>
<td>4.15</td>
<td>Very satisfied</td>
<td>3.99</td>
<td>Very Satisfied</td>
</tr>
<tr>
<td>4. Continuous care services</td>
<td>4.67</td>
<td>Highly Satisfied</td>
<td>4.17</td>
<td>Very Satisfied</td>
</tr>
<tr>
<td>5. Service improvements</td>
<td>4.17</td>
<td>Very satisfied</td>
<td>4.15</td>
<td>Very satisfied</td>
</tr>
<tr>
<td>7. Customers Care (medical personnel)</td>
<td>4.53</td>
<td>Highly Satisfied</td>
<td>4.12</td>
<td>Very Satisfied</td>
</tr>
</tbody>
</table>

Source: Primary Data

6. UHC Financial

6 INDONESIA’S JKN FINANCE

JKN as the unified social insurance program that pool contributions from three broad categories of people: (i) the poor and near-poor whose fixed premium contributions will be paid for entirely by the central government (the group that was previously covered under Jamkesmas); (ii) those employed in the formal sector, both public and private, whose salary-based contributions will be paid for by employers and employees (this group includes those that were previously covered under Askeskin and Jamsostek); and (iii) those who are non-poor and work in the informal sector who are expected to pay a fixed premium contribution upon enrollment in the program (this group would include most of those who are currently uncovered). The JKN was conceived to provide better health coverage for all Indonesians, by extending insurance to the entire population, including large swathes of the population previously not covered by any public insurance schemes (The Economist Intelligent Unit, 2015).

There are 2 kind of JKN contributions:
1. Contribution for people below the poverty line (PBI) which is paid by central and local government, and
2. Contributions of members paying their own premium
   a. Workers in formal employment premium is shared by employees and employer calculated as a percentage of salary/wage.
   b. Self and non-employed pay nominal/flat rate and determined by Presidential Decree. Contributions/premiums are pooled and create the major source of funding for the scheme.

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.

Further regulation on assessment of emergency condition and procedure for emergency services expense reimbursement shall be regulated under BPJS Healthcare Regulation.

There are 3 levels of Health care providers:

   1. Primary health care providers: Public Health Service, Private clinic, Private Doctor
   2. Secondary and tertiary health care providers: Hospitals both public hospitals and private hospitals

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 Indonesian Case-Based groups payment model in implementing JKN, 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 1 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 pay advanced health-care facilities for their services, according to the diagnosed illnesses (Kumorotomo, 2015).

In order to assess the effectiveness of Indonesian health finance policy to cover health services for the population, it is important to consider how has been the performance of the BPJS in integrating various health schemes in the country. As a health scheme specifically targeted for the poor and near-poor, the Jamkesnas is now managed by the BPJS. 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. With the funding of about a quarter of the central government budget on health, the BPJS handling on Jamkesmas target is likely determined by the Indonesian government’s intention to attain a universal coverage. As a health scheme specifically targeted for the poor and near-poor, the Jamkesnas is now managed by the BPJS. Jamkesnas program was started in 2005 as Askeskin, literary means health insurance for the poor. In 2007, the Askeskin that was originally based on households was renamed Jamkesmas to be based on individuals and expanded to also cover the near-poor. 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 (Kumorotomo, 2015).

With the funding of about a quarter of the central government budget on health, the BPJS handling on Jamkesmas target is likely determined by the Indonesian government’s intention to attain a universal coverage. It is therefore important to analyze the whole institutional arrangement for health policy in Indonesia as administrative efficiency is also a key factor determining the quality and the coverage of health services in the country.
Figure 3.9. Health Financing and Provision in Indonesia

Source: Adapted from Soewondo et al, 2011; BPJS, 2014.
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 government is to be lauded for this bold move to such a powerful payment system to encourage greater technical efficiency. The hospital INA CBG system for all covered is of particular concern. It was developed outside of Indonesia, and based on United States clinical practice patterns and cost structures. In future years, the CBGs need to reflect local cost structures and clinical practice patterns. This will require development of a cadre of local experts who are not part of the hospital sector (as they are now), but can objectively and empirically assess and refine the software groupers that generate tariffs.

As Indonesia implements the new BPJS reforms, the issue of fiscal space for UHC has become paramount. The unified social insurance program will pool contributions from three broad categories of people: (i) the poor and near-poor whose fixed premium contributions will be paid for entirely by the central government; (ii) those employed in the formal sector, both public and private, whose salary-based contributions will be paid for by employers and employees; and (iii) those who are non-poor and work in the informal sector who will be expected to pay a fixed premium contribution upon enrollment in the program. 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, added 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 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:

3. Primary health care providers: capitation

4. 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 3.10. JKN Premium

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

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 started first. 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 6 percent 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.

7. UHC Financial in 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. The 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 regulate, monitor 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) 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 3.11. Characteristics of Thailand’s three public health insurance schemes after achieving universal coverage in 2002

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

Source: Health Insurance System Research Office, 2012

On the 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 centers, district hospitals, and provincial hospitals
were pro poor while university hospitals seem to pro rich. This result can be implied that district health centers, 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 the 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, like what 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:
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 marginalized 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 Srithamrongswat 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 increase the investment in the primary care system through improving the technical quality 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 consist of 126 million members has been achieved by August 2014, with 18,355 contracted health facilities, consisting of 16,804 primary care facilities and 1,551 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. The 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 3.11. Health services tariff in Indonesia

<table>
<thead>
<tr>
<th>No.</th>
<th>Elements</th>
<th>INA-CBG (JKN, 2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Data coding</td>
<td>6,000,000 records</td>
</tr>
<tr>
<td>2</td>
<td>Costing benchmark</td>
<td>137 hospitals</td>
</tr>
<tr>
<td>3</td>
<td>Contributors</td>
<td>All classes in public and private hospitals</td>
</tr>
<tr>
<td>4</td>
<td>Case distribution</td>
<td>Normal</td>
</tr>
<tr>
<td>5</td>
<td>Trimming method</td>
<td>IQR</td>
</tr>
<tr>
<td>6</td>
<td>Tariff reference</td>
<td>Mean</td>
</tr>
<tr>
<td>7</td>
<td>Number of case-base group</td>
<td>1077 + 6 Special CMG</td>
</tr>
<tr>
<td>8</td>
<td>Tariff grouping</td>
<td>6</td>
</tr>
<tr>
<td>9</td>
<td>Proportion of implemented tariff</td>
<td>100%</td>
</tr>
<tr>
<td>10</td>
<td>Clustering</td>
<td>5 scales</td>
</tr>
<tr>
<td>11</td>
<td>Medical care class</td>
<td>3, 2, 1</td>
</tr>
</tbody>
</table>


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 organizations 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.

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. Structuring the contribution of individual members currently outside the insurance system.

![Figure 3.11. Financial sustainability of the JKN programme](source: Hidayat (2015)).

The contributions for the poor and low-income earners 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 the 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 3.12. Financial state of JKN (IDR trillion) 2014-2015

<table>
<thead>
<tr>
<th>Year</th>
<th>Deficit</th>
<th>Cumulative deficit</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>6.1</td>
<td>6.1</td>
</tr>
<tr>
<td>2015</td>
<td>7.96</td>
<td>14.1</td>
</tr>
<tr>
<td>2016</td>
<td>15.5</td>
<td>29.6</td>
</tr>
<tr>
<td>2017</td>
<td>17.1</td>
<td>46.7</td>
</tr>
<tr>
<td>2018</td>
<td>25.7</td>
<td>72.4</td>
</tr>
<tr>
<td>2019</td>
<td>23.8</td>
<td>96.2</td>
</tr>
</tbody>
</table>

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

Figure 3.13. JKN Cashless Referral Model. 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 per capita 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).

5.2. THAILAND UC’s FINANCE

As shown in Table 3.12 below, the number of people register for the UC rights has increased every year from approximately 47 million, accounted for 70.14 % of population in 2011 to almost 49 million or 73.13% in 2015. It is going to be increased in the future and expected that all Thai citizens will be covered by either UC rights or other health security rights. Both numbers of male and female populations are quite close in registering for their rights to UC, with a slightly less female are unregistered as compared to male.

Table 3.12. Number of populations in Thailand covered by UC rights and other rights categorized by Gender from year 2008-2015

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
<th>Total (Male +Female)</th>
<th>All rights (Male+Female)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right to Health Insurance</td>
<td>Other rights</td>
<td>Unregistered</td>
<td>Right to Health Insurance</td>
</tr>
<tr>
<td>2013</td>
<td>24,036,331</td>
<td>82,381</td>
<td>391,948</td>
</tr>
<tr>
<td>2014</td>
<td>23,942,134</td>
<td>120,229</td>
<td>161,680</td>
</tr>
<tr>
<td>2015</td>
<td>23,913,234</td>
<td>131,823</td>
<td>162,712</td>
</tr>
</tbody>
</table>

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

Accordingly, percentage of Thai populations entitled to Universal Health Coverage has been quite steady at approximately 73% from year 2011 to present. In year 2012, the number of people with UC scheme slightly increased by 1 %, but the years after has dropped to 73% and steady onward is because they have been covered by Social Security Scheme, the rights for those who work in private sector. The
implication is that they have found jobs and have to co-pay for the social security rights with the government and their employees.

Table 3.13: Different Health Coverage Schemes of Thai People from 2011 to present

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal coverage</td>
<td>73.44%</td>
<td>74.22%</td>
<td>73.87%</td>
<td>73.33%</td>
<td>73.36%</td>
</tr>
<tr>
<td>CMSBS &amp; state enterprise</td>
<td>15.51%</td>
<td>7.76%</td>
<td>7.57%</td>
<td>7.34%</td>
<td>7.34%</td>
</tr>
<tr>
<td>Social security</td>
<td>7.67%</td>
<td>15.90%</td>
<td>16.37%</td>
<td>16.79%</td>
<td>16.85%</td>
</tr>
<tr>
<td>Other rights and statuses</td>
<td>0.42%</td>
<td>0.28%</td>
<td>0.33%</td>
<td>0.43%</td>
<td>0.45%</td>
</tr>
<tr>
<td>Unregistered</td>
<td>0.74%</td>
<td>1.31%</td>
<td>1.07%</td>
<td>0.49%</td>
<td>0.48%</td>
</tr>
<tr>
<td>Pending status</td>
<td>2.04%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thai citizens in foreign countries</td>
<td>0.02%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foreigners</td>
<td>0.16%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Administration</td>
<td></td>
<td>0.15%</td>
<td>0.88%</td>
<td>0.91%</td>
<td></td>
</tr>
<tr>
<td>Unidentified rights and statuses</td>
<td></td>
<td>0.52%</td>
<td>0.63%</td>
<td>0.74%</td>
<td>0.61%</td>
</tr>
<tr>
<td>Total number of populations</td>
<td>64,754,31</td>
<td>65,503,95</td>
<td>65,903,94</td>
<td>65,884,70</td>
<td>65,836,24</td>
</tr>
<tr>
<td>Total (rights)</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

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

Concerning the Primary Care Units in Thailand, the services have been divided into 13 regional offices and one special group disperses to different part of the country (See Table 3). 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 11,342 PCU, mostly located in Chiangmai (1,264 units), Nakhonratchasima (1,064 units), and Ratchaburi (1,006 units), and etc. The PCUs have different capacities in number of medical doctors, nurses, personnel, and medical equipment and facilities to handle patients ranging from less than 10,000 people for the smallest PCU, to the biggest PCU which are able to handle more than 50,000 cases. In comparison, most of PCUs, accounted for 90%, can provide services to less than 10,000 people. Interestingly, Bangkok has lesser number of small PCUs, but with more large sized of PCUs and able to provide the most services to large proportion of population. 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 because they are dependent on the funding they received from the government based on the number of registered populations in the area; while small units does not have many registered patients.

Table 3.14: Numbers of Primary Care Unit in Thailand in year 2013 *

<table>
<thead>
<tr>
<th>NHSO</th>
<th>Main Units (Places)</th>
<th>Service</th>
<th>Total Primary Care Units (Places)</th>
<th>Proportion of Population to Primary Care Units (people)</th>
<th>Primary Care Unit &lt;= 10,000 people</th>
<th>Primary Care Unit &lt; 1000 0 &lt;= 30,000 people</th>
<th>Primary Care Unit &gt; 30,000 &lt;= 50,000 people</th>
<th>Primary Care Unit &gt; 50,000 people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region 1 Chiangmai</td>
<td>116</td>
<td>9.94%</td>
<td>1,264</td>
<td>3,205</td>
<td>1237</td>
<td>23</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>Region 2 Pitsanulok</td>
<td>54</td>
<td>4.63%</td>
<td>709</td>
<td>3,688</td>
<td>685</td>
<td>24</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Region 3 Nakhornsawan</td>
<td>52</td>
<td>4.46%</td>
<td>649</td>
<td>3,475</td>
<td>635</td>
<td>14</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Region 4 Saraburi</td>
<td>102</td>
<td>8.74%</td>
<td>944</td>
<td>3,535</td>
<td>898</td>
<td>45</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Region 5 Ratchaburi</td>
<td>76</td>
<td>6.51%</td>
<td>1,006</td>
<td>3,888</td>
<td>970</td>
<td>33</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Region 6 Rayong</td>
<td>84</td>
<td>7.20%</td>
<td>886</td>
<td>4,360</td>
<td>819</td>
<td>62</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Region 7 Khonkhaen</td>
<td>71</td>
<td>6.08%</td>
<td>907</td>
<td>4,202</td>
<td>886</td>
<td>21</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Region 8 Udonthani</td>
<td>88</td>
<td>7.54%</td>
<td>971</td>
<td>4,479</td>
<td>939</td>
<td>31</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Region 9 Nakhornratcharisma</td>
<td>98</td>
<td>8.40%</td>
<td>1,064</td>
<td>4,797</td>
<td>1017</td>
<td>47</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Region 10 Ubonthalani</td>
<td>77</td>
<td>6.60%</td>
<td>928</td>
<td>3,658</td>
<td>916</td>
<td>12</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Region 11 Suratthani</td>
<td>85</td>
<td>7.28%</td>
<td>820</td>
<td>4,545</td>
<td>780</td>
<td>37</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Region 12 Songkla</td>
<td>83</td>
<td>7.11%</td>
<td>923</td>
<td>4,299</td>
<td>881</td>
<td>37</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Region 13 Bangkok</td>
<td>179</td>
<td>15.34%</td>
<td>269</td>
<td>14,415</td>
<td>108</td>
<td>135</td>
<td>13</td>
<td>9</td>
</tr>
<tr>
<td>14. Special group</td>
<td>2</td>
<td>0.17%</td>
<td>2</td>
<td>37,686</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>1,167</td>
<td>100.00%</td>
<td>11,342</td>
<td>4286.73</td>
<td>10,771</td>
<td>522</td>
<td>30</td>
<td>14</td>
</tr>
</tbody>
</table>

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

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

In general, there are two different approaches to finance universal health care in most developed and developing countries around the world: 1) the compulsory or social insurance, widely known as Bismarck Model and 2) the taxation method, known as the Beveridge Model (Nitayarumphong and Mills, 2005).
The Bismarck Model is considered as an insurance based system, such as a social insurance system, depending on the ability to pay and accessibility to services at time of needs independent from the government. Initiated in Germany with tight regulation framework for the contributions to health funds, it is applied to countries like Japan, Korea, and Taiwan because it creates less political conflict and a more centralized means of fund management. Furthermore, it gives more choices to the people.

The Beveridge Model is funded by tax or government revenue. The United Kingdom and Canada are the good example of countries using this model. No other countries in Asia and Latin America has applied this model to cover health care at full range.

Learning from reform experiences in different countries in Asia and Latin America, there is no “one best way” or “one size fits all.” It all depends on the economic, political and social status of each individual country.

Another aspect of financial management to be considered is to decide whether to have a single fund or multiple funds of the money collected from the people. Various countries in Asia have adopted the multiple funds approach to health care such as Japan, Korea, and Chile; while Taiwan use the single way to manage funds. The only issue arises from multiple funds is the inefficiency of administrative cost. A single taxed-based health system would be easier to manage and Korea has been trying to merge or combine different funds into a single fund system.

In Thailand, the money used to support the National Universal Health Care Coverage comes mostly from the government. Based on the pilot implementation of capitation contract model in Banpaeo Hospital in January 2001 and Social Health Insurance early on in April 1991, the research concluded that the capitation contract model would be more suitable for increase of health care costs in the future in designing Universal Coverage Scheme. The general tax financed would be the best possible way for fund management in comparison to the fee for service reimbursement model of the CSMBS. Considering the upscale of UC scheme in the future, the copayment was contemplated to be politically and technically infeasible (Tangcharoensathien and others, n.d.). Section 38 of the 2002 Act has set up a “National Health Security Fund” (NHSF) under the National Health Security Office (NHSO) with main authorities in providing and supporting health care costs and public health services to service units.
There are at least 8 different sources of funding to ensure that all citizens can get access to cheap and quality health care services at reasonable and affordable price as follows:

1. Government annual allocation;
2. Local government administration;
3. Fees from services as specified by the Act;
4. Fine collected by the Act;
5. Donations to the National Health Service Fund;
6. Interests from the savings and asset of the Fund;
7. Other income or asset derived from related activities of the Fund; and
8. Other sources as allowed by the law, e.g. Dental Fund, Subdistrict Administrative Organization Fund, Medicine Fund, Kidney Fund, etc.

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. As seen in Table 4, 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% 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 the figure seem to be alarming, but this money is only accounted for 1.1% or 1.2% of the Annual National Gross Domestic Products (DGP), and only about 6% 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% 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.
### Table 3.15: UC Annual Budget Allocation Year 2002-2014

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>GDP (Million Baht)</td>
<td>5.4 50, 643</td>
<td>5.7 99, 700</td>
<td>6.4 76, 100</td>
<td>7.19 5,000</td>
<td>7.78 6,200</td>
<td>8.39 9,000</td>
<td>9.23 2,200</td>
<td>8.71 2,500</td>
<td>10.00,900</td>
<td>10.6 50,900</td>
<td>11.5 72,300</td>
<td>12.2 95,000</td>
<td>13.2 42,000</td>
</tr>
<tr>
<td>Annual allocated budget of Thailand</td>
<td>1.02 22,300</td>
<td>999.90 500</td>
<td>1.13 63,250</td>
<td>1.25 0,000</td>
<td>1.36 6,000</td>
<td>1.56 6,200</td>
<td>1.66 6,000</td>
<td>1.95 7,000</td>
<td>1.70 0,000</td>
<td>2.07 0,000</td>
<td>2.38 0,000</td>
<td>2.40 0,000</td>
<td>2.52 0,000</td>
</tr>
<tr>
<td>UC budget (include personnel salary)</td>
<td>56,091</td>
<td>61,212</td>
<td>67,783</td>
<td>91,699</td>
<td>108,065</td>
<td>117,969</td>
<td>129,281</td>
<td>140,609</td>
<td>141,540</td>
<td>154,258</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- UC as % in GDP</td>
<td>1.1%</td>
<td>1.1%</td>
<td>1.1%</td>
<td>1.2%</td>
<td>1.2%</td>
<td>1.2%</td>
<td>1.2%</td>
<td>1.2%</td>
<td>1.2%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- UC as % overall budget</td>
<td>6.0%</td>
<td>5.8%</td>
<td>6.1%</td>
<td>5.5%</td>
<td>6.9%</td>
<td>6.2%</td>
<td>5.9%</td>
<td>5.9%</td>
<td>6.1%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UC budget details</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. UC targeted population (million)</td>
<td>45.00</td>
<td>46.00</td>
<td>46.82</td>
<td>47.00</td>
<td>47.75</td>
<td>46.07</td>
<td>46.78</td>
<td>47.26</td>
<td>47.2397</td>
<td>47.997</td>
<td>48.333</td>
<td>48.445</td>
<td>48.852</td>
</tr>
<tr>
<td>2. Capitation (Baht/head/year)</td>
<td>1.2 02.40</td>
<td>1.3 08.50</td>
<td>1.3 63.30</td>
<td>1.65 9.20</td>
<td>1.89 9.69</td>
<td>2.10 0.00</td>
<td>2.20 0.00</td>
<td>2.40 1.33</td>
<td>2.54 6.48</td>
<td>2.75 5.60</td>
<td>2.75 5.60</td>
<td>2.89 5.09</td>
<td></td>
</tr>
</tbody>
</table>

Source: NHSO, Policy and Planning, Funds Information 2002-2014

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 11,342 PCU, 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 3.16. Numbers of Primary Care Unit in Thailand in year 2013 *

<table>
<thead>
<tr>
<th>NHSO</th>
<th>Main Service Units</th>
<th>Total Primary Care Units (Places)</th>
<th>Proportion of Population to Primary Care Units (people)</th>
<th>Primary Care Unit &lt;= 10,000 people</th>
<th>Primary Care Unit &lt;= 30,000 people</th>
<th>Primary Care Unit &gt; 30,000 people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Places %</td>
<td></td>
<td></td>
<td>Proportion of Population to Primary Care Units (people)</td>
<td>Primary Care Unit &lt;= 10,000 people</td>
<td>Primary Care Unit &lt;= 30,000 people</td>
<td>Primary Care Unit &gt; 30,000 people</td>
</tr>
<tr>
<td>Region 1</td>
<td>Chiangmai</td>
<td>116</td>
<td>9.94 %</td>
<td>1,264</td>
<td>3,205</td>
<td>1237</td>
</tr>
<tr>
<td>Region 2</td>
<td>Pitsanulok</td>
<td>54</td>
<td>4.63 %</td>
<td>709</td>
<td>3,688</td>
<td>685</td>
</tr>
<tr>
<td>Region 3</td>
<td>Nakhonratchasima</td>
<td>52</td>
<td>4.46 %</td>
<td>649</td>
<td>3,475</td>
<td>635</td>
</tr>
<tr>
<td>Region 4</td>
<td>Saraburi</td>
<td>102</td>
<td>8.74 %</td>
<td>944</td>
<td>3,535</td>
<td>898</td>
</tr>
<tr>
<td>Region 5</td>
<td>Ratchaburi</td>
<td>76</td>
<td>6.51 %</td>
<td>1,006</td>
<td>3,888</td>
<td>970</td>
</tr>
<tr>
<td>Region 6</td>
<td>Rayong</td>
<td>84</td>
<td>7.20 %</td>
<td>886</td>
<td>4,360</td>
<td>819</td>
</tr>
<tr>
<td>Region 7</td>
<td>Chonburi</td>
<td>71</td>
<td>6.08 %</td>
<td>907</td>
<td>4,202</td>
<td>886</td>
</tr>
<tr>
<td>Region 8</td>
<td>Udonthani</td>
<td>88</td>
<td>7.54 %</td>
<td>971</td>
<td>4,479</td>
<td>939</td>
</tr>
<tr>
<td>Region 9</td>
<td>Chaiyaphum</td>
<td>98</td>
<td>8.40 %</td>
<td>1,064</td>
<td>4,797</td>
<td>1017</td>
</tr>
<tr>
<td>Region 10</td>
<td>Ubonratchathani</td>
<td>77</td>
<td>6.60 %</td>
<td>928</td>
<td>3,658</td>
<td>916</td>
</tr>
<tr>
<td>Region 11</td>
<td>Suratthani</td>
<td>85</td>
<td>7.28 %</td>
<td>820</td>
<td>4,545</td>
<td>780</td>
</tr>
<tr>
<td>Region 12</td>
<td>Songkhla</td>
<td>83</td>
<td>7.11 %</td>
<td>923</td>
<td>4,299</td>
<td>881</td>
</tr>
<tr>
<td>Region 13</td>
<td>Bangkok</td>
<td>179</td>
<td>15.34 %</td>
<td>269</td>
<td>14,415</td>
<td>108</td>
</tr>
<tr>
<td>14. Special group</td>
<td></td>
<td>2</td>
<td>0.17 %</td>
<td>2</td>
<td>37,686</td>
<td>-</td>
</tr>
</tbody>
</table>

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 terms of the number of medical doctors, nurses, personnel, and medical equipment 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.

**Conclusions**

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 varies. It has 5 measurement parameters: 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 Convenient Facilities parameter and infrastructure 4.20, while the lowest is the 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. Both 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 an annual burden on the National Budget.

Reference:

29. World Bank’s (2009). Sourcebook on “Social Accountability: Strengthening the Demand Side of Governance and Service Delivery” Social Accountability Sourcebook Chapter 4 Social Accountability In The Health Sector.
31. Budi Hidayat, (2015), Financial Sustainability of the National Health Insurance in Indonesia: A First Year Review, DJSN & GTZ.
33. EY, (2015), The New Mandatory Health Insurance Scheme - Taking stock one year after the introduction, Ernst and Young (EY) Indonesia.
34. Limwattananon, S., V. Tangcharoensathien, et al. (2010)."Equity in maternal

35. Makarim, Rina, Taira S, Indonesia (2013): New Regulation on Public Health Insurance,

36. Mukti, Ali Gufron, (2012). Health Insurance Reform, Center of Health Finance Policy and Insurance Management, Faculty of Medicine, Universitas Gadjah Mada,


48. Shah, Anwar, Public Services Delivery, Edited by Anwar Shah, The

50. Soewondo P, et al. , Policy Brief Indonesia National Health Account


55. World Bank’s Sourcebook on “Social Accountability: Strengthening the Demand Side of Governance and Service Delivery” Social Accountability Sourcebook Chapter 4 Social Accountability In

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