Analysis of the Indonesian National Health Insurance Program (Jaminan Kesehatan Nasional/JKN) Policy, draft 1: 2 May 2019

What Are the Current JKN Policy Options?

An Analysis of the JKN Policy from the Perspective of Equitable Distribution of Quality and Sustainable Healthcare Services

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Introduction

The Law No. 40 of 2004 on the National Social Security System (*Sistem Jaminan Sosial Nasional*/SJSN) was made as the basis for the implementation of social security adhering to universal principles without disregarding specific conditions in Indonesia. SJSN is implemented in stages based on program viability and the society's social/economic class (The Drafting Team of Sistem Jaminan Sosial Nasional, 2003).

Conclusions from the Policy Research using Realist Evaluation Approach

In 2018, Universitas Gadjah Mada conducted an evaluation of the JKN policy by using realist approach and included 7 provinces in the study. The Indonesian National Health Insurance Program (JKN) policy manages to provide financial protection from economic risks due to illnesses to almost all population of Indonesia (Agustina, 2019), However, the research highlighted that, at the end of 2018, the eight goals of JKN as coined in in the JKN Road Map had not been realized. After 5 years of implementation, the issues of equitable distribution and quality assurance in seven provinces where the research was conducted remains. Efforts to improve equitable distribution of healthcare facilities between regions remained ineffective. Moreover, health system fragmentation have occurred due to disharmony between the centralistic nature of the parastatal institution that organizes Indonesia social security (*Badan Penyelenggara Jaminan Sosial*/BPJS) and the de-centralistic nature of the health system. Such factors have contributed to the unequitable health service distribution between regions and inadequate healthcare quality assurance system both at national and provincial levels. Significant discrepancies in healthcare quality between developed and less developed provinces were also observed. Further, various JKN principles, such as mutual assistance, transparency and accountability have not been implemented optimally.

Issues with JKN Policies

Based on findings from the evaluation research using realist approach and other previous assessments, the issues with the JKN policy resulting from the formulation and implementation of the SJSN Law and the BPJS Law are as follow:

1. The issue of equitable access to healthcare facilities; *who gets what in the health insurance system?*

   During the five years of implementation, it is revealed that the funds allocated to Premium Assistance Beneficiary (*Penerima Bantuan Iuran/*PBI) have been used to cover the deficit stemmed from utilizations by the Non-Wage Earning Workers (*Pekerja Bukan Penerima Upah*/PBPU) segment. The beneficiaris in underdeveloped regions such as East Nusa Tenggara received significantly less benefits compared to beneficiaries in, for example, the Special Region of Yogyakarta. Furthermore, the compensation policy has not been implemented and the inter-provincial portability policy was only applicable to relatively financially capable beneficiaries. Such inequalities are inconsistent with the 1945 Constitution and the objectives of the Law on SJSN and Law on BPJS that read:

   - The National Social Security System shall be implemented on the bases of the principles of humanity, benefit and social justice for the whole Indonesians.
   - The Law on SJSN stipulates that funds allocated to PBI shall be used by the underpriviledged.

   Hence, the principle of social justice has not been realized.

2. The disharmony between the centralized system adopted by the BPJS *Kesehatan* and the regional government's decentralized system has resulted in flawed policy and decision making on JKN where it is not based on transparent data and limited involvement of relevant

stakeholders at the central and regional levels. In addition and partly as the effect of the disharmony, regional governments still lacked the sense of responsibility towards JKN. Additionally, fragmentation is found within the healthcare system. Such a condition betrays the principles of accountability and transparency that should be implemented and are mandated by the law.

3. JKN budget deficit as well as the causes have not been monitored and investigated in detail, especially in relation to the segments of beneficiaries and premium payment sufficiency of each segment. Moreover, the utilization of healthcare services between segments and between regions remains inequitable. Adverse selection within the PBPU segment had triggered high reimbursement charges, and constitutes as the main cause of JKN budget deficit. For the past five years, there has been no transparency relating to this issue. Issues relating budget deficit and inequitable use of health service and funding are a violation to the principles of, among others, cooperation, and resulted in the difficulty in finding a solution to the budget deficit.

4. The Law on BPJS is not effective to ensure a quality healthcare as the establishment of the quality assurance system had only been completed in 2019, not to mention the absence of legal sanctions against any potential fraud. Such a condition betrays the benefit principle that should have been applied by BPJS.

These problems require immediate action, otherwise they may hinder the attainment of the objectives of the Law on SJSN and the Law on BPJS. They call for a number of policy options, which should be analyzed to improve the existing JKN policy.

Policy options to cope with the policy issues

It is vital to improve JKN policy based on the principles of good governance, which presently receive little attention. It is expected that policy-related decision making is carried out transparently. Therefore, Policy Options need to be analyzed transparently. The following are the Policy Options in relation to the issues surrounding JKN:

Option 1:
The Law on SJSN and the Law on BPJS are not amended. The Law on SJSN and the Law on BPJS remain the same with its problematic implementation, especially in connection with the issues of inequitable distribution of healthcare and varying degree of quality.

Option 2:
BPJS should remain as the only social security administering body, but supported with a mutual agreement to build firewalls between PBI pooling, PPU (*Pekerja Penerima Upah*/Wage Earning Workers) pooling and PBPU pooling. In addition, no PBI funds should be used to finance PBPU. If they switched to a higher class, the privileged community members/PBPU should pay their treatment in full, take non-BPJS Kesehatan commercial health insurance or opt for a fixed cost-sharing. These firewalls or compartments are expected to ensure that the poor and vulnerable population are prioritized in the utilization of PBI funds (as the embodiment of social justice for the people of Indonesia).

Option 3:
There are other health insurance agencies (other poolings) in addition to BPJS Kesehatan. The privileged community members may choose to not enroll as a BPJS Kesehatan

participant on the condition that they purchase a commercial health insurance product. They may enroll as a BPJS Kesehatan participant as well, but they must opt for the standard class, rather than Class 1, 2 or 3. Furthermore, they cannot switch to a higher class.

Projection:

1.1. Equity

- ❑ BPJS Kesehatan's budgeting condition will keep deteriorate if the privileged community members (PBPU) realized that they will get abundant health benefits with a relatively low premium after becoming a participant.
- ❑ As the number of privileged participants with good access to good healthcare facilities enjoy a uncapped benefit plan for a low premium payment, the budget deficit in the PBPU segment will also see an increase. In addition, the utilization by the underprivileged (PBI) will see a similar trend. There is a likelihood that, in the future, the amount of PBI budget allocation from central and regional goverments will decrease.
- ❑ The data derived from BPJS Kesehatan shows that Java and many big cities have greater access to advanced cardiovascular healthcare facilities. Many privileged BPJS Kesehatan participants (i.e. PBPU consisting of Informal Sector Workers and Non-Workers) have utilized this services.

Projection:

- ❑ Limited funding due to recurring deficit will hamper the establishment of cardiovascular health facilities and the distribution of cardiologists. Additionally, there may be a reversed flow of funds, i.e. from underdeveloped regions to the developed regions. This single-pool scheme of the system will drive the occurrence of this unjust phenomena.
- ❑ As a result of the deficit and single-pool scheme, PBI budget surplus from underdeveloped regions such as East Nusa Tenggara dan Papua cannot be used to fund the compensation policy.
- ❑ If the issues of healthcare facilities and human resources in underdeveloped regions were not addressed immediately, future access to the benefit plans will be more inequitable (in connection with the supply-side equity).
- ❑ This would require a follow-up, otherwise the disparity in terms of the access to Advanced Healthcare Facilities (*Fasilitas Kesehatan Tingkat Lanjut*/FKTL) between PBI and non-PBI may also grow.

1.2. Effectiveness: Whether the options proposed bring an optimal result (outcome)

Projection:

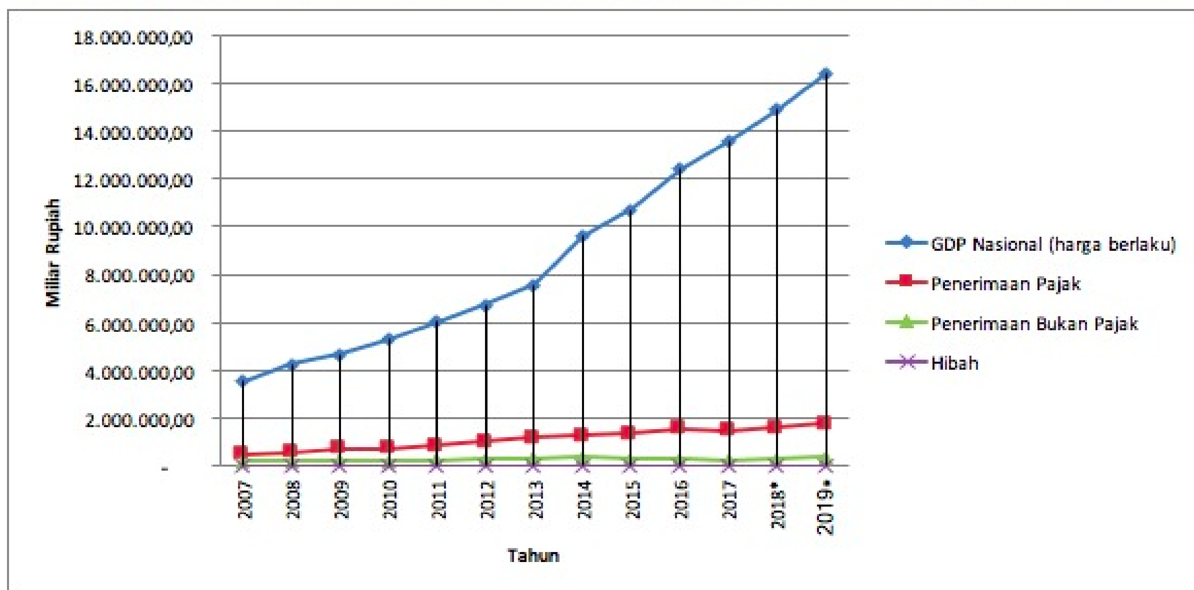
- ❑ Service quality would be increasingly difficult to manage.
- ❑ The risk of fraud will increase in the absence of sanctions. Fraud performed as a coping strategy will be increasingly popular.

Projection:

The inaction will result in the regional governments' unresponsiveness towards the problems surrounding JKN. Regional governments will always view BPJS *Kesehatan* as a source of income for the health facilities in their respective regions. Furthermore, joint planning based on joint monitoring and evaluation becomes increasingly impossible to perform. As a result, numerous activities will not be aligned with the developments within BPJS *Kesehatan*.

- ❑ The State Budget (*Anggaran Pendapatan dan Belanja Negara*/APBN) ability to cover the resulting deficit is limited. Currenty, the tax collectability is low. The figure below shows that, since 2006, the increase in the tax to GDP (Gross Domestic Product/*Produk Domestik Bruto*) ratio is not been significant.

Figure 1. Development of GDP and Tax Revenue in Indonesia



Source: The Central Bureau of Statistics, 2018

Aside from that, the tax-backed APBN currently have to allocate funds for infrastructures as well. The APBN, as stipulated by the Law, should focus on the underpriviledged. In the future, considering GDP trends and APBN, the role of the APBN as a source of funds for BPJS may still be limited since a certain portion of it must still be allocated to bring about more equitable distribution of healthcare facilities and health workers—an expense that will keep increasing. Moreover, from the perspective of equitable distribution, the continous use of APBN bailout fund will instead be used to cover the deficit occurring in relatively wealthier groups.

- The reluctance to raise the PBPU premium intended for the privileged community members that is coupled with insufficient APBN will result in a poor health system. Conditions will worsen if: (1) regional governments refused to cover for the BPJS deficit in their respective region; (2) the privileged community members considered that the responsibility to cover healthcare costs lies in the government or that healthcare should be low-priced, thus refusing to pay a higher premium.
- If the PBPU premium and quality assurance system were not improved, the deficit in the PBPU segment is bound to experience an increase. Meanwhile, the GDP has potential funds generated from the income of the privileged community members that can be used to pay for the health insurance.
- PBPU tariff adjustment will continuosly create problems if it still requires the considerations of the House of Representative (*Dewan Perwakilan Rakyat*/DPR). Considering the GDP trend, Option 1 will fail in taking the advantage of current economic growth to provide funds for the health sector.

Financially, Option 1 offers an unsustainable prospect. The health system, especially the health insurance, will be increasingly reliant on the APBN and the political decisions made at DPR. Potential funding from the population may not be able to find its way to the health sector.

Option 2. The Law on SJSN and the Law on BPJS are revised: BPJS still adopts the single-pool system

1.1. Equity: Whether the alternative proposal will result in more equitable distribution of resources to the population.

Projection:

- ❑ The existence of compartments or firewalls between PBI, PBPU and PPU poolings will help halt the flow of PBI funds to the PBPU pool. This would enable the implementation of compensation or affirmative policies as BPJS funds for the underpriviledged. PBPU participants could be encouraged to realize the significant benefit of paying a higher premium for their own health interests.
- ❑ The implementation of the compensation policy is predicted to open up more opportunities for the underprivileged (PBI) to access healthcare, as mandated in the constitution. This policy could be implemented by mobilizing health workers and providing sufficient transportation allowances for the purpose of patient referrals. Such practice was done in Taiwan, where the government provides compensation fund for transportation for patients from mountaneous and rural areas (Lee et al. 2018). Based on Hsiao's research 2013, Indonesia should also learn how to improve the previously low utilization through a number of policies to boost targeted investment in rural healthcare facilities.

Consequences/prospect : This policy option intends to address potential inequalities in terms of access to healthcare and to achieve the objectives stipulated in the Law on SJSN and the Law on BPJS *based on the principles of humanity, benefit, and social justice for all Indonesians*.

1.3. Effectiveness: Whether the option proposed gives an optimal result (outcome).

Projection:

- ❑ This policy option is projected to be a solution to the dilemma between maintaining quality or expanding healthcare coverage in regions with poor access/supply-side.
- ❑ The risk of fraud can be minimized, as regional governments are to monitor/supervise the execution of JKN in their respective regions. Furthermore, there will be sufficient funds to develop a system to prevent fraud and set out punitive measures against it.

1.4. Responsiveness: The extent to which the option successfully satisfies the needs, preference, or values of particular community groups

Projection:

- In Option 2, policies are formulated so as to delegate the responsibilities regarding JKN implementation to regional governments. It is expected that this option will facilitate access to JKN data, especially the ones required for health planning development at regional level, monitoring the quality of the healthcare services, establishing regional government programs on disease control and performing tariff negotiations among regional governments, regional health workers and BPJS *Kesehatan*.
- It is expected that the central government will assist regions with low or limited fiscal capacity in attempts to develop healthcare in their respective regions as a response to the issues surrounding JKN. As for regional governments with high fiscal capacity, they will be encouraged to take part and assume the duty of contributing to the attainment of JKN objectives (Decentralization Concept).
- This option is projected to be able to prevent the central government from being the only party covering the deficit. Regional governments should also contribute and cover the deficit. Moreover, this option is expected to be able to improve equitable distribution of access to healthcare to the whole population.

- ❑ **Responsiveness towards JKN needs to be viewed from the public's perspective**

Projection

- The participant pooling compartment option would enable the restriction on the services provided to the privileged (PBPU).
- This restriction aims to distribute access to advanced healthcare facilities more equitable to the underpreviledged population.
- It is predicted that the erroneous implementation of the cooperation principle could be reduced. Any surplus from PBI funds derived from the APBN/APBD (*Anggaran Pendapatan dan Belanja Daerah*/Regional Budget) could be used for the underpriviledged, and would *minimize the possibility* of such funds being used to pay for the medical treatment of the privileged community members (PBPU).
- Possible complaints may come from PBPU or non-worker participants in the middle-range status, who might express an objection if the BPJS premium in their segment exceeded the amount they can afford.

Consequence/prospect : This policy option will facilitate the agendas of the National Medium-Term Development Plan 2015-2019 (*Rencana Pembangunan Jangka Menengah Nasional 2015-2019*/RPJMN) to address the gap between regions, especially between the Western Indonesian Region (*Kawasan Barat Indonesia*/KBI) and the Eastern Indonesian Region (*Kawasan Timur Indonesia*/KTI), which is the main issue of the development direction.

1.5. **Economic and financial possibility**: The cost of each policy option and whether the resulting outcome can be deemed beneficial.

Projection

- ❑ This Option 2 would coupled with the policy on the restriction on high-cost services in the privileged compartment. An increase in BPJS funds intended for catastrophic patients such as those suffering from heart disease above will be restricted. It is expected that by adopting this policy, the privileged members will use their own money to purchase additional health insurance. This eventually would reduce the APBN's expenses and thus, increase fund availability for improvidng infrastructure gaps or for disease prevention.
- ❑ With an inflow of community funds to the healthcare sector and the addition of the APBN/APBD budget for the equitable distribution of healthcare facilities and quality improvement, the percentage of GDP allocated to the healthcare sector would increase.
- ❑ An increase in GDP for the healthcare sector would improve healthcare, including in terms of health workforce and the pharmaceutical/health equipment industry.

1.6. **Political viability**: Measures whether each policy option will have an impact on the political power of certain groups.

Projection

If this option were to be implemented, conflicting ideologies, interpretations and/or political supports may arise. There would be a lot of debates loaded with various interests. The middle and upper class who are accustomed to government subsidies through BPJS *Kesehatan* (APBN) will tend to oppose this option. This may cause a political uproar.

Hence, it is important to provide the community with detailed explanations of what is currently happening. Moreover, it is also vital to instill the view that the government is not the only party

responsible for paying for the health insurance. If such view is not instilled, Option 2 would not work well.

Option 3. The Law on SJSN and the Law on BPJS are revised: Other health insurance agencies (other pooling) in addition to BPJS *Kesehatan* are employed.

This is the policy option that changes BPJS *Kesehatan*, making it no longer the only pool for health insurance scheme. The privileged may opt for not becoming a BPJS *Kesehatan* participant on the condition that they must purchase a commercial health insurance product. They may enroll as a BPJS *Kesehatan* participant as well, but only by opting for the standard class and may not switch to a higher class. BPJS Classes (1, 2, and 3), that have been proven to have the characteristics of a commercial health insurance based on real-life experiences for the past five years, should not be used again. This policy option would still require that all Indonesian citizens to have a health insurance protection. It is implemented by first establishing rules regarding restrictions on healthcare benefit plans based on the economic group of the participants. This aims to maintain the stability of the JKN program and sustain the state's limited capability in prioritizing the underprivileged.

This policy option is not intended to limit access to healthcare. Rather, it displays strong concern to groups that should be prioritized in terms of the fulfillment of the right to health care within the context of growing social, economic and geographical disparities. This option is based on the fact that despite a marked increase in GDP, Indonesia still has problems collecting taxes.

Moreover, this option would provide the freedom of choice to financially independent Indonesia citizens so that they can choose a service that meets their expectation. This has already happened in various countries, including Thailand, Malaysia, and the United Kingdom, where demands differ between community groups. Some people (especially those privileged) are not satisfied with the standard services provided by social health insurance companies. This group is willing to pay more and would encourage improvement in the commercial health insurance sector, pharmaceutical industry, healthcare professionals and hospitals.

This option is predicted to be able to provide incentives (compensation) to regions with limited access so that they can meet the needs for healthcare facilities and thereby realizing the objective of social insurance, which is to ensure access for every single citizen.

Aside from the policy regarding the elimination of commercial health insurance components (PBPU's Class 1, 2, and 3), other policies that should be in place are:

- Governance improvement: strengthening the cooperation between BPJS *Kesehatan* and both the central and regional governments. The Law on SJSN and the Law on BPJS *Kesehatan* need to be revised in order to strengthen the cooperation between BPJS and the Ministry of Health (central government) and the Department of Health (regional government).
- Regulatory improvement should be performed by raising the upper limit for income that is subjected to premium payment for the PPU segment. A compartment separating PPU and PBI would still be implemented.
- Service quality should be improved by putting an emphasis that national policies need to be added into the existing law.
- Improvement on preventive and promotive policies should be implemented.

Forecasts:

1.1 Equity: Whether the alternative proposed brings about a more even distribution of resources among the community.

Current Situation

The latest data show that the type of segment of participant is an important variable that affected the utilization of health services. The results of the analysis indicate that the privileged participant pool (PBPU) enjoyed the most of the health insurance (PKMK FK-KMK UGM, 2019). These

participants enjoyed benefits for extremely cheap premiums. Surprisingly, despite affordable premiums, about 45% of these PBPU participants did not make payment on time. On the other hand, until 2019, about 40 million Indonesian citizens have not enrolled themselves as a BPJS *Kesehatan* participant.

Projection:

- The implementation of market mechanism to the PBPU would allow the privileged community members to choose a health insurance scheme that meets their expectations. However, the underpriviledged may either switch to the PBI segment or take the standard class using government subsidies on the condition that they cannot switch to a higher class. It is projected that PBPU participants who wished to enjoy different or more comprehensive healthcare services would choose this option.
- The APBN funds that hitherto have been largely used to cover PBPU budget deficit could be used to fund for the compensation policy. This would enable the implementation of compensation or other affirmative policies as BPJS *Kesehatan* funds for the underpriviledged would be available.
- The implementation of the compensation policy is predicted to open up more opportunities for the underprivileded (PBI) to access healthcare, as mandated in the constitution.

Consequence/prospect: This option demands that the privileged population pay premiums proportionally to the use of healthcare so as to contribute to the realization of social justice or rights referred to in Paragraph 28 H of the 1945 Constitution, which reads "*Every person shall have the right to obtain medical care, the same opportunity and benefit in order to achieve equality and fairness, and social security in order to develop oneself fully as a dignified human being*."

1.2 Effectiveness: Whether the option proposed brings about an optimal result (outcome).

Current Situation

The current service quality is not well managed. This was resulted from, among others, BPJS' low claim and capitation funds. Moreover, its referral system tends to be based on profit and loss calculation rather than healthcare quality. For the past 5 years, BPJS Kesehatan has acquired healthcare services without involving local governments in terms of quality assurance.

Projection:

- Service quality could be controlled because this option encourages that health providers to not operate below standard cost as what happens presently.
- Fraud supervision is predicted to remain weak due to the lack of funds and the desire to get additional claims as a coping strategy. The inflow of more funds to the hospital sector is expected to reduce potential fraud as a result of an increased amount of claim and capitation.
- There is a possibility of two-tier health service along with its various side effects. These side effects could be reduced if BPJS funds were increased so as to improve its service quality.
- BPJS *Kesehatan* would have less expenses and thus, enabling it to focus on participants in PBI and PPU segments by paying more attention to the service quality. BPJS *Kesehatan* would no longer be burdened to collect premiums as this task will be delegated to more competent commercial health insurance agencies.
- Local governments would be more capable in monitoring the healthcare quality delivered by BPJS *Kesehatan* and other commercial health insurance agencies.

Consequence/Prospect : The so-called good governance could be realized in JKN program management as this option is projected to be capable of anticipating the practices of monopsony in BPJS *Kesehatan* in terms of health service purchasing.

1.3 Responsiveness: The extent to which the option successfully meets the needs, preference, or value of particular community groups.

- **Responsiveness towards JKN needs to be viewed from the government's perspective**
  Regional governments and professional associations/healthcare facilities may initiate adjustments to tariffs, service quality, timeliness in paying premiums and development of health programs through organizational arrangements in conjunction with BPJS Kesehatan in order to discuss control over medical costs and ensure decent income for health workers.

- **Responsiveness towards JKN needs to be viewed from public's perspective**
  This option would enable the JKN program to successfully respond to all of the basic medical needs of the entire population by adopting the established schemes, which give priority to the welfare of the underpriviledged. As a result, the privileged community members would feel more satisfied with the health insurance system that better meets their expectation. Furthermore, various commercial health insurance plans would be developed and would offer attractive innovations that meet public expectations. Such interesting innovations would be delivered through the combination of healthcare with health maintenance activities such as fitness sessions, home-care services and so on.

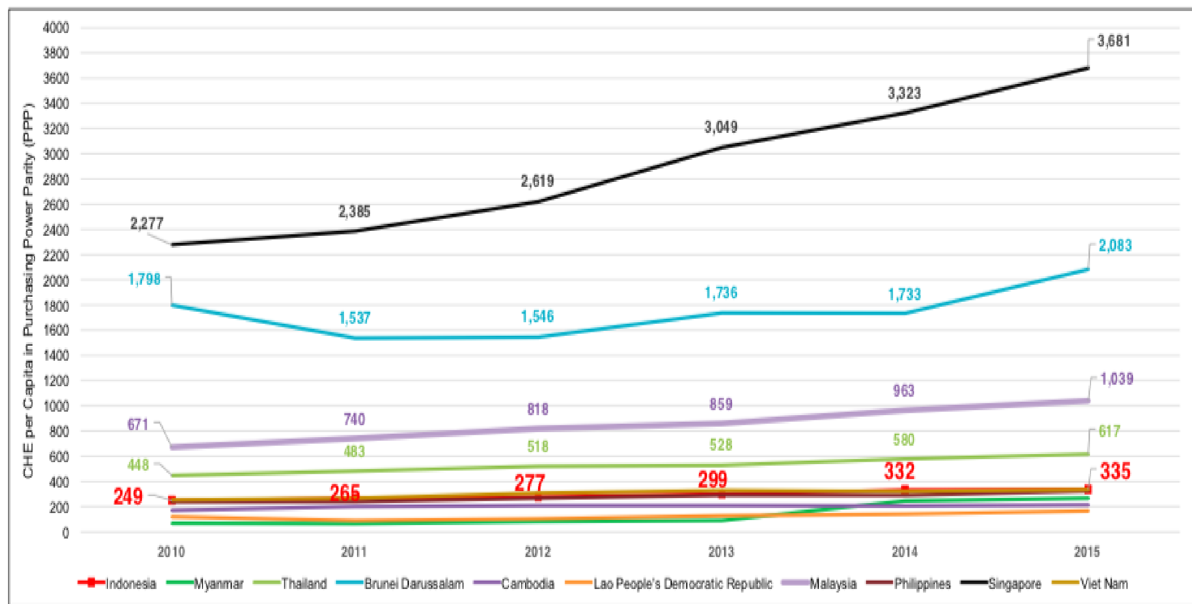
Consequence/Prospect: In this option, BPJS Kesehatan would serve only as a payer of social health insurance. The programs and policies established must be based on local contexts (social, economic, and geographical) and be decided on the basis of quality evidences and legitimized by normative instruments. In addition, BPJS *Kesehatan* regionalization would possibly be implemented according to the situation of particular healthcare facilities. Moreover, a commercial health insurance market would also emerge.

1.4 Economic and financial possibility: The cost each policy option and whether the resulting outcome can be deemed beneficial.

Current Situation

Indonesia is currently implementing a national healthcare service/financing system that relies on taxes, APBN, and APBD. This proves to be problematic since the individual taxes in Indonesia are not progressive and has a low amount. Moreover, a bigger portion of health funds is allocated to curative efforts that are enjoyed more by privileged BPJS *Kesehatan* participants. On the other hand, the funds allocated for promotive and preventive efforts are more limited. The way these health funds are spent are not balanced enough to attain public prosperity. The 2016 NHA data show that Indonesia's per-capita health spending is far lower than Singapore, Brunei Darussalam, Malaysia, and Thailand. Thailand, a country which has implemented a social security program, has a per-capita health spending that is almost 2 times higher than Indonesia.

Figure 2. Indonesia's Per Capita Health Spending with Other Countries



Source: WHO Global Health Expenditure Database, data updated in 2015, NHA 2016

Projection

- ❑ Option 3 is expected to increase funds collected from the privileged for the health sector, especially for curative services, and thus increasing per capita health funds.
- ❑ Option 3 is formulated so that the government's funds can be focused on the underpriviledged community members and provide the government with opportunities to increase the budget for preventive and promotive services and the expansion of healthcare infrastructures.
- ❑ Option 3 would provide additional funds for the health sector through payments made by the privileged to the commercial health insurance companies.

Consequence/prospect : To increase health fund allocation by at least 5% of the APBN and at least 10% of the APBD is mandated in Articles 170–171 of the Law No. 36 of 2009, which read *to provide sufficient, equitably allocated, effectively utilized, and efficient health financing in a sustainable manner so as to ensure healthcare development to further increase the degree of public health to the utmost extent.*

1.5 Political viability: Measures whether each policy option will have an impact on the political power of certain groups. PBI funds will be focused on the underprivileged.

Projection

It is predicted that this policy option would cause a lengthy disagreement or debate as a result of major changes in the Indonesian health security system. Such debate needs to be based on the Rawlsian ethical thinking where it is expected that all parties realize that, ethically, this policy does not harm any community groups.

Final notes prior to implementing these recommendations:

These options need to be discussed ideologically with all relevant stakeholders. The discussion should be based on the understanding of ideological principles employed to analyze this policy.

- The proposed policy changes in this Policy Analysis are formulated based on the ideology present in the 1945 Constitution. The government prioritizes the provision of benefits to the underprivileged community members. On the other hand, the privileged community members, considering the government's limited capacity, need to pay more. The privileged must start purchasing health insurance since youth.
- These changes are also based on the idea that the GDP has the economic potentials that could be beneficial to the health sector. Such potential may be beneficial through the mechanisms of taxes and public funding. The economic potentials that GDP has for the health sector may also be exploited by other sectors.
- In addition, these changes are also made using cultural approach and formulated by considering the community's preferences and access to health services. Without the compartmentalization of health insurance funds, the use of BPJS funds by participants from the middle class will continue to occur.

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