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Perihal : Revisi ke-1 Klarifikasi Karya Ilmiah
a.n. Dr. Gita Susanti, M.Si.

Yth. Direktur Sumber Daya
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Berdasarkan Rekap Hasil Tahapan Penilaian Usulan Jabatan Fungsional/Pangkat Dosen pada laman https://pak.kemdikbud.go.id Periode Agustus 2023 status usulan kenaikan jabatan akademik/pangkat Sdr. Dr. Gita Susanti, M.Si. NIP 196503111991032001, NIDN 0011036506 dari Lektor Kepala, Pembina (Gol. IV/a) menjadi Guru Besar/Profesor, Pembina Tingkat I (Gol. IV/b) belum dapat diproses lebih lanjut dengan alasan (terlampir).

Sehubungan dengan hal tersebut, dengan hormat kami sampaikan klarifikasi dan bukti korespondensi karya ilmiah yang diajukan sebagai syarat khusus (terlampir).

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Atas perhatian dan kerjasamanya, disampaikan terima kasih.

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Atas Nama Dr. Gita Susanti, M.Si

Yth. Reviewer Penilai Usulan Jabatan Akademik Guru Besar

Menindaklanjuti hasil review periode Agustus 2023 mengenai usulan Jabatan Akademik Guru Besar atas nama Dr. Gita Susanti, M.Si. Maka bersama dengan ini saya ingin melakukan klarifikasi mengenai bukti korespondensi jurnal bereputasi sebagai syarat khusus pengusulan Guru Besar telah menunjukkan proses pembahasan pada aspek-aspek subtantif dari karya ilmiah. Hal ini merujuk pada artikel yang telah saya bersama tim submit pada tanggal 28 Februari 2021. Setelah itu, hasil review artikel diterima pada tanggal 18 agustus 2021 dengan status artikel diterima dengan catatan adanya revisi dalam korespondensi pada aspek-aspek subtantif. Kemudian artikel yang telah revisi, disubmit kembali pada tanggal 17 Desember 2021 dan direspon oleh editor pada tanggal 24 November 2022 bahwa artikel akan publish pada isu ke-4(empat) tahun 2022.

Artikel yang disubmit dan artikel yang revisi menunjukkan adanya perbedaan pada subtansi artikel sebagaimana hasil review yang diinginkan oleh reviewer A (ditandai warna abu-abu) dan reviewer B (ditandai warna kuning) pada Public Policy and Adminstration Journal. Bersama dengan surat klarifikasi ini, Berikut terlampir artikel yang telah disubmit dan yang telah direvisi sebagai bukti proses korespondensi pada aspek-aspek subtantif.

Selain itu, saya juga perlu klarifikasi mengenai hasil turnitin artikel kami yang 4% kesamaan dari sumber *Research Gate* yang membuat hasil Turnitin kami menjadi 21%. Versi yang kami Turnitin tersebut adalah versi on line dalam kondisi *on proof* belum versi cetak.

Demikian surat klarifikasi saya bersama tim penulis atas tanggapan reviewer dari naskah jurnal kami. Kami sangat berharap klarifikasi ini bisa membantu proses usulan Guru Besar kami. Atas perhatian dan pertimbangannya, kami haturkan banyak terima kasih.

Makassar, 28 Agustus 2023

Mengetahui,
Dekan
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[PPA] Submission Acknowledgement

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Dr Gita Susanti:

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Balas Teruskan

Assesing National Health Insurance System: A Policy Implementation Study of Indonesia Health Insurance Policy

Abstract
This study analyses the implementation of National Healthcare System which has been implemented since 2014 in Indonesia. The study applied the qualitative approach and data were collected through observation, interviews, and documents study. The informants are grouped into three categories namely health insurance user, hospital management and health insurance company (BPJS) as an implementing organisation in management of national healthcare insurance services. The study used interpretative method as data analysis technique. The result of study shows that the National Healthcare Insurance – Indonesia healthcard (JKN-KIS) is a strategic policy especially for basic health needs. However, various problems that occur such as membership aspects, inappropriate contributions, and benefit package systems cause fragmentation of health service delivery, as well as ineffective risk management. Budget deficit experienced by BPJS as the implementing agency has a significant impact on the limitations of hospitals in providing services. This is mainly due to hospital payment claims that are not being paid by BPJS-Kesehatan.

Keywords: Policy Implementation, health Insurance, health policy, Indonesia

Introduction
In the field of health policy, the national health insurance system is one of the important issues that guarantees the quality and access of health services to all citizens. Until now, the resolution of the problem of the national health insurance system has been the focus of scholars, governments, practitioners and international institutions. This is because the problem is complex. Studies on Social Health Insurance in Western Europe show the characteristics of self-regulation where the special conditions for financing and providing health services are regulated by social-insurance institutions through mutual self-governance. However, the principle of self-regulation began to weaken with increasing state regulation and market competition, which were introduced in response to economic and social changes (Wendt, Agarta & Kaminska, 2013). For example, study in Japan explains the advantages and disadvatage of pursuing universal health coverage by establishment of employee-based and community-based social health insurance. On the positive side, nearly everybody was covered in 1961; the enforcement of the same fee schedule for all plans and almost all providers has maintained equity and contained costs; and the co-payment rate has become the same for all, except for elderly people and children. This equity has been achieved by provision of subsidies from general revenues to plans that enrol people with low incomes, and enforcement of cross-subsidisation among the plans to finance the costs of health care for elderly people. On the negative side, the fragmentation of enrolment into 3500 plans has led to a more than a three-times difference in the proportion of income paid as premiums, and the emerging issue of the uninsured population (Ikegami, Yoo, Hashimoto, Matsumoto, Ogata, Babazono, Watanabe, Shibuya., Yang, Reich, Kobayashi, 2011).
In 2016, China has three sorts of medical insurance systems. First, Urban Employee Basic Medical Insurance System; Basic Medical Insurance System for Urban Residents from personal account saving are used to pay for medical treatments and medication (public health insurance fund). Second, New Rural Co-operative Medical Care System (NRCMCS) (free). Urban Employee Basic Medical Insurance System and Basic Medical Insurance System for Urban Residents were

integrated into Urban and Rural Residents' Basic Medical Insurance Systems (Matsuoka & Fukai, 2018).

Medical health insurance system in Singapore is based on the fund system which manages the fund in the Central Provident Fund (CPF). This capital and labors compulsory build up money of a certain percentage from wages to a labor's personal account. There are three kinds of medical insurance systems namely : Medifund; Medisave; MediShield (Matsuoka & Fukai, 2018).

The other case, Malaysia plans to have fair medical access, rather than public medical insurance system. This measure can facilitate the residents to have medical services at public medical institutions with less self-burden where the help of federal budget is provided. Further , the cost of medical treatment of public medical institution has regulated based on fee act in 1951 where additional charges as examinations , medicine , hospitalization and surgery with standard low cost .Then, in urban areas tends to be dominated by medical treatment of a medical institution private that are not covered by health insurance (Matsuoka & Fukai, 2018).

The fulfillment of the basic needs of citizens is the domain of the government. One of them is by giving and guaranteeing citizens to get proper health services. Included in this is ensuring that every citizen who has financial problems can still access health services. This is in line with the concept of Universal Health Coverage where every community in the population has fair and equitable access to holistic health services including promotive, preventive, curative, and rehabilitative services that are quality and needed at affordable costs (Yuningsih, 2013).

Health development policy in Indonesia is currently still facing various problems that have not been completely resolved. Based on the Legatum Prosperity Index Report (Legatum Prosperity Index, 2018), it shows that Indonesia's health index is in the poor category and ranks 94 out of 146 countries. Therefore, improving the system and quality of health services in Indonesia is a must. In response, the government has carried out reforms in the health sector by introducing National Health Insurance System and Indonesia Healthcare Card (JKN-KIS) for every citizen. The program is organized by the Healthcare and Social Security Agency (BPJS) and health insurance, especially for the poor, is fully covered by the government.

The study aims to analyze the implementation of the JKN-KIS policy. The implementation of policies in the last two decades is one of the fundamental issues among researchers and practitioners of public administration in order to bridge the gap between concept and reality. The policy implementation study analyzes policy outputs and outcomes. These two parameters will determine whether the policy performance is achieved as expected in the policy formulation process.

Various literatures have revealed and formulated theories, concepts and methods in analyzing social health insurance performance. For instance, the concept of social health insurance (SHI) is deeply generated in the fabric of health care systems in western Europe. It actually has the organizing principle and the majority of its funding coming from these seven countries - Austria, Belgium, France, Germany, Luxembourg, the Netherlands and Switzerland. The concept has also become the legal basis for health services management in Israel since 1995 (Saltman, Busse & Figueras, 2004)). OECD has differentiates between national health services, social health insurance, and private health insurance types of base systems and three dimensions namely coverage, funding and ownership (OECD, 1987). Furthermore, as mentioned in several literature, SHI is a tool for achieving several goals: mobilizing more funds for health, promoting equal access to reasonable health care for the poor, pooling health risks and preventing impoverishment, and improving the efficiency and quality of health care. The design of SHI

essentially involves maximizing social benefits under financial and political constraints (Hsiao & Shaw, 2007).

This study applies the Social Health Insurance (SHI) approach as the principal method of health financial systems to measure policy outputs and policy outcomes of JKN-KIS policies. This approach can be used to analyze health insurance performance by using several indicators for monitoring and evaluating the performance of the health insurance system. From this stage, achieving universal health coverage in a country can be evaluated. Furthermore, the purpose of health financing is to provide funding, financial incentives for health care providers and ensure that all individuals can access health services effectively (Carrin & James, 2005). In particular, SHI analysis is carried out using 3 indicators namely: a) revenue collection; b) pooling; c) purchasing (Carrin & James, 2005; WHO, 2000).

First of all, revenue collection which consists of population coverage and method of finance. This dimension relates to the coverage of the health insurance population and efforts to obtain funding in order to finance health insurance through various methods carried out by BPJS. The collection of funding can come from households, companies, government or other sources (WHO, 2000). This indicator is an important factor because financial accessibility is influenced by efforts and methods to obtain health insurance funding. If the revenue collection is not effective, it is likely to have an impact on the accessibility of health services obtained by the community or user. The second indicator, pooling, consists of composition of risk pooling, fragmentation or risk pooling and management of risk pooling. These dimensions relate to the accumulation of funding and funding management in limiting contributions paid by health insurance participants. The goal is that the additional funding burden for health services they receive at health facilities will no longer be borne by individual participants (Carrin & James, 2005). This indicator ensures the existence of financial protection for health insurance participants and the existence of cross subsidies among health insurance participants. The third, purchasing, includes indicators of benefit package, provider payment mechanisms and administrative efficiency. Basically this dimension relates to the package of benefits obtained by participants when accessing health services with the standard cost as per applicable rules. This aims to avoid excessive costs but participants still get the maximum benefit package (WHO, 2000).

Then, purchasing in SHI approach is based on equity and efficiency in deciding the benefit package obtained by national health insurance participants. Indicator provider payment mechanisms are also provided as incentives for individual health workers and health facilities as a front group in providing health services. Finally, administrative efficiency is related to administrative costs incurred, as a consequence, of the management of the national health insurance system. Various projections of conditions such as the emergence of additional costs and the readiness of reserve funds to meet unexpected costs need to be considered in the national guarantee policy system. From a performance perspective, SHI approach can be used by governments to measure achievement of targets and performance of universal health insurance providers. With this framework, this study aims to analyze the performance of the national health insurance system applied by Indonesian Government since 2014.

Method

Research Design and Strategy

This study applies a qualitative approach to explain the performance of the national health insurance system organized by the Healthcare and Social Security Agency (BPJS-Kesehatan) as the leading sector for organizing health insurance in Indonesia. In addition, the community and health facilities are also the focus on this study. These three parties are known as the pillars of national health insurance system. Then a case study with exploratory type is chosen as research strategy (Yin, 2009).

Informants

To explain the performance of the national health insurance system, we interviewed several key informants. As the primary data source, the informants involved have important information regarding the conditions and reality of this study. Informants in this study include: a) 10 BPJS Health officials and staff; b) 30 individual recipients of assistance (PBI) and non-PBI participants; c) 8 officials and employees of health facilities (sub-district health centers and hospitals); and d) 20 BPJS Health participant patients who are undergoing treatment.

Data Collection Techniques

Data collection techniques used in this research were observations, indepth-interviews, and document study. The observations focused on tangible objects, such as the participant registration process, health insurance financing process, the process of claiming health facilities to BPJS, the process of payment of health insurance premiums and health service delivery at health facilities. In-depth interviews were conducted to key informants as mentioned above. Furthermore, various documents were collected, such as regulations, laws, statistics data, performance report over a period of four years, from 2015 to 2019 and institutional activities reports relating to the implementation of the health insurance policy.

Data Processing and Analysis

This study employs interpretative approach to analysis data based on three stages namely, data reduction, data display and drawing, and verifying conclusion (Miles & Huberman, 2014). The gathered data obtained through observation, in-depth interviews and documents was categorised and classified, based on its similarities and differences. The next step was data reduction from which conclusion and analysis results were obtained. The explanation regarding data reduction is further explained in the next section. The analysis techniques used in this study involve pairing patterns and time series techniques. These techniques are utilised together to complete one another (BPJS Kesehatan, 2019). performance measurement comes more to the foreground with the advancement in the high technology. So as to manage this power, which is an important element of the organizations, it is needed to have a performance measurement system. Increased level of competition in the business environment and higher customer requirements forced industry to establish a new philosophy to measure its performance beyond the existing financial and non-financial based performance indicators. In this paper, a conceptual performance measurement framework that takes into account company-level factors is presented for a real world application problem. In order to use the conceptual framework for measuring performance, a methodology that takes into account both quantitative and qualitative factors and the interrelations between them should be utilized. For this reason, an integrated approach of analytic hierarchy process (AHP.

Results

This study aims to analyze and explore the performance of the national health insurance system organized by the Healthcare and Social Security Agency (BPJS-Kesehatan) using Social Health Insurance (SHI) indicators consisting of a) revenue collection; b) pooling; c) purchasing (Carrin & James, 2005).

Revenue Collection

Revenue collection is measured based on population coverage and the method of finance. The total income derived from participants' health insurance contributions reached 81.97 trillion. In terms of membership coverage, this health insurance is projected to guarantee the entire population of Indonesia and is carried out gradually. At present, the number of memberships continues to increase every year. Based on the data from the Healthcare and Social Security Agency (BPJS-Kesehatan), the membership has reached 208,054,199 participants until December 2018 (BPJ Kesehatan, 20019). The details can be seen in the table below:

Table 1. Revenue collection performance indicator

Indicator	Year/Million					Problems
	2014	2015	2016	2017	2018	
Population Coverage	133,42	156,79	171,93	187,98	208,05	• Business Entity Compliance to register its employee • Non-civil servant government employee wages are below the City Minimum Wage • Individual awareness to register as participants
Indicator	Year/Billion					Problems
	2014	2015	2016	2017	2018	
Method of Finance	40,72	52,69	67,4	74,25	81,97	• Arrears on payment of individual participants and business entities • Individual and business entity awareness to pay participant contributions

Source: Data processed, 2019

As shown in Table 1 above, it is clear that the number of participants registered has increased every year. However, this increase in membership coverage has not met the target set per year. These conditions make the target of universal health coverage (UHC) in Indonesia unachievable. The main problem in population coverage is the low level of awareness to enroll in the national health insurance program, although it is very important for every individual. The fact is that there are still many participants in the Government and private business entities that have not yet registered their employees. The same also happens for most of the participants in the Non-Wage Workers (PBPU) and Non-Workers (BP) segments including independent participants,

investors, employers, and private pension recipients. Another problem in terms of increasing the number of health insurance enrollments is that many non-civil servant government workers are paid below city/regional minimum wages (UMK/UMR) which put them in a difficult situation to register as a participant in health insurance.

The method of health insurance finance or referred to as Social Security Fund (DJS) is carried out by the contribution mechanism paid by all participants. The amount of the fee is based on the selected health service class. Participant contributions or premiums are the main funding source. Besides, health insurance financing also comes from government assistance funds and other income such as investment income obtained by BPJS-Kesehatan as the manager of the health insurance system. The collection of health insurance funding includes the income derived from the contributions of the poor PBI participants paid by the central government, contributions from non-PBI participants, and participant contributions of the poor category paid by local governments. Various efforts have been made in facilitating the accessibility of contribution payments by participants. For instance, the collection of contributions obtained is paid through 4 BUMN bank partners consisting of BNI, Mandiri, BRI, and BTN. Payment through banks can be done via internet banking and mobile banking, where the Bank also has an auto-debit service directly from participant savings. In addition to collecting fees, the Bank's Online Payment Point method is also carried out with several payment channels reaching more than 600,000 payment points including e-commerce and virtual money.

The amount of contribution rates is often controversial. On the one hand, the benefits received by the health nsurance participants are so great which even cover the entire cost of health services received. On the other hand, contribution rates are considered too cheap so that there have been several tariffs increases since 2014. Since implemented in 2014, the arrears in payment have always been a major problem. This results in not achieving revenue targets. This condition causes the financing budget deficit which leads to ineffective implementation of health insurance. Budget deficit has occurred since the health insurance system was first put in place. The gap ratio between income of the Social Security Fund (DJS) and the cost of benefits and the cost of health services amounts to 107.39% (BPJS Kesehatan, 2019). performance measurement comes more to the foreground with the advancement in the high technology. So as to manage this power, which is an important element of the organizations, it is needed to have a performance measurement system. Increased level of competition in the business environment and higher customer requirements forced industry to establish a new philosophy to measure its performance beyond the existing financial and non-financial based performance indicators. In this paper, a conceptual perfor- mance measurement framework that takes into account company-level factors is presented for a real world application problem. In order to use the conceptual framework for measuring perfor- mance, a methodology that takes into account both quantitative and qualitative factors and the interrelations between them should be utilized. For this reason, an integrated approach of analytic hierarchy process (AHP.

BPJS-Kesehatan has made various efforts to overcome these problems. These are conducting intensive socialization of registration and payment of contributions, encouraging local governments to issue regulations on the obligations of business entities to become participants, working closely with the Employment Agency and Judiciary Office to monitor corporations that

have not registered their workers and pay contribution bills. BPJS also cooperates with the Department of Population and Civil Registration to identify individuals who have not been registered as participants through Population Identification Number (NIK). Furthermore, BPJS cooperated with the neighborhood chief (RW) to collect fee arrears and impose sanctions on those who have not paid. However, these efforts have not been effective enough to increase the number of participants in the health insurance program and compliance for paying contributions.

Pooling

The function of pooling in organizing JKN-KIS is to guarantee the risk of financing health services that have been carried out by participants. This was done because of the dues they had paid. Furthermore, the financing risk factors are jointly borne by the participants cross-subsidies mechanism, or, in other words, the healthy helps the sick. As known, this health insurance is mandatory for all citizens and adheres to the principle of mutual cooperation (*gotong royong*). The details are shown in the following table:

Table 2. Pooling performance's indicator

Indicator	Result	Problem
Composition of risk pool	• Consists of 3 PBI and non PBI segments and JAMKESMAS / JAMKESDA integration • Three types of tuition and class • Health insurance is mandatory with the principle of mutual cooperation and a mechanism of cross-subsidies	• Many non-PBI segment participants have not yet registered • Not all participants of the PBI segment and and JAMKESMAS / JAMKESDA are registered by the government
Fragmentation of risk pooling	• INA-CBG's package system • Fragmented financing	• The claim cost gap of the INA-CBG system between hospitals in Java and outside Java
Management of risk pool	• Financial sustainability • Participants satisfaction • Coverage of participants	• The low collectibility of fees and the amount of fees that do not match economic prices • High complaints against health facilities (moral hazard) and membership administration services • Low support from regulators and other stakeholders for the JKN-KIS program • Enforcement of compliance pay contributions

		• Potential health facility fraud • Additional costs paid by participants • Unequal distribution of participants in health facilities

Source: Data processed, 2019

Based on composition of risk pool, national health insurance membership is mandatory for all citizens. This applies both to Participants who pay individually as well as those paid by the government. The fee rates paid depend on the type of treatment class they choose. There are three types of treatment class rates, starting from the lowest class III with fees of Rp. 25,000, middle class II with Rp. 51,000 and the highest class I with a fee of Rp. 80,000. The difference in the three classes lies in the treatment room. For non PBI segments, they can choose classes based on their level of payment ability. Unlike the PBI segment of the central government and participants from the regional government which is the integration of community health insurance program (JAMKESMAS/JAMKESDA), both segments are only entitled to have class III because the payment is covered by the central and regional governments.

The fragmentation of risk pool dimension shows the potential loss of health insurance financing. INA-CBGs package system causes fragmentation in health services and health facilities. This standardized treatment package has the potential to cause a mismatch in the process of grouping disease cases that can lead to diagnostic errors. Then, the INA-CBG package system actually causes differences in the cost of health services and often pressures the health facilities to solve the problem. As a result, health services are carried out unevenly, resulting in ineffective implementation of universal health insurance.

The self-financing scheme through membership fees is actually based on payment for the standard INA-CBG drug package. Meanwhile, the determination of the packaging for drug packages is determined entirely by market mechanisms. Therefore, the increase in fees as an implication of the increase in drug prices cannot be avoided. This condition is different when the drug price is controlled by the government.

Management of risk pool as one of the dimensions in Social Health Insurance (Carrin & James, 2005), shows the occurrence of various problems such as the low collectability of insurance payments and its rates that do not match economic prices. Another problem is the high complaints against health facility services and membership administration services, the low support of regulators and other stakeholders for national health insurance programs, enforcement of payment compliance, the potential for fraudulent health facilities, additional participant fees to be paid, and distribution of participants in service facilities. Various problems in the implementation of JKN-KIS pooling show that the implementing agency, BPJS, needs to make various improvements and the government support to encourage this is crucial. This health insurance system raises moral hazard by the participants. For example, the case reported revealed that some participants received advanced health services for the treatment of chronic

diseases but were listed as new categories of participants. Besides, often someone just registers as a participant when he is sick and they need health services.

Purchasing

Purchasing dimension in the national health insurance system in Indonesia shows that the benefits package offered to participants is considerable. All costs for health services received by beneficiaries are borne by BPJS-Kesehatan. However, the benefits package causes the inability of national health insurance providers to pay claims for health services received at health facilities. High benefit package expenditure when contribution fees are lower causes a budget deficit. Meanwhile, financing expenditures are affected by the number of service rates and the efficiency of the control results. As a result, the imbalance ratio between income and benefit and health service costs amounts to 107.39% (BPJS Kesehatan, 2019).

Provider payment mechanisms in the national health insurance system in Indonesia tend not to satisfy health service providers, both health facilities and health workers who provide medical treatment. For example, invoices for medical actions that have been given by health facilities to patients (participants) are often mismatched with what is supposed to be, according to BPJS. In contrast to the incentives obtained by medical personnel, the amount of money has been determined in the INA-CBG system package. Our interviews revealed that the incentives they received were smaller compared to the previous health insurance system such as ASKES and other health insurance by other providers. INA-CBG's package system is a financing package system based on the illness suffered by the patient where the system is based on the average cost spent by a diagnosis group. Furthermore, the INA-CBG rate consists of 1,077 CBG codes consisting of 789 inpatients and 288 outpatients with three severity levels. In the implementation of JKN BPJS-Kesehatan program, INA-CBG's rates are grouped into 6 types of hospitals, namely D, C, B, and A class hospitals, as well as public hospitals and special referral hospitals. INA-CBG's rates are also based on 1, 2, and 3 class treatments. This system was originally intended to improve the efficiency of health facilities, but the tariff system that was put in place was considered to be slightly valued by health facilities, creating limitations in medical service delivery.

Discussion

Various problems in the implementation of national health insurance in Indonesia indicate the need for managerial improvements by BPJS and government support in encouraging quality improvement. The goal of universal health coverage is to provide health services for all citizens at affordable cost standards. Therefore, great attention to management and the health insurance system becomes very important in order to optimize targets, resources, and monitor progress (Carrin & James, 2019). The biggest challenge in optimizing national health insurance in Indonesia currently lies in the three dimensions (revenue collection, pooling and purchasing) as mentioned in the concept of social health insurance in order to achieve universal health coverage.

Conclusion

Indonesia national health insurance aims to ensure that all individuals have access to health services at affordable costs. Therefore, in terms of revenue collection, it is important to meet the scope of membership and financing where all citizens are aware of the benefits of being part

of and registered in the health insurance system. Then, pooling in national health insurance which often creates moral hazard and fraud requires great attention, mainly by monitoring the implementation at the health service level. Finally, purchasing is needed to improve the quality of the INA-CBG package system and a comprehensive understanding of health facilities with the mechanism of the system. Achieving success on universal health coverage requires joint awareness and action by BPJS as implementing organisation, the community and health facilities as the main pillars of this national health insurance system.

Acknowledgements

The study was supported by Hasanuddin University and we would also like to thank the Badan Penyelenggara Jaminan Sosial (BPJS) Kesehatan for providing the data required in this research. All errors and omissions are our own.

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Universitas Hasanuddin

Andi Ahmad Yani <aayani@unhas.ac.id>

[PPA]

2 messages

Aleksandras Patapas <patapas@mruni.eu> Wed, Aug 18, 2021 at 3:22 PM
To: Dr Gita Susanti <gitasusanti65@gmail.com>
Cc: Andi Ahmad Yani <aayani@unhas.ac.id>, Muhammad Irvan Nur Iva <m.irvan.nuriva@gmail.com>, Andi Rahmat Hidayat <andirahmatfisip@gmail.com>

Dear Author!

Please find the reviews attached. Please make the corrections to the article accordingly. Upload the corrected version to the OJS (not as a new submission!).

The maximum length of the acceptable article can be 12 pages in Times New Roman with 1.5 spaces between the lines. Please shorten your article accordingly.
Please provide info about the author at the end of the article using our journal standard:

Rafał. Prof., Adjunct in Department of Macroeconomics Institute of Economics at the
Faculty of Economics and Nagaj, Assoc Management University of Szczecin, Poland.
E-mail: wasik@wneiz.pl

Brigita Žuromskaitė, Assoc. Prof., Institute of Management at Faculty of Politics and Management
Mykolas Romeris University in Vilnius, Lithuania.
E-mail: brigita@wp.eu

Please use Chicago style for references, this is the new requirement:
(Rostkowski 2016, 6-7)
Please upload updated article to the OJS (not as a new submission).
The numbered conclusions are the strict requirement of the format.
If you would have any questions please do not hesitate to ask me.

Best regards,
Executive Editor

Reviewer A:

General recommendation:
to be accepted with minor corrections, without further review

Type of article:
case study

Is the article appropriate to the subject matter of the journal?:
appropriate

Article evaluation• The front matter of the article (summary, introduction):

1. Presentation of the issues and selected objectives:
Adequate

2. Evaluation of existing literature on the issue:
Questionable

3. Selected methodology for the analysis of the issue:
Appropriate

4. Is the issue current?:
Yes

5. Is the issue relevant?:
Yes

Comments: :
The topic is current and relevant, presented objectives are solid. Appropriate methods are chosen to achieve the set objectives. Still the literature analysis seems a bit poor. It mainly consists of the review of official reports, while disclosing the views of scholars on key aspects of the topic would be very useful and benefit.

2. The contents of the article:

1. Is the title appropriate to the contents?:
Yes

2. Should the text be abridged or parts of it edited out?:
No

3. Are included graphs and tables necessary, appropriate and informative?:
Yes

4. Are all references necessary and are they precise?:
Yes

5. Are the keywords and the summary informative?:
Questionable

6. Is the author’s literary style satisfactory?:
Yes

Comments: :
Tables are informative, and the decision to highlight key problems in them makes sense. The introduction is too long comparing to the other parts of the paper in my personal opinion.
The summary in Lithuanian should be added. Keyword "Indonesia" is not necessary, because it is known from the title.

3. The concluding text:

1. How do the conclusions reflect the title and objectives of the article, the presented facts and findings?:
Questionable

2. References and bibliography:
Questionable

Comments: :
The conclusions reflects the title. However, they basically only identify problems of the health insurance system in Indonesia. No highlighted

measures or proposals to solve these problems and improve the system are provided. They could be hypothetical, normative, but would still add weight to the conclusions of the paper.

4. Presentation of research findings:
1. Depth of analysis:
Questionable

2. Appropriate use of selected methodology:
Questionable

3. Are the main arguments sound?:
Questionable

4. Are the conclusions and recommendations clear and concise?:
Questionable

Comments: :
Used research methods look capable. While the usage of these methods are not fully disclosed in the text. For this reason some readers may have serious doubts about the validity of the study. The presentation of the application of the methods could take up more space instead of a slightly too long introduction.
Some might say that naming problems is a sufficient conclusion for the case study, but in my opinion more specific recommendations would give more solidity for the work.

In your opinion, what are the main strengths and weaknesses of this article?:
A wide range of research methods are used to reveal the topic, which allows the problematic aspects to be examined comprehensively.
More precise presentation of scientific methods use is desirable.
Greater attention should be paid to the compliance of the article with the requirements of the journal. There is not even named the author of the article.

Other comments: :
A lot of work has been put into and the paper is significant. Critical remarks presented in this review is not criticism of the work already done. I believe that these remarks will help to highlight some minor aspects that in my personal opinion need to be corrected and will help for the future researches.

Reviewer B:

General recommendation:
to be accepted after applying indicated changes

Type of article:
case study

Is the article appropriate to the subject matter of the journal?:
appropriate

Article evaluation• The front matter of the article (summary, introduction):
1. Presentation of the issues and selected objectives:
Adequate

2. Evaluation of existing literature on the issue:
Adequate

3. Selected methodology for the analysis of the issue:
Questionable

4. Is the issue current?:
Yes

5. Is the issue relevant?:
Yes

Comments: :
The methodology is not clear, so it is difficult to assess its reliability.

2. The contents of the article:
1. Is the title appropriate to the contents?:
Yes

2. Should the text be abridged or parts of it edited out?:
Yes

3. Are included graphs and tables necessary, appropriate and informative?:
Yes

4. Are all references necessary and are they precise?:
Yes

5. Are the keywords and the summary informative?:
Yes

6. Is the author's literary style satisfactory?:
Yes

Comments: :
The discussion required greater interpretation of the literature and demonstrating what is the theoretical contribution.

3. The concluding text:
1. How do the conclusions reflect the title and objectives of the article, the presented facts and findings?:
Adequate

2. References and bibliography:
Adequate

Comments: :
-

4. Presentation of research findings:
1. Depth of analysis:
Needs editing

2. Appropriate use of selected methodology:
Needs editing

3. Are the main arguments sound?:
Needs editing

4. Are the conclusions and recommendations clear and concise?:

Yes

Comments: :
The methodological part is unclear. You use several methods, but the research sample and the reasons for the choice are unclear too.
The discussion required greater interpretation of the literature and demonstrating what is the theoretical contribution. The data and analyzes presented appropriately should be refined more in line with the benefits and practical value of the study.

In your opinion, what are the main strengths and weaknesses of this article?:
The main strengths: relevance and specificity of the research object
Main weaknesses: unclear methodological substantiation and interpretation of the discussion part.

Other comments: :
-

Public policy and administration/Viešoji politika ir administravimas
https://www3.mruni.eu/ojs/public-policy-and-administration

Andi Yani <aayani@unhas.ac.id> Thu, Aug 19, 2021 at 9:56 PM
To: Aleksandras Patapas <patapas@mruni.eu>
Cc: Dr Gita Susanti <gitasusanti65@gmail.com>, Muhammad Irvan Nur Iva <m.irvan.nuriva@gmail.com>, Andi Rahmat Hidayat <andirahmatfisip@gmail.com>

Dear Prof Aleksandras Patapas,

Thank you for your email and considering our manuscript.
We will revise based on Reviewers' suggestions and submit it via PPA's submission system.

Best regards,

Andi Ahmad Yani

Department of Administrative Science
Hasanuddin University
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[PPA]

3 messages

Aleksandras Patapas <patapas@mruni.eu> Mon, Dec 6, 2021 at 12:02 PM
To: Dr Gita Susanti <gitasusanti65@gmail.com>
Cc: Andi Ahmad Yani <aayani@unhas.ac.id>, Muhammad Irvan Nur Iva <m.irvan.nuriva@gmail.com>, Andi Rahmat Hidayat <andirahmatfisip@gmail.com>

Dear author!

Have you got my previous letter? If there is no reaction from you to my previous letter within 2 weeks we will be forced to decline your submission and remove it from the system.

Best regards,
Alex

Public policy and administration/Viešoji politika ir administravimas
https://www3.mruni.eu/ojs/public-policy-and-administration

Andi Yani <aayani@unhas.ac.id> Tue, Dec 7, 2021 at 4:04 PM
To: Aleksandras Patapas <patapas@mruni.eu>
Cc: Dr Gita Susanti <gitasusanti65@gmail.com>, Muhammad Irvan Nur Iva <m.irvan.nuriva@gmail.com>, Andi Rahmat Hidayat <andirahmatfisip@gmail.com>

Dear Prof Aleksandras,

Thank you for your email and apologies for the late reply.
We did receive your previous letter and we are working on revising the article based on reviewers' comments.
We will sent revised version as soon as possible (before two weeks as you requested)
Lastly, thank you for considering our article to be published in the PPA

Best regards,

On behalf all authors

Andi Ahmad Yani

Senior Lecturer
Department of Administrative Science
Universitas Hasanuddin
Indonesia
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Andi Yani <aayani@unhas.ac.id> Fri, Dec 17, 2021 at 2:50 PM
To: Aleksandras Patapas <patapas@mruni.eu>
Cc: Dr Gita Susanti <gitasusanti65@gmail.com>, Muhammad Irvan Nur Iva <m.irvan.nuriva@gmail.com>, Andi Rahmat Hidayat <andirahmatfisip@gmail.com>

Dear Prof Aleksandras,

I hope this email finds you well.
On behalf of Dr Gita Susanti as the first author, I would like to inform you that we have already uploaded a revised

version of our article at PPA website.
Herewith attached revised version for your reference.

Best regards,

Andi Ahmad Yani
Department of Administrative Science
Hasanuddin University
Indonesia

On Mon, Dec 6, 2021 at 12:02 PM Aleksandras Patapas <patapas@mruni.eu> wrote:
[Quoted text hidden]

ASSESSING NATIONAL HEALTH INSURANCE SYSTEM: A POLICY IMPLEMENTATION STUDY OF INDONESIA HEALTH INSURANCE POLICY

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Abstract
This study aims to analyse the implementation of Indonesia's Health Insurance policy which has been in effect since the year 2014. This research uses a qualitative approach. Data gathering is done through observations, interviews, Focus Group Discussions (FGD) and reviews of documents. The informants in this study consist of three groups: citizens as insurance recipients, hospital management, and Indonesian national health insurance management institutions. The study analysed the data using interpretive methods. The results of the study indicates that the National Health Insurance - Healthy Indonesia Card (JKN-KIS) system is a useful policy, especially in meeting basic needs within the public health sector. However, there are several problems from aspects such as participation, inappropriate fees, a benefit package system that actually creates fragmentation in health services, as well as ineffective risk management. The budget deficit within the Social Security Agency of Health (BPJS Kesehatan) as the policy implementer has significantly impacted the limitations upon hospitals in providing services as a result of claims that hospital payments are not being paid by BPJS Kesehatan.

Keywords: *policy implementation, health insurance, health policy, Indonesia*

Introduction
In the field of health policy, national health insurance systems have become one of the most important issues in guaranteeing quality access to health services for all people. Until now, solving the problem of a complex national health insurance system has been the focus of scholars, governments, practitioners and even international agencies. Studies of social health insurance in western Europe have shown that there are characteristics of self-regulation, in which special conditions for financing and providing health services are regulated by social-insurance institutions through mutual self-governance.

However, the principle of self-regulation begins to weaken simultaneously along with the increase of state regulation and market competition, which were introduced in response to economic and social changes (Wendt et al., 2013). Furthermore, in Japan studies show the advantages and limitations of

pursuing universal health coverage by establishment of employee-based and community-based social health insurance. On the positive side, almost everyone came to be insured in 1961; the enforcement of the same fee schedule for all plans and almost all providers have maintained equity and contained costs; and the co-payment rate has become the same for all, except for elderly people and children. On the negative side, the fragmentation of enrolment into 3500 plans has led to a more than a three-times difference in the proportion of income paid as premiums, and the emerging issue of the uninsured population (Ikegami et al., 2011).

In 2016, China has three sorts of medical insurance systems. First, Urban Employee Basic Medical Insurance System; Basic Medical Insurance System for Urban Residents from personal account saving are used to pay for medical treatments and medication (public health insurance fund). Second, New Rural Co-operative Medical Care System (NRCMCS) (free) (Matsuoka and Fukai, 2018).

Medical health insurance systems in Singapore are based on the Fund system, managing the fund in the Central Provident Fund (CPF), which capital and labours compulsory build up money of a certain percentage from wages to a labour's personal account. There are three kinds of medical insurance systems: Medisave; MediShield; Medifund (Matsuoka and Fukai, 2018).

Malaysia is aiming to succeed fair medical access, in spite of no public medical insurance system. Residents can receive medical services at public medical institutions with less self-burden, due to the help of federal budget. Medical treatment fees of public medical institutions have been set up, based on the Fee Act in 1951(Matsuoka and Fukai, 2018).

The concept of Universal Health Coverage is that every community within the population has equal and equitable access to holistic health services including promotive, preventive, curative, and rehabilitative services that are of high quality and are essential, at affordable costs (Yuningsih, 2013). Report shows that Indonesia's health index is in the poor category and ranks 94 out of 146 countries (Legatum Prosperity Index, 2018). Therefore, it is necessary to improve the health system to improve the quality of health in Indonesia. To achieve this, the government carried out reforms in the health sector through the policy of the National Health Insurance - Healthy Indonesia Card (JKN-KIS) system for every citizen. The health insurance is administered by the BPJS Kesehatan.

This study aims to analyse the implementation of the JKN-KIS policy. The study of this policy's implementation in the past two decades is one of the fundamental issues among researchers and practitioners of public administration, in order to bridge the gap between the concept and its reality. The study of the policy implementation analyses policy outputs and policy outcomes. These two parameters will determine whether or not the policy has performed as well as expected from when it was formulated

Various literature has revealed and formulated theories, concepts and methods in analysing the performance of social health insurance (SHI). Norman and Busse (2002, 60) are of the view that SHI has various definitions but it has two basic characteristics, namely health insurance recipients who pay regularly, usually based on the amount of salary, and quasi-independent public organizations whose role is to manage health insurance funds for financing health services. Further characteristics typically found in SHI studies include:

a) Social health insurance is compulsory for the majority or for the whole population;
b) There are several funds, with or without choice and with or without risk-pooling;

c) Contributions made by government (or special funds) on behalf of people not in employment are usually channelled through the sickness fund(s);
d) Both employers and employees pay contributions and share responsibility for managing fund(s) (Norman and Busse 2002, 60-61).

Other opinions suggest that health insurance should generate a broad effective resource pooling, ideally incorporating the whole population in a single risk fund, delinking financial contributions from health needs. This can be achieved through different institutional designs including such as the National Health Service (NHS), National Health Insurance (NHI) or Social Health Insurance(SHI) schemes (Cuadrado et all., 2019).

The concept of social health insurance (SHI) is deeply ingrained in the fabric of health care systems in western Europe. It provides the organizing principle and a preponderance of the funding in seven countries – Austria, Belgium, France, Germany, Luxembourg, the Netherlands and Switzerland. Since 1995, it has also become the legal basis for organizing health services in Israel (Saltman et al., 2004). OECD has distinguishes between National health service, social health insurance, and private health insurance type of system based on three dimensions namely coverage, funding and ownership (OECD, 1987). In literature, SHI is a tool for achieving several goals: mobilizing more funds for health, promoting equal access to reasonable health care for the poor, pooling health risks and preventing impoverishment, and improving the efficiency and quality of health care. The design of SHI essentially involves maximizing social benefits under financial and political constraints (Hsiao and Shaw, 2007).

This study uses a Social Health Insurance (SHI) approach as the principal method of health financial systems to measure policy outputs and policy outcomes of the JKN-KIS policy. This approach is used to analyse the performance of health insurance by using several indicators to monitor and evaluate the health insurance system's performance. This SHI is evaluated in order to achieve universal health coverage in a country. Furthermore, the purpose of health financing is to provide funding, as well as financial incentives for health care providers and ensuring that all individuals can access public health services effectively (Carrin, 2005). Analysis of SHI is done using three indicators, that is: a) revenue collection; b) pooling; c) purchasing (Carrin, 2005; WHO, 2000).

Firstly, *revenue collection* which consists of population coverage and method of finance. This dimension relates to the population coverage of health insurance and efforts to obtain funding to finance health insurance through various methods carried out by the national health insurance providers. That fundraising can be sourced from households, companies, governments or other sources (WHO, 2000). This indicator is an important factor because financial accessibility is influenced by efforts and methods to obtain health insurance funding. If revenue collection is not effective, its impact the accessibility of existing health services for the community or users.
Secondly, *pooling* consists of composition of risk pooling, fragmentation or risk pooling, and management of risk pooling. This dimension is related to the accumulation and management of funds in limiting the fees paid by health insurance recipients so that no longer carry the risk of additional financing costs for the health services they receive at health (Carrin, 2005).
Thirdly, the *purchasing* dimension consists of indicators of benefit packages, provider payment mechanisms and administrative efficiency. In general, this dimension relates to the benefit packages that recipients obtain when accessing health services with standard costs according to regulations, avoiding excessive payments while still maximizing the benefit package (WHO, 2000). Furthermore, purchasing in the SHI approach, is based on equity and efficiency in

determining the benefit package national health insurance recipients receive. The provider payment mechanisms indicator relates to incentives obtained by individual health workers and health facilities as the front line in providing health services. Indicators of provider payment mechanisms related to incentives received by individual health workers and health facilities are the front line in providing health services.

Lastly, administrative efficiency in relation to administrative costs that occur within the management of national health insurance systems. Various projected conditions such as additional costs and the preparation of reserve funds for unexpected costs need to be considered in this national insurance policy system. From a performance perspective, the SHI approach can be used by the government in measuring the target milestones and performance of universal health insurance providers. Based on this analytical framework, the study aims to analyse the performance of the national health insurance system that has been implemented by the Indonesian government since 2014.

Method

Research Design and Strategy

This study uses a qualitative approach to explain the phenomenon of national health insurance system's performance the organized by the BPJS Kesehatan as the leading sector and main pillar in providing health insurance in Indonesia. Furthermore, health facilities are the second pillar that acts as a health service provider that cooperates with the BPJS Kesehatan. Furthermore, the final pillar is the community, the target object of national health insurance, who has the right to receive health benefits and is obligated to pay monthly fees. Thus, the BPJS Kesehatan, Health Facilities and the community are the objects of this research as the pillars of national health insurance in Indonesia. Then the research strategy used in this study are explorative-type case studies (Yin, 2009). This strategy was chosen so that the phenomenon of implementing national health insurance policies can be explored according to Indonesia's context.

The study was conducted in three public and private hospitals in Makassar City, which is one of the urban areas with the largest urban population in Indonesia. Data from the Makassar City Central Statistics Agency (2020) reports that the population of Makassar City is 1.4 million people. In addition, Makassar City has two state hospitals which are a reference source for chronic diseases whose patients come from various regions in Eastern Indonesia.

Informants

Information was gathered from informants in order to explain the phenomena of the performance of the national health insurance system. As primary data sources, informants hold important information about the condition and reality of this study. The informants in this study include: a) 10 BPJS Kesehatan officials and staff; b) 30 Recipients of Financial Aid (PBI) and non-Recipients of Financial Aid; c) 8 officers and staff of health facilities (*puskesmas* and hospitals); and d) 20 BPJS Kesehatan patients who are undergoing treatment at health facilities. The reason for the selection of informants as mentioned above is because they are relevant actors, both as implementers and object of policy targets. The informants as implementers are aware of all processes and regulations in implementing policies, and the informants who are patients know, experience, and pay for the services of health insurance in health facilities first-hand.

Data Collection Techniques

Data collection techniques used in this research were observations, in depth-interviews, and document studies. Observations focused on tangible objects, such as the processes of health insurance recipients registering at the BPJS office, accessing services in health facilities such as hospitals and clinics, paying for health insurance in those health facilities, claiming and billing health facilities to BPJS Health as organizers and managers of health insurance funds,

and the process of recipients paying health insurance premiums at the Bank and through the BPJS Health applications. Moreover are observations of recipient's health service at secondary level health facilities, in this case hospitals and primary clinics as health service providers in collaboration with BPJS Health. In depth-interviews were addressed to key informants as mentioned above. Furthermore, the various documents were collected, such as regulations Law no. 40 year 2004 regarding National Social Security Systems (SJSN) as a main legal basis, Regulation of the Health Social Security Agency no. 1 year 2015 regarding the Implementation of Health Insurance, data statistics such as the performance report of BPJS Kesehatan between 2015-2019, institutional activity reports relating to the implementation of the health insurance policy.

Data Processing and Analysis

This study employs interpretative approach to analysis data based on three stages namely, data reduction, data display and drawing, and verifying conclusion (Miles et all., 2014). The gathered data obtained through observation, in-depth interviews and documents was categorised and classified, based on its similarities and differences. The next step was data reduction from which conclusion and analysis results were obtained. The explanation regarding data reduction is further explained in the next section. The analysis techniques used in this study involve pairing patterns and time series techniques. These techniques are utilised together to complete one another (Miles et al.,2014). performance measurement comes more to the foreground with the advancement in the high technology. So as to manage this power, which is an important element of the organizations, it is needed to have a performance measurement system. Increased level of competition in the business environment and higher customer requirements forced industry to establish a new philosophy to measure its performance beyond the existing financial and non-financial based performance indicators. In this paper, a conceptual performance measurement framework that takes into account company-level factors is presented for a real world application problem. In order to use the conceptual framework for measuring performance, a methodology that takes into account both quantitative and qualitative factors and the interrelations between them should be utilized. For this reason, an integrated approach of analytic hierarchy process (AHP.

Results

This study aims to analyse and explore the performance of the national health insurance system conducted by the BPJS Kesehatan using Social Health Insurance (SHI) indicators that include: a) revenue collection; b) pooling; c) purchasing (Carrin, 2005).

Revenue Collection

Revenue collection is measured based on population coverage and method of finance. The total amount of revenue sourced from health insurance recipient's fees reached 81.97 trillion. Viewed from the aspect of the amount of participation and membership, this health insurance is projected to gradually cover the entire population of Indonesia in stages. Until now, the number of health insurance memberships continues to increase every year. Based on data from the BPJS Kesehatan, there have been 208.054,199 participants as of December 2018 (BPJS Kesehatan, 2019). For more details, see the table below:

Table 1. Revenue collection performance's indicators

Indicator	Year/Million					Problems
	2014	2015	2016	2017	2018	

Population Coverage	133,42	156,79	171,93	187,98	208,05	• Business compliance in registering workers • Salaries/wages of non-civil servant and government employees below the UMK • Individual awareness to register as a health insurance recipient
Indicator	Year/Billion					Problems
	2014	2015	2016	2017	2018	
Method of Finance	40,72	52,69	67,4	74,25	81,97	• Arrears in payments of individual recipients and businesses • Awareness of individuals and business entities to pay health insurance fees

Source: Processed data, 2019

Based on Table 1 above, the number of new members and recipients experienced growth each year. However, the increase in covered members do not fulfil the targets numbers set annually. These conditions in turn cause efforts for universal health coverage (UHC) in Indonesia to also not reach its set target. In general, the main problem in this population coverage is the low level of awareness among people to register for health insurance, regardless of its importance for every individual. This was conveyed by informant H who is the head of the Unit Head of the Participation Management Unit and the Service Quality Control unit and the Handling of BPJS Health Participation Complaints. He stated that:

> *"the level of public awareness to register as BPJS participants still needs to be increased, both for the Business Entity segment and independent participants. Often people only realize that BPJS Health is important when they are sick, because the cost of care without health insurance is expensive" (Source: interview excerpt)*

The reality is there are still even many private and state business entities who have not yet registered their own works for health insurance. This is similar for Non-Wage Recipient Workers and Non-Workers informants who consist of independent participants, investors, employers, and private pension recipients. Another issue in the efforts to increase health insurance membership and recipients are that many non-civil servant government workers earn low salaries below regional minimum wage, so they experience financial difficulties to register themselves for health insurance. This was stated by the staff of the Membership Management Unit and the Service Quality Control unit and the Handling of BPJS Health Membership Complaints. This condition generally occurs in daily workers who are paid less than Rp. 100,000 (6 EUR) per day or non-government workers with low salaries and are not registered by the government. business entity/company where they work.

The method of finance for health insurance, referred to as the Social Security Fund (DJS) is carried out with a fee mechanism paid by all recipients with the fee rate based on their selected class or tier of health service. Participant's fees or premiums are the main source of income, in addition to that, health insurance financing is also sourced from government assistance funds and other income such as from investments obtained by BPJS Kesehatan as the manager of the health insurance system. The collection of funding for health insurance includes income sourced from fees from poor communities or PBI participants that are paid by the central government, contributions from non-PBI participants and contributions from 'poor family participants' paid by local governments. Contribution Assistance Recipients (PBI) are participants in Indonesia health insurance system (BPJS Kesehatan) who are the poor and underprivileged groups whose contributions are paid by the Government as mandated by the Law on the National Social Security System.

Various efforts have been made to ease the accessibility of paying health insurance fees for participants, including the collection of contributions obtained through main banking channels, where BPJS Kesehatan cooperates with 4 (four) state-owned banks: BNI, Mandiri Bank, BRI and BTN Bank. Payments through banks can be made via internet banking and mobile banking, where the bank also has a direct auto-debit service or it is automatically deducted from the participant's savings. In addition to collecting fees, it is also carried out through the Payment Point Online Bank method where the number of payment channels reach more than 600,000 payment points including e-commerce and virtual money.

The amount of fee rates until now has often been controversial, on the one hand the benefits received by health insurance recipients are so large that they even cover the entire cost of health services received at health facilities. However, on the other hand, the contribution rate is considered too cheap, so that there have been several rates increases since it took effect in 2014. However, since the health insurance system was implemented in 2014, the problem of payment arrears has always also been a major problem. This was confirmed by informant D, who is a staff member of the Legal, Public Communication and Compliance BPJS Health unit. He said that:

> *"This problem occurs because the level of participant payment compliance is quite low, even though BPJS Kesehatan itself often conducts socialization and educates companies or employers and the public". (Source: interview excerpt)*

The problem in collecting income from fees is not reaching the revenue target. This causes a budget deficit in financing so then the implementation of health insurance becomes ineffective. This budget deficit has occurred since the health insurance system was first introduced. The problem is due to the large number of arrears in dues. In fact, the inequality ratio between the income of the Social Security Fund (DJS) and the cost of benefits and the cost of health services reaches 107.39% (BPJS Kesehatan, 2019). performance measurement comes more to the foreground with the advancement in the high technology. So as to manage this power, which is an important element of the organizations, it is needed to have a performance measurement system. Increased level of competition in the business environment and higher customer requirements forced industry to establish a new philosophy to measure its performance beyond the existing financial and non-financial based performance indicators. In this paper, a conceptual perfor- mance measurement framework that takes into account company-level factors is presented for a real world application problem. In order to use the conceptual framework for measuring perfor- mance, a methodology that takes into account both quantitative and qualitative factors and the interrelations between them should be utilized. For this reason, an integrated approach of analytic hierarchy process (AHP.

BPJS Kesehatan has made various efforts to overcome these problems, including conducting intensive socialization of registration and payment of fees carried out by the institution or through JKN-KIS teams, encouraging local governments to issue regulations on the obligations of business entities to register for health insurance, collaborating with the Manpower and Transmigration Office and the Attorney General's Office to monitor businesses that have not registered their workers and paid due bills. BPJS Kesehatan also cooperates with the Population and Civil Registration Offices to conduct searches using the Citizen Identification Number (NIK) for information on individuals who have not been registered as health insurance recipients. BPJS Kesehatan even cooperates with the head of the local neighbourhood associations (RW) to collect the arrears of dues. In addition, sanctions have also been imposed for arrears in bills. However, these various efforts have not been effective enough to increase the number of Health Insurance participants and compliance with payment of contributions. This problem was confirmed by informant S, who is a staff of the BPJS Health Billing and Finance Unit who stated that

> *"because of the low awareness of the public and business entities/companies regarding the importance of health insurance for them. Even though the INA-CBGs BPJS Health package system is very profitable because it covers almost all disease, so that the burden of participant contributions is basically cheap" (Source: interview excerpt).*

Pooling

The function of pooling in the implementation of National Health Insurance (JKN) with the Healthy Indonesia Card (KIS) program - the President Jokowi's program - is to guarantee the risk of financing recipients' health services as feedback on the fees they have paid. The risk factor for financing is shared by the participants with a cross subsidy mechanism where those who are healthy pay for the sick. As is known, this health insurance is mandatory for all citizens and adheres to the principle of *gotong royong* or mutual cooperation. For more details, see the following table:

Table 2. Pooling performance's indicator

Indicator	Result	Problem
Composition of risk pool	• Consists of 3 PBI and non-PBI segments and the integration of regional health insurance • Fees and classes of health care are divided into 3 types • Health insurance is mandatory with the principle of gotong royong and cross subsidy mechanism	• Many non-PBI segment recipients have not registered yet • Recipients in the PBI and regional health insurance segments have not all been registered by the government
Fragmentation of risk pooling	• INA-CBG's package system • Financing fragmentation	• The gap in the cost of using the INA-CBG's claim system between hospitals in Jawa island and outside Jawa island
Management of risk pool	• Financial sustainability • Participant satisfaction • Coverage of participants	• The low collection of fees and the amount of fees that

		do not match the economic price • The high level of complaints about health facility services (moral hazards) and membership administration services • Low support from regulators and other stakeholders for the JKN-KIS program • Problems in enforcement for compliance paying dues • Potential for health facility fraud • Additional recipient fees to be paid • Uneven distribution of recipients in health facilities

Source: Processed data, 2019

Based on the composition of risk pool, membership of the National Health Insurance is mandatory for all citizens, both for participants who monthly pay individually and those paid by the government as a subsidy for poor families. The fees paid are adjusted to the tier of healthcare treatment that they choose. This type of treatment class tariff is divided into three, the third-class has lowest rate is Rp. 25,000 (1.5 EUR), the second-class fee is Rp. 51,000 (3 EUR) and the first-class has highest rate is Rp. 80,000 (4.9 EUR). The difference between the three classes is in the inpatient treatment room. For the non-PBI segment, they are entitled to determine the choice of healthcare treatment tier based on how much they can pay. This is opposed to participants of the PBI segment in the central government and participants from local government integrated with the regional health insurance, who are only entitled to the third level healthcare because the payment is done by the central and local governments.

This dimension of fragmentation within the risk pool, shows the potential loss in financing health insurance. Based on the INA-CBGs package system, it actually causes fragmentation in health services at health facilities. In fact, he standardized treatment package has the potential to cause a mismatch in the process of grouping disease cases, which can have implications for misdiagnosis. Moreover, the INA-CBGs package system also causes a disparity in the cost of health services when claiming benefits and often puts pressure on the Health Facilities to solve the problem. This makes health services unequal so that the implementation of universal health insurance is not effective.

The self-financing scheme through healthcare recipient fees is actually based on payments for the standard INA-CBG drug package. Meanwhile, the pricing of packaged drugs is fully determined by market mechanisms, so the potential for an increase in fees due to an increase in drug prices cannot be avoided. The conditions are different when drug prices are controlled by government health authorities.

Management of risk pool as one of the dimensions of Social Health Insurance (Carrin, 2005), in its implementation, shows the occurrence of various problems such as low collection of dues and the amount of fees that do not match the economic price, high complaints against health facility services related to moral hazard and membership administration services, lack of support from regulators and other stakeholders for the National Health Insurance program, low enforcement of dues compliance, potential for fraud in health facilities, additional participant fees to be paid, and unequal distribution of participants to facilities. Various problems in the implementation of JKN-KIS pooling indicate the need for several improvements by BPJS Kesehatan and the government. Furthermore, this health insurance system actually creates a moral hazard for recipients. For instance, there have been cases of recipients who should be receiving advanced health services such as treatment for chronic diseases, but are instead placed in the category of new recipients. In addition, there are often cases where people in general only register as healthcare recipients when they become sick to get health services. This condition was confirmed by informant C who is one of the BPJS Health participant patients who is receiving health services at a regional hospital. She said that

> *"the service obtained is not good and incurs additional costs such as drugs that are not available in hospitals when they should be borne by BPJS Kesehatan. Meanwhile, the hospital reasoned that the availability of their medicine was empty. When confirmed with the director of medical services at the hospital, it was said that this was the impact of arrears in hospital claims that had not been paid by BPJS Kesehatan, thus affecting the medical services received by patients. Meanwhile, the head of the BPJS Health Referral Health Service Management unit argued that their late payment of hospital claims was due to a budget deficit." (source: interview excerpt)*

Purchasing

The purchasing dimension within the perspective of Social Health Insurance in the context of the health insurance systems in Indonesia shows that the benefit package offered to recipients is very large. All costs for health services received by beneficiaries are carried by BPJS Kesehatan in accordance with applicable procedures. However, the size of the benefit package causes national health insurance providers to be unable to pay claims for health services received at health facilities. This was revealed by informant X, who is the head of the collection and finance unit. He who stated that:

> *"there is an imbalance between the amount of funding for participant revenue collection which is lower than the claim financing that must be paid by BPJS Kesehatan where there is a deficit of 9.1 Trillion [around 550 million EUR]" (Source: interview excerpt)*

The high expenditure of benefit packages when the income from fees are low causes a budget deficit. Meanwhile, expenditures are influenced by the amount of service tariffs and the efficiency of the control results. The inequality in the ratio between income, the cost of benefits and costs of health services now reaches 107.39% (BPJS Kesehatan, 2019).

Provider payment mechanisms in the Indonesian national health insurance system tend to be unsatisfactory for health service providers, health facilities and medical workers who provide treatment. This situation is confirmed by informant M, who is a staff of the Referral Health Service Management unit. She said:

> *"there are cases of failed payment claims from BPJS Health to advanced health facilities in this case the Hospital because the claims submitted are not in accordance with BPJS Health procedures or there are deficiencies such as completeness of medical resumes, operation sheets, transfusion sheets. and other equipment so that it needs to be revised due to diagnostic errors or errors in diagnosis codes that often occur. Errors that must*

be revised by the hospital or completeness of the files will delay the process of replacing funds from BPJS". (Source: interview excerpt)

This is different from what was complained by health facilities which was revealed by the director of medical services at a regional hospital who considered all claim documents to be complete and in accordance with applicable procedures. When there is a claim submitted by the Hospital to BPJS Health that fails to claim, then the consequence is that the hospital itself bears the cost of patient care because BPJS Health considers the error to be on the hospital side.

This is due to the fact that claims by health facilities against the medical actions of patients (healthcare recipients) are often deemed to be inconsistent with the majority of claims charged by health facilities when verified by BPJS Kesehatan. In contrast to the incentives obtained by medical personnel, the number of claims obtained has been determined in the INA-CBG's system package. INA-CNG is payment system in the form of packages based on the diagnosis of the disease and the treatment procedure suffered by the patient. This rate is paid by BPJS Kesehatan to the hospital. The calculation uses the standard tariff for health services in the implementation of the health insurance program.

Based on the results of interviews with these informants, their incentives are smaller than the previous health insurance system, namely Health Insurance (Askes) and other health insurance by other providers. As informant P stated that:

the amount of incentives obtained by medical personnel in the INA-CBG's BPJS Health package system tends to be small because the system has regulated various financing and actions for each category of disease in the package. services to be provided by health workers. The value of claims received by the hospital has an impact on the amount of medical services received by medical personnel. The INA CBGs tariff, which is considered to be still lower than the expected standard, results in physicians' dissatisfaction with BPJS". (Source: interview excerpt)

The INA-CBG's package system is a healthcare financing package system based on the illness that the patient is suffering from. This system is based on the average cost spent by a group of diagnoses. Furthermore, INA-CBG's rates consist of 1,077 CBG codes consisting of 789 inpatients and 288 outpatients with three levels of severity. For the implementation of the JKN BPJS Health program, INA-CBG's rates are grouped into 6 types of hospitals, namely class D, C, B, and A hospitals, as well as national referral hospitals and hospitals. INA-CBG's tariffs are also arranged based on treatment classes I, II, and III. This system was originally intended to increase the efficiency of health facilities in providing services, but they actually considered the applied tariff system to be small, causing limitations for them in providing those medical services.

Discussion

Several issues in the implementation of the Indonesian national health insurance indicate the need for more support and quality improvements by the BPJS Kesehatan and government. The goal of universal health coverage is to provide health services for all citizens at an affordable cost. Therefore, it is necessary to pay great attention to the management and health insurance system that is universal in nature in order to optimize targets and resources, as well as to monitor its development (Carrin, 2005).

The biggest challenge in optimizing Indonesia’s national health insurance lies in three things, the dimensions of revenue collection, pooling and purchasing in the concept of Social Health Insurance to achieve Universal Health Coverage. If revenue collection cannot be maximized, the health insurance budget deficit will become a systemic threat. Therefore, major action is needed to fix the amount of fees and rationalize tariffs so that the process of financing health

services for individual recipients runs smoothly. The appropriate mechanism to collect revenue can reduce the financial risk for the national health insurance providers and provide health financial protection for healthcare recipients (Carrin, 2005; OECD, 2004). It is critical to improve the quality of health services provided by health facilities such as clinics and hospitals in order to build trust among health insurance recipients. By receiving quality health services, they will feel more obligated and willing to pay their bills and fees. This is a crucial element to improve pooling performance in the national health insurance system in Indonesia.
The effectiveness of the national health insurance's implementation is an important point in the financial protection of health. According to several literature, insurance is a method of distributing financial risk related to individual health financing by regular collecting premiums or individual contributions. There usually is a established national health insurance institution that collects funds on a national scale so that it can cover the financing of the entire population (OECD, 2004).

Conclusion

National health insurance is a program that aims to ensure that all individuals have access to health services at an affordable cost. Therefore, in terms of revenue collection, it is important to meet and maximize the number of recipients and financing, where all citizens are aware of the benefits of participating in the health insurance system. Then, pooling within the national health insurance, which often creates moral hazard and fraud, requires further attention and monitoring of its implementation at the health service level. Moreover, there is a fragmentation of different service tiers and classes which creates a negative stigma from society. Lastly, purchasing is necessary to improve the quality of the INA-CBG's package system and in-depth understanding of health facilities regarding the mechanism of the system. To achieve the success of Universal Health Coverage, a collective awareness among BPJS Health organizers, the community and health facilities is necessary with the latter as the main pillar.
There are challenges ahead in the study of Social Health Insurance or national health insurance for countries that want to implement it. They need to consider the factors of financing health insurance sourced from participants' periodic contributions. Risk of deficit is a big threat when revenue collection does not run effectively while on the other hand, financing health insurance that must be paid to health facilities increases. In implementing the health insurance treatment classes and tiers, it is better to use only 1 type of class and contributions so that all health insurance participants get equal service without any differences. The commitment of health facilities such as hospitals and clinics in providing services must be considered and monitored so that health insurance participants can obtain maximum service. The satisfaction of health insurance recipients must be a special concern considering its potential impact on public trust and their desire to continue paying health insurance fees. Various studies and cases of the implementation of national health insurance or SHI in several countries have not led to the impact of developing public trust within the community, even though these dimensions need to be considered in achieving the effectiveness and efficiency of health insurance policies.
Lastly, we acknowledge that the study has method limitations with a focus on only one area in Makassar City, South Sulawesi Province. For this reason, the study reveals a case that may not apply in other areas. However, this study has investigated the national social security program that is applicable in all regions. In addition, another weakness of the study is that the research period was conducted prior to the Covid-19 pandemic, which limits the study findings to not yet cover events during the pandemic. Nevertheless, BPJS Kesehatan is very helpful for people affected by the pandemic, especially people from the vulnerable and poor who have been covered by the state (Sparrow, et al. 2020; Djalante, et al., 2020).
In the future we hope that other studies can be carried out in various regions that represent regions nationally. In addition, we hope that the following study will explore various

dimensions in the implementation process of National Health Insurance because this policy has a multi-player effect. In the future, further studies will be carried out by adding several dimensions such as public trust, institutions and fraud in the implementation of National Health Insurance policies.

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Gita Susanti, Muhammad Irvan Nur Iva, Andi Ahmad Yani, Andi Rahmat Hidayat

Nacionalinės Sveikatos Draudimo Sistemos Įvertinimas: Indonezijos Sveikatos Draudimo Politikos Politikos Įgyvendinimo Tyrimas

Anotacija

Šiuo tyrimu siekiama išanalizuoti, kaip įgyvendinama Indonezijos sveikatos draudimo politika, kuri galioja nuo 2014 m. Šiame tyrime naudojamas kokybinis metodas. Duomenų rinkimas atliekamas atliekant stebėjimus, interviu, fokuso grupės diskusijas (FGD) ir dokumentų peržiūras. Šio tyrimo informantai susideda iš trijų grupių: piliečių, kaip draudimo gavėjų, ligoninės vadovybės ir Indonezijos nacionalinio sveikatos draudimo valdymo institucijų. Tyrimo metu duomenys buvo analizuojami naudojant interpretacinius metodus. Tyrimo rezultatai rodo, kad Nacionalinio sveikatos draudimo – Sveikos Indonezijos kortelės (JKN-KIS) sistema yra naudinga politika, ypač tenkinant pagrindinius visuomenės sveikatos sektoriaus poreikius. Tačiau yra keletas problemų, susijusių su tokiais aspektais kaip dalyvavimas, netinkami mokesčiai, išmokų paketo sistema, kuri iš tikrųjų sukuria sveikatos paslaugų susiskaidymą, taip pat neefektyvus rizikos valdymas. Biudžeto deficitas Sveikatos socialinės apsaugos agentūroje (BPJS Kesehatan), kaip politikos įgyvendintojas, labai paveikė ligoninių paslaugų teikimo apribojimus dėl teiginių, kad BPJS Kesehatan nemoka ligoninių įmokų.

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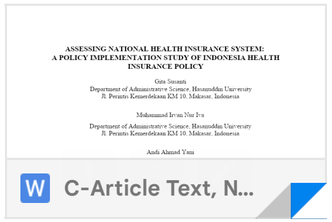
ASSESSING NATIONAL HEALTH INSURANCE SYSTEM:
A POLICY IMPLEMENTATION STUDY OF INDONESIA HEALTH INSURANCE POLICY

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ASSESSING THE NATIONAL HEALTH INSURANCE SYSTEM: A STUDY OF THE IMPLEMENTATION OF HEALTH INSURANCE POLICY IN INDONESIA

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Abstract. *This study aims to analyse the implementation of Indonesia's Health Insurance policy, which has been in effect since 2014. This research uses a qualitative approach to analyse data that was gathered through observations, interviews, focus group discussions (FGD) and the review of documents. The respondents in this study consist of three groups: citizens as insurance recipients, hospital management, and Indonesian national health insurance management institution. The study analysed the data using interpretive methods. The results of the study indicate that the National Health Insurance – Healthy Indonesia Card (JKN-KIS) system is a useful policy, especially in meeting basic needs within the public health sector. However, there are several problems regarding aspects such as participation, inappropriate fees, a benefit package system that actually creates fragmentation in health services, as well as ineffective risk management. The budget deficit within the Social Security Agency of Health (BPJS Kesehatan) as the policy implementer has placed significant limitations upon hospitals in providing services as a result of claims that hospital payments are not being paid by BPJS Kesehatan.*

Keywords: *policy implementation, health insurance, health policy, Indonesia*

Reikšminiai žodžiai: *politikos įgyvendinimas, sveikatos draudimas, sveikatos politika, Indonezija*

Introduction

In the field of health policy, national health insurance systems have become one of the most important issues in guaranteeing quality access to health services for all people. Until now, solving the problem of a complex national health insurance system has been the focus of scholars, governments, practitioners and even international agencies. Studies of social health insurance (SHI) in western Europe have shown that there are characteristics of self-regulation, in which special conditions for financing and providing health services are regulated by social-insurance institutions through mutual self-governance.

However, the principle of self-regulation began to weaken alongside the increase of state regulation and market competition, which were introduced in response to economic and social changes (Wendt et al. 2013). Furthermore, in Japan studies show the advantages and limitations of pursuing universal health coverage by the establishment of employee-based and community-based SHI. The positives of this approach are numerous: almost everyone came to be insured by 1961; the enforcement of the same fee schedule for all plans and almost all providers has maintained equity and contained costs; and the co-payment rate has become the same for all, except for elderly people and children. On the negative side, the fragmentation of enrolment into 3,500 plans has led to a more than three-fold difference in the proportion of income paid as premiums, and the issue of the uninsured population is emerging (Ikegami et al. 2011).

In 2016, China had three sorts of medical insurance systems: the Urban Employee Basic Medical Insurance System; the Basic Medical Insurance System for Urban Residents from personal accounts, where savings are used to pay for medical treatment and medication (public health insurance fund); and the New Rural Co-operative Medical Care System (NRCMCS) (free) (Matsuoka and Fukai, 2018).

Medical health insurance systems in Singapore are based on the Fund system, where the Central Provident Fund (CPF) manages money built up compulsorily from a certain percentage of capital and labour into a personal account. There are three kinds of medical insurance systems: Medisave; MediShield; and Medifund (Matsuoka and Fukai, 2018).

Malaysia is aiming to achieve fair medical access in spite of the absence of a public medical insurance system. Residents can receive medical services at public medical institutions with less of a financial burden due to assistance from the federal budget. The medical treatment fees of public medical institutions were set up based on the Fee Act of 1951 (Matsuoka and Fukai, 2018).

The concept of Universal Health Coverage is that every community within the population has equal and equitable access to holistic health services, including promotive, preventive, curative, and rehabilitative services that are of high quality and are essential, at affordable costs (Yuningsih 2013). A recent report shows that Indonesia's health index is in the poor category, and ranks 94 out of 146 countries (Legatum Institute 2018). Therefore, it is necessary to improve the health system to improve the quality of health in Indonesia. To achieve this, the government carried out reforms in the health sector through the policy of the National Health Insurance – Healthy Indonesia Card (JKN-KIS) system for every citizen. Health insurance in Indonesia is administered by the BPJS Kesehatan.

This study aims to analyse the implementation of the JKN-KIS policy. The study of this policy's implementation over the past two decades is one of the fundamental issues among researchers and practitioners of public administration, in order to bridge the gap between the concept and its reality. The study of the implementation of this policy analyses policy outputs and policy out-

comes. These two parameters will determine whether or not the policy has performed as well as was expected when it was formulated

Various literature has revealed and formulated theories, concepts and methods in analysing the performance of SHI. Norman and Busse (2002, 60) are of the view that SHI has various definitions but it has two basic characteristics, namely: health insurance recipients who pay regularly, usually based on the amount of their salary; and quasi-independent public organizations, whose role is to manage health insurance funds for financing health services. Further characteristics typically found in SHI studies include:

a) SHI is compulsory for the majority or for the whole population;

b) there are several funds, with or without choice and with or without risk-pooling;

c) contributions made by the government (or special funds) on behalf of people not in employment are usually channelled through the sickness fund(s);

d) both employers and employees pay contributions and share responsibility for managing fund(s) (Norman and Busse 2002, 60–61).

Other opinions suggest that health insurance should generate broad effective resource pooling, ideally incorporating the whole population in a single risk fund, delinking financial contributions from health needs. This can be achieved through different institutional designs including such as the National Health Service (NHS), National Health Insurance (NHI) or SHI schemes (Cuadrado et al. 2019).

The concept of SHI is deeply ingrained in the fabric of health care systems in western Europe. It provides the organizing principle and a preponderance of funding in seven countries – Austria, Belgium, France, Germany, Luxembourg, the Netherlands and Switzerland. Since 1995, it has also become the legal basis for organizing health services in Israel (Saltman et al. 2004). The OECD (1987) distinguishes between national health service, SHI, and private health insurance types of systems based on three dimensions: coverage, funding and ownership. In the literature, SHI is seen as a tool for achieving several goals: mobilizing more funds for health; promoting equal access to reasonable health care for the poor; pooling health risks and preventing impoverishment; and improving the efficiency and quality of health care. The design of SHI essentially involves maximizing social benefits under financial and political constraints (Hsiao and Shaw 2007).

This study uses a SHI approach as the principal method of health financing systems to measure the outputs and outcomes of the JKN-KIS policy. This approach is used to analyse the performance of health insurance by using several indicators to monitor and evaluate the health insurance system's performance. SHI is evaluated in order to achieve universal health coverage in a country. Furthermore, the purpose of health financing is to provide funding as well as financial incentives for health care providers and to ensure that all individuals can access public health services effectively (Carrin and James 2005). Analysis of SHI is performed using three indicators: a) revenue collection; b) pooling; and c) purchasing (Carrin and James 2005; WHO 2000).

Firstly, *revenue collection* consists of population coverage and method of finance. This dimension relates to the population coverage of health insurance and efforts to obtain funding to finance health insurance through various methods carried out by national health insurance providers. This fundraising can be sourced from households, companies, governments or other sources (WHO 2000). This indicator is an important factor because financial accessibility is influenced by efforts and methods to obtain health insurance funding. If revenue collection is not effective, this impacts the accessibility of existing health services for the community or users.

Secondly, *pooling* consists of the composition, fragmentation, and management of risk pooling. This dimension is related to the accumulation and management of funds in limiting the fees paid by health insurance recipients so that they no longer carry the risk of additional financing costs for the health services they receive (Carrin and James 2005).

Thirdly, the *purchasing* dimension consists of indicators of benefit packages, provider payment mechanisms and administrative efficiency. In general, this dimension relates to the benefit packages that recipients obtain when accessing health services with standard costs according to regulations, avoiding excessive payments while still maximizing the benefit package (WHO, 2000). Furthermore, purchasing in the SHI approach is based on equity and efficiency in determining the benefit package that national health insurance recipients receive. The provider payment mechanisms indicator relates to incentives obtained by individual health workers and health facilities, as they represent the front line in providing health services.

Administrative efficiency in relation to administrative costs that occur within the management of national health insurance systems is also crucial. Various projected conditions such as additional costs and the preparation of reserve funds for unexpected costs need to be considered in the national insurance policy system. From a performance perspective, the SHI approach can be used by governments in measuring the target milestones and performance of universal health insurance providers. Based on this analytical framework, this study aims to analyse the performance of the national health insurance system that has been implemented by the Indonesian government since 2014.

Method

Research Design and Strategy

This study uses a qualitative approach to explain the performance of the national health insurance system organized by the BPJS Kesehatan as the leading sector and main pillar in providing health insurance in Indonesia. Furthermore, health facilities are the second pillar, acting as health service providers and cooperating with the BPJS Kesehatan. The final pillar is the community – the target object of national health insurance, who has the right to receive health benefits and is obligated to pay monthly fees. Thus, the BPJS Kesehatan, Health Facilities and the community are the objects of this research as the pillars of national health insurance in Indonesia. The research strategy used in this study is that of an explorative case study (Yin 2009). This strategy was chosen so that the phenomenon of implementing national health insurance policies can be explored according to the Indonesian context.

This study was conducted in three public and private hospitals in Makassar City, an area with one of the largest urban populations in Indonesia. Data from the Makassar City Central Statistics Agency (2020) reports that the population of Makassar City is 1.4 million people. In addition, Makassar City has two state hospitals which are reference sources for chronic diseases, and whose patients come from various regions in Eastern Indonesia.

Respondents

Information was gathered from respondents in order to explain the phenomena of the performance of the national health insurance system. As primary data sources, respondents provide important information about the conditions and realities of the object under study. The participants in this study included: a) 10 BPJS Kesehatan officials and staff; b) 30 recipients of financial

aid (PBI) and non-recipients of financial aid; c) 8 officers and staff of health facilities (*puskesmas* and hospitals); and d) 20 BPJS Kesehatan patients who were undergoing treatment at health facilities. The reason for the selection of respondents as mentioned above was because they are relevant actors, both as implementers and objects of policy targets. The respondents who act as implementers are aware of all processes and regulations in implementing policies, and the respondents who are patients know, experience, and pay for the services of health insurance in health facilities first-hand.

Data Collection Techniques

The data collection techniques used in this research were observation, in depth-interview, and document study. Observations focused on tangible objects, such as the processes of health insurance recipients: registering at the BPJS office; accessing services in health facilities such as hospitals and clinics; paying for health insurance in those health facilities; claiming and billing health facilities to BPJS Health as organizers and managers of health insurance funds; and paying health insurance premiums at their bank and through the BPJS Health applications. Moreover observations of recipients' health services took place at secondary level health facilities – in this case hospitals and primary clinics as health service providers in collaboration with BPJS Health. In-depth interviews were addressed to key respondents as mentioned above. Furthermore, various documents were collected, such as: the regulations of Law No. 40 of 2004 regarding National Social Security Systems (SJSN) as a main legal basis; Regulation of the Health Social Security Agency No. 1 of 2015 regarding the Implementation of Health Insurance; data statistics such as the performance report of BPJS Kesehatan between 2015–2019; and institutional activity reports relating to the implementation of the health insurance policy.

Data Processing and Analysis

This study employs an interpretative approach to analysing data based on three stages: data reduction, data display and drawing, and verifying conclusions (Miles et al. 2014). The data obtained through observation, in-depth interviews and document analysis was categorised and classified based on its similarities and differences. The next step was data reduction, from which conclusion and analysis results were obtained. The explanation regarding data reduction is further elaborated in the next section. The analysis techniques used in this study involve pairing patterns and time series techniques. These techniques are utilised together to complement one another (Miles et al. 2014)performance measurement comes more to the foreground with the advancement in the high technology. So as to manage this power, which is an important element of the organizations, it is needed to have a performance measurement system. Increased level of competition in the business environment and higher customer requirements forced industry to establish a new philosophy to measure its performance beyond the existing financial and non-financial based performance indicators. In this paper, a conceptual performance measurement framework that takes into account company-level factors is presented for a real world application problem. In order to use the conceptual framework for measuring performance, a methodology that takes into account both quantitative and qualitative factors and the interrelations between them should be utilized. For this reason, an integrated approach of analytic hierarchy process (AHP.

Results

This study aims to analyse and explore the performance of the national health insurance

system conducted by the BPJS Kesehatan using SHI indicators that include: a) revenue collection; b) pooling; and c) purchasing (Carrin and James 2005).

Revenue Collection

Revenue collection is measured based on population coverage and method of finance. The total amount of revenue sourced from health insurance recipients' fees reached Rp. 81.97 trillion. Viewed from the aspect of the amount of participation and membership, this health insurance is projected to gradually cover the entire population of Indonesia in stages. The number of health insurance memberships has continued to increase every year to date. Based on data from the BPJS Kesehatan (2019), there were 208,054,199 participants as of December 2018. Table 1 provides more details of this growth.

Table 1. Revenue collection performance's indicators

Indicator	Year/Million					Problems
	2014	2015	2016	2017	2018	
Population Coverage	133.42	156.79	171.93	187.98	208.05	• Business compliance in registering workers • Salaries/wages of non-civil servant and government employees below the UMK • Individual awareness of the need to register as a health insurance recipient
Indicator	Year/Billion Rp.					Problems
	2014	2015	2016	2017	2018	
Method of Finance	40.72	52.69	67.4	74.25	81.97	• Arrears in payments of individual recipients and businesses • Awareness of individuals and business entities of the need to pay health insurance fees

Source: Processed data, 2019

Based on Table 1, the number of new members and recipients experienced growth each year. However, the increase in covered members did not fulfil the target numbers set annually. These conditions in turn meant that efforts towards universal health coverage (UHC) in Indonesia also did not reach their set targets. In general, the main problem regarding population coverage is the

low level of awareness among people that they must register for health insurance, regardless of its importance for every individual. This was conveyed by respondent H, who is the Unit Head of the Participation Management Unit and the Service Quality Control Unit, and is charged with the handling of BPJS Health Participation complaints. H stated that:

The level of public awareness of the need to register as a BPJS participant still needs to be increased, both for the Business Entity segment and independent participants. Often, people only realize that BPJS Health is important when they are sick, because the cost of care without health insurance is expensive. (Source: interview excerpt)

The reality is that there are still many private and state business entities who have not yet registered their own workers for health insurance. This is similar for both non-wage recipient workers and non-worker respondents, who consist of independent participants, investors, employers, and private pension recipients. Another issue in the efforts to increase health insurance membership and the number of recipients is that many non-civil servant government workers earn salaries below the regional minimum wage, so they experience financial difficulties in registering themselves for health insurance. This was stated by the staff of the Membership Management Unit, the Service Quality Control Unit, and the Unit in charge of the Handling of BPJS Health Membership Complaints. This condition generally occurs in daily workers who are paid less than Rp. 100,000 (€6) per day, or non-government workers with low salaries who are not registered by the government or business entity/company where they work.

The method of finance for health insurance, referred to as the Social Security Fund (DJS), is carried out with a fee mechanism paid by all recipients with the fee rate based on their selected class or tier of health service. Participants' fees or premiums are the main source of income, but health insurance financing is also sourced from government assistance funds and other income such as from investments obtained by the BPJS Kesehatan as the manager of the health insurance system. The collection of funding for health insurance includes income sourced from fees from poor communities or PBI participants that are paid by the central government, contributions from non-PBI participants, and contributions from "poor family participants" paid by local governments. Contribution Assistance Recipients (PBI) are participants in the Indonesian health insurance system (BPJS Kesehatan) that include poor and underprivileged groups whose contributions are paid by the Government as mandated by the Law on the National Social Security System.

Various efforts have been made to ease the accessibility of paying health insurance fees for participants, including the collection of contributions obtained through the main banking channels, where BPJS Kesehatan cooperates with four state-owned banks: BNI, Mandiri Bank, BRI, and BTN Bank. Payments through banks can be made via internet banking and mobile banking, where the bank also has a direct debit service or payments are automatically deducted from the participant's savings. In addition, collecting fees is also carried out through the Payment Point Online Bank method, where the number of payment channels reaches more than 600,000 – including e-commerce and virtual money.

The fee rates have often been controversial. On the one hand, the benefits received by health insurance recipients are so large that they cover the entire cost of health services received at health facilities. On the other hand, the contribution rate is considered too low, so there have been several rate increases since this system took effect in 2014. Since the health insurance system was implemented in 2014, payment arrears have also been a major problem. This was confirmed by respondent D, who is a staff member of the Legal, Public Communication and Compliance BPJS Health unit. D said that:

This problem occurs because the level of participant payment compliance is quite low, even though BPJS Kesehatan itself often conducts socialization and educates companies or employers and the public. (Source: interview excerpt)

There is another problem in that the income collected from fees does not reach the revenue target. This causes a budget deficit in financing, so the implementation of health insurance then becomes ineffective. This budget deficit has occurred since the health insurance system was first introduced. This problem is due to the large amount of arrears in dues. In fact, the inequality ratio between the income of the Social Security Fund (DJS) and the cost of benefits and health services reaches as high as 107.39% (BPJS Kesehatan 2019)performance measurement comes more to the foreground with the advancement in the high technology. So as to manage this power, which is an important element of the organizations, it is needed to have a performance measurement system. Increased level of competition in the business environment and higher customer requirements forced industry to establish a new philosophy to measure its performance beyond the existing financial and non-financial based performance indicators. In this paper, a conceptual performance measurement framework that takes into account company-level factors is presented for a real world application problem. In order to use the conceptual framework for measuring performance, a methodology that takes into account both quantitative and qualitative factors and the interrelations between them should be utilized. For this reason, an integrated approach of analytic hierarchy process (AHP.

The BPJS Kesehatan has made various efforts to overcome these problems, including by: conducting intensive socialization of the registration and payment of fees carried out by the institution or through JKN-KIS teams; encouraging local governments to issue regulations on the obligations of business entities to register for health insurance; and collaborating with the Manpower and Transmigration Office and the Attorney General's Office to monitor businesses that have not registered their workers and paid due bills. The BPJS Kesehatan also cooperates with the Population and Civil Registration Offices to conduct searches using the Citizen Identification Number (NIK) for information on individuals who have not been registered as health insurance recipients. The BPJS Kesehatan even cooperates with the heads of local neighbourhood associations (RW) to collect arrears of dues. In addition, sanctions have also been imposed for arrears in bills. However, these various efforts have not been effective enough to increase the number of health insurance participants and increase compliance with the payment of contributions. This problem was confirmed by respondent S, who is a staff member at the BPJS Health Billing and Finance Unit. S stated that this problem emerges:

Because of the low awareness of the public and business entities/companies regarding the importance of health insurance for them. This is despite the fact that the INA-CBGs BPJS Health package system is very profitable because it covers almost all diseases, so the burden of participant contributions is effectively cheap. (Source: interview excerpt)

Pooling

The function of pooling in the implementation of National Health Insurance (JKN) with the Healthy Indonesia Card (KIS) – President Jokowi's program – is to guarantee the risk of financing recipients' health services via feedback on the fees they have paid. The risk factor for financing is shared by the participants with a cross-subsidy mechanism, where those who are healthy pay for the sick. As is known, this health insurance is mandatory for all citizens and adheres to the principle of *gotong royong*, or mutual cooperation. Table 2 provides more detail on this indicator.

Table 2. Pooling performance's indicator

Indicator	Result	Problem
Composition of risk pool	• Consists of 3 PBI and non-PBI segments and the integration of regional health insurance • Fees and classes of health care are divided into 3 types • Health insurance is mandatory with the principle of gotong royong and a cross-subsidy mechanism	• Many non-PBI segment recipients have not registered yet • Recipients in the PBI and regional health insurance segments have not all been registered by the government
Fragmentation of risk pooling	• INA-CBG's package system • Financing fragmentation	• The gap in the cost of using the INA-CBG's claim system between hospitals in Jawa island and outside Jawa island
Management of risk pool	• Financial sustainability • Participant satisfaction • Coverage of participants	• The low collection of fees and the amount of fees that do not match the economic price • The high level of complaints about health facility services (moral hazards) and membership administration services • Low support from regulators and other stakeholders for the JKN-KIS program • Problems in enforcement for compliance paying dues • Potential for health facility fraud • Additional recipient fees to be paid • Uneven distribution of recipients in health facilities

Source: Processed data, 2019

Based on the composition of the risk pool, membership in the National Health Insurance is

mandatory for all citizens – both for participants who pay individually every month and those who are paid for by the government as a subsidy for poor families. The fees paid are adjusted to the tier of healthcare treatment that they choose. This type of treatment class tariff is divided into three: the third class has the lowest rate, Rp. 25,000 (€1.5); the second class fee is Rp. 51,000 (€3); and the first class has the highest rate, Rp. 80,000 (€4.9). The difference between the three classes is in the inpatient treatment room. For the non-PBI segment, they are entitled to determine the choice of healthcare treatment tier based on how much they can pay. This is opposed to participants of the PBI segment in the central government and participants from local government integrated with the regional health insurance, who are only entitled to the third level of healthcare because their payment is made by the central and local governments.

This dimension of fragmentation within the risk pool shows the potential loss in financing health insurance. Based on the INA-CBGs package system, this actually causes fragmentation in health services at health facilities. In fact, the standardized treatment package has the potential to cause a mismatch in the process of grouping disease cases, which can have implications for misdiagnosis. Moreover, the INA-CBGs package system also causes a disparity in the cost of health services when claiming benefits and often puts pressure on health facilities to solve the problem. This makes health services unequal so that the implementation of universal health insurance is not effective.

The self-financing scheme through healthcare recipient fees is actually based on payments for the standard INA-CBG drug package. Meanwhile, the pricing of packaged drugs is fully determined by market mechanisms, so the potential for an increase in fees due to an increase in drug prices cannot be avoided. The conditions are different when drug prices are controlled by government health authorities.

Management of the risk pool, as one of the dimensions of SHI (Carrin and James 2005), shows in its implementation the occurrence of various problems, such as: low collection of dues and amounts of fees that do not match the economic price; high complaints against health facility services related to moral hazard and membership administration services; lack of support from regulators and other stakeholders for the National Health Insurance program; low compliance with the enforcement of dues; potential for fraud in health facilities; additional participant fees to be paid; and unequal distribution of participants to facilities. Various problems in the implementation of JKN-KIS pooling indicate the need for several improvements by BPJS Kesehatan and the government. Furthermore, this health insurance system actually creates a moral hazard for recipients. For instance, there have been cases of recipients who should be receiving advanced health services such as treatment for chronic diseases, but are instead placed in the category of new recipients. In addition, there are often cases where people in general only register as healthcare recipients when they become sick in order to receive health services. This condition was confirmed by respondent C, who is one of the BPJS Health participant patients who is receiving health services at a regional hospital. C said that:

The service obtained is not good and incurs additional costs such as for drugs that are not available in hospitals, which should be borne by the BPJS Kesehatan. In one instance, the hospital reasoned that the supply of their medicine was empty. When confirmed with the director of medical services at the hospital, it was said that this was the impact of arrears in hospital claims that had not been paid by the BPJS Kesehatan, thus affecting the medical services received by patients. Meanwhile, the head of the BPJS Health Referral Health Service Management unit argued that their late payment of hospital claims was due to a budget deficit. (Source: interview excerpt)

Purchasing

The purchasing dimension within the perspective of SHI in the context of the health insurance systems in Indonesia shows that the benefit package offered to recipients is very large. All costs for health services received by beneficiaries are carried by the BPJS Kesehatan in accordance with applicable procedures. However, the size of the benefit package causes national health insurance providers to be unable to pay claims for health services received at health facilities. This was revealed by respondent X, who is the head of the collection and finance unit. X stated that:

There is an imbalance in the amount of funding for participant revenue collection, which is lower than the claim financing that must be paid by the BPJS Kesehatan, where there is a deficit of [Rp.] 9.1 trillion [around €550 million]. (Source: interview excerpt)

The high expenditure on benefit packages when incomes from fees are low causes a budget deficit. Meanwhile, expenditures are influenced by the amount of service tariffs and the efficiency of the control results. The inequality in the ratio between income, the cost of benefits and the costs of health services has now reached 107.39% (BPJS Kesehatan 2019).

Provider payment mechanisms in the Indonesian national health insurance system tend to be unsatisfactory for health service providers, health facilities and medical workers who provide treatment. This situation was confirmed by respondent M, who is a staff member at the Referral Health Service Management unit. M said:

There are cases of failed payment claims from BPJS Health to advanced health facilities, in this case the hospital, because the claims submitted are not in accordance with BPJS Health procedures. There are also deficiencies such as completeness of medical resumes, operation sheets, transfusion sheets, and other equipment, meaning that they need to be revised due to diagnostic errors or errors in diagnosis codes that often occur. Errors that must be revised by the hospital or in regard to the completeness of files will delay the process of replacing funds from BPJS. (Source: interview excerpt)

This is different from the complaints of health facilities, which were revealed by the director of medical services at a regional hospital. This director considered all claim documents to be complete and in accordance with applicable procedures. When there is a claim submitted by the hospital to BPJS Health that fails, then the consequence is that the hospital itself bears the cost of patient care because BPJS Health considers the error to be on the hospital's side.

This is due to the fact that claims by health facilities against the medical actions of patients (healthcare recipients) are often deemed to be inconsistent with the majority of claims charged by health facilities when verified by BPJS Kesehatan. In contrast to the incentives obtained by medical personnel, the number of claims obtained has been determined in the INA-CBG system package. INA-CBG is payment system in the form of packages based on the diagnosis of diseases and the treatment procedures given to a patient. This rate is paid by the BPJS Kesehatan to the hospital. The calculation uses the standard tariff for health services in the implementation of the health insurance program.

Based on the results of interviews with these respondents, their incentives are smaller than the previous health insurance system – namely Health Insurance (Askes) and other health insurance by other providers. As respondent P stated:

The amount of incentives obtained by medical personnel in the INA-CBG's BPJS Health package system tends to be small because the system has regulated various financing actions for each category of disease in the package of services to be provided by health workers. The value of claims received by the hospital has an impact on the amount of medical services received by medical personnel. The INA CBGs tariff, which is considered still to be lower than the expected standard, results in physicians'

dissatisfaction with BPJS. (Source: interview excerpt)

The INA-CBG package system is a healthcare financing package based on the illness that the patient is suffering from. This system is based on the average cost of a group of diagnoses. Furthermore, the INA-CBG rates consist of 1,077 CBG codes consisting of 789 inpatients and 288 outpatients with three levels of severity. For the implementation of the JKN BPJS Health program, the INA-CBG rates are grouped into 6 types of hospitals: class D, C, B, and A hospitals, as well as national referral hospitals and other hospitals. INA-CBG tariffs are also arranged based on treatment classes I, II, and III. This system was originally intended to increase the efficiency of health facilities in providing services, but they actually considered the applied tariff system to be small, causing limitations for them in providing those medical services.

Discussion

Several issues in the implementation of Indonesian national health insurance indicate the need for more support and quality improvements by the BPJS Kesehatan and the government. The goal of universal health coverage is to provide health services for all citizens at an affordable cost. Therefore, it is necessary to pay great attention to developing a management and health insurance system that is universal in nature in order to optimize targets and resources, as well as to monitor its development (Carrin and James 2005).

The greatest challenge in optimizing Indonesia's national health insurance lies in three areas: the dimensions of revenue collection, pooling and purchasing in the concept of SHI to achieve Universal Health Coverage. If revenue collection cannot be maximized, the health insurance budget deficit will become a systemic threat. Therefore, major action is needed to fix the amount of fees and rationalize tariffs so that the process of financing health services for individual recipients runs smoothly. An appropriate mechanism to collect revenue can reduce the financial risk for national health insurance providers and provide health-based financial protection for healthcare recipients (Carrin and James 2005; OECD 2004). It is critical to improve the quality of health services provided by health facilities such as clinics and hospitals in order to build trust among health insurance recipients. By receiving quality health services, recipients will feel more obligated and willing to pay their bills and fees. This is a crucial element to improving pooling performance in the national health insurance system in Indonesia.

The effectiveness of the implementation of national health insurance is an important point in the financial protection of health. According to several literature sources, insurance is a method of distributing financial risk related to individual health financing by regularly collecting premiums or individual contributions. There is usually an established national health insurance institution that collects funds on a national scale so that it can cover the financing of the entire population (OECD 2004).

Conclusion

National health insurance is a program that aims to ensure that all individuals have access to health services at an affordable cost. Therefore, in terms of revenue collection, it is important to maximize the number of recipients and financing, where all citizens are aware of the benefits of participating in the health insurance system. Pooling within national health insurance, which often creates moral hazards and fraud, then requires further attention and the monitoring of its implementation at the health service level. Moreover, there is fragmentation in the different service tiers and classes, which creates a negative stigma in society. Lastly, purchasing is necessary to

improve the quality of the INA-CBG package system and provide an in-depth understanding for health facilities regarding the mechanism of the system. To achieve the success of Universal Health Coverage, collective awareness among BPJS Health organizers, the community, and health facilities is necessary, with the latter as the main pillar.

There are challenges ahead in the study of SHI or national health insurance for countries that want to implement it. They need to consider the factors of financing health insurance sourced from participants' periodic contributions. Risk of deficit is a big threat when revenue collection does not run effectively while the finance behind health insurance that must be paid to health facilities increases. In implementing health insurance treatment classes and tiers, it is better to use only 1 type of class and contribution, so that all health insurance participants receive equal service without any differences. The commitment of health facilities such as hospitals and clinics to providing services must be considered and monitored so that health insurance participants can obtain maximum service. The satisfaction of health insurance recipients must be a special concern, considering its potential impact on public trust and recipients' desire to continue paying health insurance fees. Various studies and cases of the implementation of national health insurance or SHI in several countries have not led to the development public trust within the community, even though these dimensions need to be considered in achieving the effectiveness and efficiency of health insurance policies.

Lastly, we acknowledge that this study has methodological limitations, with a focus on only one area in Makassar City, South Sulawesi Province. For this reason, this study reveals a case that may not apply in other areas. However, this study has investigated a national social security program that is applicable in all regions. In addition, another weakness of this study is that the research period was conducted prior to the COVID-19 pandemic, which limits the study findings as they do not cover the events of the pandemic. Nevertheless, the BPJS Kesehatan was very helpful for people affected by the pandemic, especially people from vulnerable and poor backgrounds who are covered by the state (Sparrow et al. 2020; Djalante et al. 2020).

In future, we hope that other studies can be carried out in various regions that represent national trends. In addition, we hope that following studies will explore various dimensions in the implementation process of National Health Insurance, because this policy has a multi-layered effect. In the future, further studies will be carried out by adding several dimensions such as public trust, institutions and fraud in the implementation of National Health Insurance policies.

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NACIONALINĖS SVEIKATOS DRAUDIMO SISTEMOS ĮVERTINIMAS: INDONEZIJOS SVEIKATOS DRAUDIMO POLITIKOS ĮGYVENDINIMO TYRIMAS

Anotacija. *Šiuo tyrimu siekiama išanalizuoti, kaip įgyvendinama Indonezijos sveikatos draudimo politika nuo 2014 m. Straipsnyje taikomas kokybinis metodas. Duomenų rinkimas buvo atliekamas vykdant stebėjimus, interviu, fokusuotos grupės diskusijas (FGD) ir dokumentų analizę. Šio tyrimo informantus galima skirstyti į tris grupes: piliečių kaip draudimo gavėjų, ligoninės vadovybės ir Indonezijos nacionalinio sveikatos draudimo administravimo institucijų. Gauti duomenys buvo analizuojami taikant interpretacijos metodus. Tyrimo rezultatai parodė, kad Nacionalinio sveikatos draudimo – Sveikos Indonezijos kortelės (JKN-KIS) – sistema yra naudinga, ypač tenkinant pagrindinius visuomenės sveikatos sektoriaus poreikius. Tačiau yra keletas problemų, susijusių su tokiais aspektais kaip piliečių dalyvavimas, netinkami mokesčiai, išmokų paketo sistema, kuri iš tikrųjų sukuria sveikatos paslaugų susiskaidymą, taip pat neefektyvų rizikos valdymą. Sveikatos ir socialinės apsaugos agentūros (BPJS Kesehatan) kaip politikos vykdytojos biudžeto deficitas turėjo didelės įtakos ligoninių teikiamų paslaugų apribojimams dėl esą ligoninių negaunamų mokėjimų iš BPJS Kesehatan.*

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