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Evaluation of the Implementation of the Indonesia Social Insurance Model of Health Care

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EVALUATION OF THE IMPLEMENTATION OF THE INDONESIA SOCIAL INSURANCE MODEL OF HEALTH CARE

By

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February, 2022

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A thesis submitted in partial fulfilment of the University's requirement for the Degree of Doctor of Philosophy

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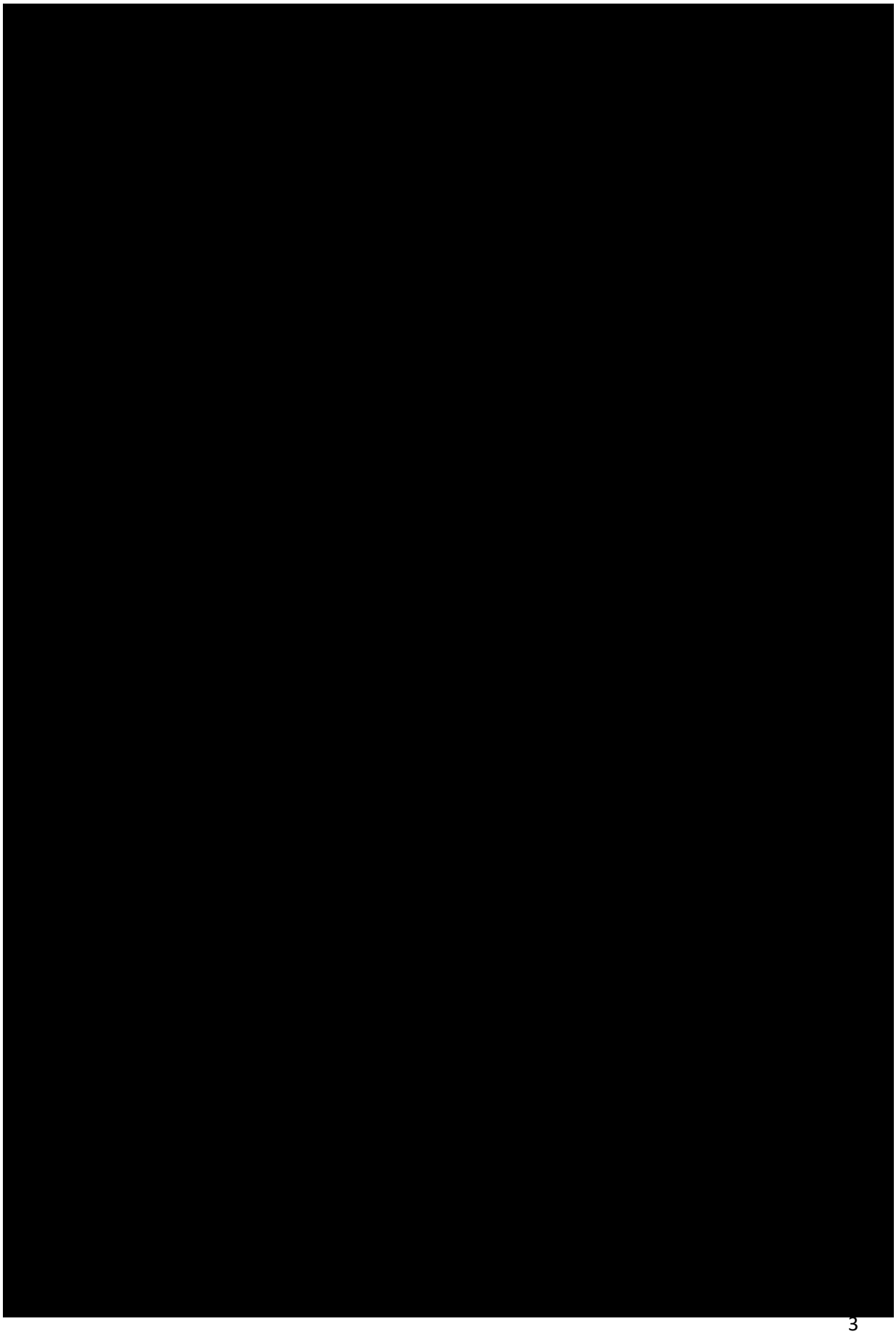

Certificate of Ethical Approval

Applicant:

Rosyidah Rosyidah

Project Title:

Evaluation of the implementation of the Indonesia Social Insurance Model of Health Care

This is to certify that the above named applicant has completed the Coventry University Ethical Approval process and their project has been confirmed and approved as Medium Risk

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ABSTRACT

This thesis aims to critically evaluate the Government of Indonesia's implementation of its Universal Health Coverage (UHC) to assist Indonesia's policymakers and other key stakeholders (the Board of National Security Council/DJSN), BPJS Kesehatan, Ministry of Health, Ministry of Social Welfare and Ministry of Finance) as they consider how best to develop a sustainable UHC system. UHC is based on a public policy that seeks to provide a country or region's whole population with both health protection and health services that it requires without the financial burden that would otherwise negatively impact upon individuals, families, and the wider society (WHO cited Reeves et al., 2017). Currently, Indonesia's implementation of its UHC is struggling as it transitions from multiple health insurance systems into a single, collective insurance scheme that covers all of Indonesia's 270 million populations (Britnell, 2015). Previous researchers have carried out studies of other nations' social health insurance (for example, Bradenkamp et al., 2015; Rolindrawan, 2015; Ekawati et al., 2017). However, unlike this study, these did not apply a mixed-methods approach. Instead, they used either a qualitative or quantitative method for data collection and analysis.

This thesis employs a mixed-methods approach, informed by the Context, Input, Process and Product (CIPP) evaluation model. The research was undertaken between May 2019 and May 2021. Quantitative data was accessed via official data sets, whilst qualitative interviews and focus group discussions were conducted with key stakeholders in Jakarta and Yogyakarta from July to September 2019.

The thesis concludes that Indonesia's UHC implementation needs greater synchronisation between its key stakeholders, not least the Ministry of Health, the DJSN, BPJS Kesehatan and the Ministry of Social Welfare. This suggests that the Indonesia UHC system needs further improvements in order to ensure

effective benefits and outcomes for the Indonesia people. These necessary improvements include the supply of sufficient human resources (health and other professions) as well as sufficient procurement and supply of medical equipment and drugs. Other necessary improvements include the timely payment by BPJS Kesehatan of claims to hospitals and other healthcare providers, improvements to the referral system; adequate provision and distribution of health care providers to ensure that all UHC members (including those living in remote areas) are covered, and improvements to the online referral system (including ensuring that healthcare providers provide accurate data on usage and provision (including hospital occupancy and room availability rates).

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GLOSSARY

Askes	Social Insurance Scheme for Civil Servants Provides health insurance services to active and retired civil servants, including their family members.
ASKESKIN/JAMKESMAS	The Social Health Insurance for low-income group programme aims to improve the access of quality health care services for all low-income people and underprivileged to effectively and efficiently achieve optimal health status.
ASPAK	Medical Devices (ASPAK) This ASPAK application refers to the regulation of the Minister of Health Republic of Indonesia No. 31 of 2018. This system is an application to assist in the preparation of infrastructure planning, as well as good and integrated medical equipment at the level of the District Health Office and Hospitals (www.aspak.net/application.)
APBN	Annual State Budget- a detailed list or statement of expected state revenues and expenditures within a certain period, usually one year.
APBD	Annual Regional Budget is an annual regional financial plan that is discussed and jointly approved by the regional government and by the House of Representatives, also stipulated by a regional regulation (Permendagri No. 13 of 2006).
Bhinneka Tunggal Ika	*Bhinneka Tunggal Ika* or Unity in Diversity

	(Santoso 1975) is the official national motto of the Republic of Indonesia. “We are of many kinds, but we are one.” It is also mentioned explicitly in Article 36A of the Indonesian Constitution “National emblem is Garuda Pancasila with motto *Bhinneka Tunggal Ika*” (Mahkamah Konstitusi 1999).
BPJS	BPJS is a public legal entity formed to organise social security programmes, consisting of BPJS Kesehatan and BPJS Ketenagakerjaan (BPJS Kesehatan, 2019).
BPJS Kesehatan	BPJS Kesehatan is a public body that administers the Health Insurance programme (UHC) in Indonesia
BPJS Ketenagakerjaan	Welfare benefits for workers and retirement scheme - a social security and protection program aimed at Indonesian workers and foreign workers who work in Indonesia for at least six months.
BPS	The Central Statistics Agency is a Non-Ministerial Government Institution that is directly responsible to the President. Previously, BPS was the Central Bureau of Statistics, which was established based on Law No. 6/1960 on Census and Law No. 7/1960 on Statistics. As a replacement for the two laws, Law No. 16/1997 on Statistics was enacted. Based on this Law which was followed up with the legislation below, the name of the Central Bureau of Statistics was formally changed to the Central Bureau of Statistics (Profile BPS,2019)

BPDPK	The Agency for Healthcare Funds (Badan Penyelenggara Dana Pemeliharaan Kesehatan–BPDPK) was established for civil servants and the military a year prior to the major project of the Five Year Plans.
Clinic Pratama	Clinic Pratama is a clinic that provides basic medical services.
DAK	District Allocation Funds Article 162 of Law No. 32/2004 states that District Allocation Funds is allocated in the Annual State Budget for certain regions in the context of decentralized funding to (1) finance special activities determined by the Central Government based on national priorities and (2) finance special activities proposed by certain regions.
DAU	General Allocation Funds According to Law No.25, 1999, the allocated funds from the central government are block grants to be used by the local governments according to their own priorities.
DJSN	The Board of National Security The National Social Security Council (DJSN) is a Council whose function is to assist the President in formulating general policies and synchronizing the implementation of the National Social Security System.
Dinkes Propinsi	Provincial Health Office is the implementing element of regional autonomy in the health sector in accordance with the affairs of the Provincial Government and applicable laws and

	regulations. The Health Service is led by a Head of Service who is under and responsible to the Governor through the Regional Secretary.
Dinkes Kota	District Health Office is one of the City Government apparatuses that has the task and function of assisting the Mayor in the Health Sector.
FKTP	First Level Health Facility Primary care facilities in the form of essential health services provided by community health centres, clinics or general practitioners or primary health care facilities.
FKRTL	Advanced Level Referral Health Facility (FKRTL). The patient will receive further treatment according to his medical needs.
Gotong Royong	Cooperation, whereby Indonesian usually raise funds to jointly help people who need assistance due to economic, health, or other calamities.
JAMSOSTEK	Social Insurance Scheme for Formal Sector Employees. The Jamsostek programme provides basic protection to meet the minimum needs of workers and their families, by providing 4 (four) programmes; Security Program (JKK), Death Security (JKM), Old Age Security (JHT) and Health Care Security (JPK) for all workers and their families.
JPSBK	Social Safety Net for the Low-Income Group is implemented with the aim at helping low-income families in the health sector due to the impact of the monetary crisis.
JAMKESDA	Social Insurance Scheme Provided by District

	and Provincial Government.
JAMKESOS	Social Health Insurance- social health insurance scheme under the Government of the Special District of Yogyakarta (DIY) coordinated with regencies/city governments. The Jamkesos participants are the low-income group in Yogyakarta not yet covered by social health insurance, either National Health Insurance, District Health Insurance, or other social health insurance.
JAMPERSAL	The Universal Delivery Care is a government-supported maternity care policy primarily targeting pregnant women who, irrespective of their socioeconomic status, are not covered by any other health insurance scheme.
JKN or JKN-KIS	The National Health Insurance or JKN is one of the social security programs provided by the government to the Indonesian people to provide financial capacity for the community when they need health services or medical care.
JPKM	Community Health Insurance is a health care programme that is aimed directly at participants in the field of implementing and financing based on existing guarantees with the power (*daya guna*) to improve the health status of the community.
KBK	Service-Based Capitation to improve the quality of health services in First Level Health Facilities which has been implemented since 2016 at health centres in 33 provincial capitals with a total of 995 health centres. The implementation

	of Capitation Payments based on Service Commitment Fulfillment (KBK) has begun in accordance with the Joint Regulation of the Secretary General of the Ministry of Health and the President Director of BPJS Health Number HK.02.05/III/SK/089/2016 and Number 3 of 2016 concerning Technical Guidelines for the Implementation of Capitation Based Payments.
KIS	Indonesian Health Card is the identity card of the participants of the National Health Insurance (JKN) managed by the Social Security Administering Body (BPJS) Kesehatan. The replacement of the BPJS Health card to KIS began on March 1, 2015.
KKS	Family Welfare Card is a card issued by the government for low-income households/families. However, there are still many people who are confused about making KKS to receive government assistance.
Kemenkes (MoH)	The Indonesian Ministry of Health is responsible for assisting the President in carrying out some government affairs in the health sector.
Kemensos	Ministry of Social Welfare - the Presidential Decree Number 46, 2015 concerning the Ministry of Social Affairs stated that the Ministry of Social Affairs has the responsibility for conducting affairs in the field of social rehabilitation, social security, social empowerment, social protection, and inadequate care to assist the President in organising the government of the State and

	inclusivity.
Kemenko PMK	The Coordinating Ministry of Human Development and Culture of the Republic of Indonesia.
INA-CBG	Schedule for Determining the Amount of Reimbursement for Given Diagnosis.
OOP	Out of Pocket (OOP) is direct expenditure by households (expenditures that are actually incurred by the household) for health services, including doctor consultation fees, drug purchases, health service fees or alternative and/or traditional treatments, gratuities or payments in kind to a health practitioner or health facility. Does not include costs borne by third parties. For example family, neighbours, friends, office, insurance, and others (WHO, 2017).
Pancasila	Pancasila is the Indonesia nation`s identity, which indicates that Pancasila is a national characteristic that is unique which cannot be found in any country. Pancasila points are taken from noble values of the Indonesian state. These principles include culture, customs, and national character known as manners, cooperation, and high sense of nationalism.
PRB	Reverse Referral Programme provides medicines for chronic diseases at First Level Health facilities as part of the referral service on this programme.
P-Care	BPJS Kesehatan Primary Care

	Primary Care or Care is a BPJS Kesehatan application which provides access for participants to first-level health facilities (FKTP). P-Care has a function to maximise services that can be obtained by BPJS Health participants. In addition, this P-Care application also has quite a variety of other functions. What is clear is that the functions offered by the P-Care application will provide convenience for BPJS Health users or participants. One of them seems to make it easier without the need to queue when going to take care of administrative needs. This is because the P-Care application will process data digitally which can only be done online (BPJS Kesehatan, 2019).
PBI	Government Contribution Beneficiaries Recipients. Government Contribution Beneficiaries type of participation is only intended for the low-income group, according to data from the Ministry of Social Welfare. BPJS Government Contribution Beneficiaries participants are not burdened with monthly fees because the government entirely bears all costs.
Non-PBI	Non-Government Contribution Beneficiaries participants are obliged to pay their monthly fees because the participants of the Non-Government Contribution Beneficiaries are considered economically capable and are not included in the category of needy and low-income people.
PBI APBD	Government Contribution Beneficiaries paid for

	by sub-national government.
PBI APBN	Government Contribution Beneficiaries, paid for by central government.
PBPU	Informal Sector Workers BPJS Informal Sector Workers are people who work or undertake business at their own risk, such as independent or other workers who meet the criteria of PBPU. Non-Indonesia citizens who work for at least six months in Indonesia are included in BPJS-PBPU`s category. The participants bear the monthly fees themselves, and they are free to include their family members without limitation.
PPU BU	Formal Private Sector Paid Workers Paid Workers Formal Private Sector and their Family members; employees who work for Stated-Owned Enterprises or Regional State-Owned Enterprises, formal private employees, employees who work for foundations/charities or not-for-profit companies, joint ventures and foreign workers who have already worked for at least six months.
Puskesmas	Community Health Centre or Public Health Centre Hereinafter referred to as Puskesmas, are health service facilities that carry out public health efforts as first-level individual health efforts, by prioritizing promotive and preventive efforts in their working areas. Puskesmas should be established in each sub-district (Ministry of Health Decree Number 43/2019).

Pustu	Auxiliary Primary Health Centre is a health centre service network that provides permanent health services in a location within the working area of the Puskesmas. The Sub-Puskesmas is an integral part of the Puskesmas, which must be fostered periodically by the Puskesmas. The objective of the sub-health centre is to increase the reach and quality of health services for the community in its working area.
Polindes	Village Maternity Clinic is a form of community participation or participation in providing a place for delivery assistance, maternal and child health services, including family planning where the place and location is in the village.
Poskesdes	Village Health Post is Community Based Health Efforts (UKBM) which were formed in villages to bring/provide basic health services for rural communities.
Pusling	Mobile Community Health Centre that serves the community by visiting certain areas to help sufferers who cannot visit the main health centre or auxiliary health centre.
Posyandu	Integrated Health Services Post is a form of Community-Based Health Efforts (UKBM) which is managed and organized from, by, for and with the community in the implementation of health development to empower the community and provide convenience to the community in obtaining basic/basic social health services to accelerate the reduction of maternal and infant mortality rate.

PROLANIS	PROLANIS is an integrated health care system and a proactive approach that is implemented involving Participants, Health Facilities and BPJS Kesehatan in the framework of health care for BPJS Kesehatan participants who suffer from chronic diseases to achieve optimal quality of life with service costs effective and efficient (BPJS Kesehatan, 2020).
PKU Muhammadiyah Yogyakarta	Board of Trustees of General Welfare Muhammadiyah Yogyakarta Private Hospital.
RPJM	National Medium Term Development Plan is a planning document for a period of 5 (five) years.
RSUD	District Hospital Hospitals that provide health services for all types of diseases ranging from basic, specialist, to sub-specialist which are organised and managed by the Regional Government.
RSUP	Public Hospital or Government Hospital (Class A). A class hospital is a hospital that can provide a wide range of specialist and subspecialist medical services. A class hospital is designated as a place of service for the highest referral hospital (top referral hospital) or a central hospital.
SJSN	National Social Security System SSN is a state program that aims to provide protection and social welfare for all Indonesian people. Through this program, every resident is expected to be able to meet the basic needs of a decent life if things happen that can result in loss or decrease in income, due to illness, accident, loss of job,

	entering old age, or retirement.
SILPA	Excess Remaining Budget Financing for the Year. That is the difference between the budget surplus/deficit and net financing. In the preparation of the APBD this SILPA number should be equal to zero. This means that finance received must be able to cover the budget deficit that occurs.
SDMK	Health Human Resources
Sympus	Puskesmas Information System (SIMPUS)
SIM RS	Hospital Information System (SIM-RS)
Susenas	National Socio-Economic Survey or Susenas is a survey designed to collect relatively broad population social data and is carried out annually. The data collected includes, among others, the fields of education, health/nutrition, housing, other socioeconomics, socio-cultural activities, household consumption/expenditure and income, travel, and public opinion regarding their household welfare.
TNP2K	National Team for the acceleration of Poverty Reduction.
UHC	Universal Health Coverage is the concept of providing the health services needed by the whole society without the individual financial burden that may negatively impact on individuals, families, and the wider society economically (WHO, 2017).

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CHAPTER ONE
INTRODUCTION

1.1. Overview

This Chapter provides a general introduction to the phenomena of Universal Health Coverage (UHC), as well as an evaluation of the implementation of the Universal Health Coverage (UHC) system in Indonesia. The thesis does this by analysing the inputs, process and outputs of UHC evaluation. As such, it gives a brief introduction to social health insurance in Indonesia before and following the introduction of UHC from 1st January 2014, including with references to what previous studies have shown particularly regarding the issues encountered during UHC implementation. The chapter also sets out the structure of the thesis.

1.2. Research Background

Universal Health Coverage is a concept promoted by the World Health Organisation (WHO) that acknowledges the importance of providing health insurance protection to a nation's people and providing comprehensive health services including; promotive, preventive, curative, and rehabilitative aspects at rational and affordable costs. The programme that is carried out to realise the SDGs in the health sector is the Healthy Indonesia Programe with three pillars: the healthy paradigm, health service provision, and national health insurance. The SDGs programme is very relevant to the implementation of UHC in Indonesia. The SDG's targets include universal health coverage, including financial risk protection, access to good essential health services, and access to safe, effective, good quality and affordable essential medicines and vaccines for everyone.

After WHO promoted the UHC concept, many countries worldwide made this programme a critical plan to be realised. However, there are still many

obstacles in its implementation due to various factors. For Indonesia, there remain many challenges in terms of a large population, varying levels of provision across and within its geographic regions, especially in remote areas, as well as diverse cultures, and the large number of low-income people that need to be covered by the GoI's UHC system.

As defined by Avedoff, Ferranti, *et al*., (2012), Universal Health Coverage is a system of ensuring that society can access health services without financial hardships. This means that good health services are essential to sustain economic and social growth. At the same time, and inter-related, societies and nations endeavour to reduce the levels of poverty. The costs of health care and health care services, if they have to be met by individuals and families, can cause or exacerbate poverty levels. Wagstaff et al., (2016) describe UHC as a protection programme covering the costs of health care. Widjaja (2014) and Moses (2018) highlight that UHC should encompass health provision, including promotion, prevention, cure, and rehabilitation within reasonable costs. Additionally, Jain and Alam, (2017) explore three primary key drivers of UHC concepts: (1) Who accesses the health services? (2) What services are provided? and (3) What proportion of a country's budget is allocated to ensure UHC coverage?

Based on these explanations, UHC means a situation in which all individuals and communities have access to health services, whenever and wherever they need, without financial barriers to obtaining it. UHC covers a wide range of essential health services, from promotion, prevention, treatment, care, rehabilitation, and palliative care for patients with chronic diseases.

Universal Health Coverage starts from the acknowledgement of health as part of every individual's human rights (United Nations, 2020). There are various key factors that contribute to the fulfilment of health as part of human rights, i.e., availability, accessibility, acceptability and quality of facilities and health services. Thus, UHC aims to create equality in health services access and to

ensure that no one faces financial loss due to health services costs. To achieve this outcome, states need a robust, efficient health system that is professionally managed to ensure the quality of health services provision.

According to the World Health Organisation (WHO), the best way to minimise UHC costs is to cut UHC expenses by enlarging mandatory health services coverage paid by the state, such as through tax, and social insurance premiums. Nonetheless, this should be in line with the spirit of UHC. In other words, it is debatable as to whether a citizen`s ability to pay should be considered, among others by policy subsidy targeted at low-income and vulnerable groups.

The Government of Indonesia (GoI) has been working since 1968 to establish comprehensive social protection, including health protection, for all Indonesian citizens (Agustina *et al.* 2019). The social security aims are to ensure that:

- All residents have access to affordable primary, secondary, and tertiary health care.
- All children have access to basic nutrition, education, and other necessary goods and/or services.
- All individuals unable to earn enough income due to sickness, unemployment, maternity, or disability are able to receive basic income security,
- All senior citizens receive income security through pension benefits (UNDP, 2014).

Therefore, one of GoI's aims has been to implement a more comprehensive social health insurance system for the entire Indonesian population with the launch of Jaminan Kesehatan Nasional (UHC) on 1st January 2014, managed by *BPJS Kesehatan* – (BPJS, 2014). BPJS Kesehatan stands for *Badan Penyelenggara Jaminan Sosial* (Social Insurance Administration Organisation). According to the GoI's plans, the transformation of five existing social health

insurance schemes: Social Insurance for low-income groups, Social Health Insurance for Civil Servants, Social Insurance Schemes for Formal Sector Employees, and District Health Insurance were brought together into a single scheme under BPJS by 2014. BPJS system covers the premium payers and the low-income people who pay the premium subsidised by the GoI (see pages 3-8). BPJS covers health insurance, work accident protection, loss of income protection and insurance for the elderly (old age protection), pension protection, and death protection (Rolindrawan, 2015).

The Government of Indonesia has made it mandatory for all Indonesians to become BPJS Kesehatan participants, and specifically for participants who cannot afford it. The government has provided a solution by contribution assistance, especially for members registered independently as BPJS Kesehatan participants. They should pay a monthly fee according to the health service benefits that have been selected at the time of initial registration. Referring to Presidential Regulation (PERPRES) Number 64 of 2020, the following will explain how much the participants must pay each month according to 3 different classes of health services.

Members who have chosen first class health insurance have to pay the equivalent of £8.14 per month per person. Where there are 6 family members who are already BPJS participants, the premium to be paid per month amounts to £48.84 per Family Card. This is because if one family member has chosen first class coverage, then the other members automatically have first class membership, too. In cases where a first-class member is hospitalised, the person in question is entitled to a first class hospital room which normally consists of 2-3 people.

In cases where a member finds the first-class premium to be too expensive, he or she can opt for second class premium by paying £5.60 per month per

person. In case of hospitalisation, they would then be put in the second class hospital room which normally consists of 3-6 people depending on the hospital. Second class members can request for an upgrade, if necessary, by paying the balance not covered by BPJS Kesehatan.

Third class health insurance is deemed the most economical and affordable by the public. The premium to be paid per month by BPJS members is IDR42, 000 per person-meaning that if there are 6 family members the premium to be paid becomes £12.62. Third class members will be put in third class hospital rooms in cases of hospitalisation. Where the individual requests an upgrade, the person in question must pay the balance in full.

That is, in the Indonesian public health system, individuals can choose to pay additional contributions that then entitle them to ‘top up services’ such as the type of hospital bed or hospital ward that they occupy as an in-patient. Some may argue that this creates a two-tier system whilst others would argue the system remains ‘universal’ in that everyone has access to the ‘basic level of treatments and services.

Following the National Social Security System regulation, article 19, paragraph 1 state “that health insurance is administered nationally based on the principle of social insurance and the principle of equity." Article 19, paragraph 2 "contains the provision that health insurance is administered with the aim of ensure that participants receive health care benefits and protection in providing basic health needs."

Article 23 paragraph 4 "if a participant requires hospitalisation in a hospital, then the level of service class at the hospital is given based on the standard class" Explanation of the article: that participants who want a class higher than their rights (standard class) can increase their entitlements by taking out additional health insurance or paying the difference between the costs themselves which

is guaranteed by BPJS Kesehatan with costs paid due to an increase in the class of care.

BPJS is a public legal entity formed to organise social security programmes, consisting of BPJS Kesehatan and BPJS Ketenagakerjaan (BPJS Kesehatan, 2019: Yusriady 2019). Therefore, BPJS comprises two parts: BPJS Kesehatan (Health) and BPJS Ketenagakerjaan (welfare benefit for workers as well as a pension scheme). BPJS Kesehatan administers the National Health Insurance programme (UHC); BPJS Ketenagakerjaan manages workers' compensation and pension programme (Law Number 24/2011).

Under Law Number 24/2011, BPJS is a public legal entity formed to organise social security programmes, consisting of BPJS Kesehatan and BPJS Ketenagakerjaan (BPJS Kesehatan, 2019: Yusriady 2019). BPJS Kesehatan membership is divided into two groups: Government Contribution Beneficiaries and Non-Government Contribution Beneficiaries:

a. according to data from the Ministry of Social Welfare, Government Contribution Beneficiaries type of participation is only intended for the low-income group. BPJS Government Contribution Beneficiaries participants are not burdened with monthly fees because the government bears all costs. Apart from the low-income group, those who have the right to become BPJS Government Contribution Beneficiaries participants will have disabilities. BPJS Government Contribution Beneficiaries participation is only for the low-income group whose eligibility has been verified by the Social Welfare Ministry. The government fully covers Government Contribution Beneficiaries' health insurance premiums, and the members can access health service facilities in primary healthcare and Class III secondary and tertiary hospitals.
b. non-Government Contribution Beneficiaries participants are obliged to pay their monthly fees because the participants of the Non-Government Contribution Beneficiaries are considered economically capable and are not

included in the category of needy and low-income people. BPJS Non-Government Contribution Beneficiaries consist of three groups: Paid Workers are all people who work and receive a salary or wage, including Civil Servants, the Police, and the Armed Force members. Government officials, contract-based workers, private employees, and other workers who meet the criteria as a worker receiving wages. Non-Government Contribution Beneficiaries participants includes:

1. Paid Workers and their Family Members in the Public Sectors who receive a salary or wage, for example, Civil Servants, Police Members, and Armed Force Members. BPJS Non-Government Contribution Beneficiaries participants are registered by the company where they work; therefore, the company's monthly fees are partly borne by the participants (workers) and the participant's /family member also covered (up to five family members).
2. Paid Workers in the Formal Private Sector and their Family members; that is employees who work for Stated Owned Enterprises or Regional State-Owned Enterprises, formal private employees, employees who work for foundations/charities or not-for-profit companies, joint ventures and foreign workers who have already worked for at least six months.
3. Informal Sector Workers and their family membersBPJS Informal Sector Workers are people who work or undertake business at their own risk, such as independent or other workers who meet the criteria of PBPU. Non-Indonesia citizens who work for at least six months in Indonesia are included in BPJS-PBPU`s category. The participants bear the monthly fees themselves, and they are free to include their family members without limitation.
4. Non-Paid Workers and Family Members. This scheme includes investors, employers, retired people, veterans, and their family members who can pay monthly contributions. For this selected class, they must register as BPJS Independent participants and pay monthly fees (premium), i.e., Class I, II, and III in the public or private hospitals that have collaboration with BPJS Kesehatan. All family members listed in

one Family Card Holder must be registered as BPJS-Independent participants without exception. They are responsible for paying the -

one Family Card Holder must be registered as BPJS-Independent participants without exception. They are responsible for paying the monthly fees, the participant's contribution is dependent on the selected class (all family members receive the same package).

Concerning the premiums or monthly contributions paid by non- PBI participants to BPJS Kesehatan from 2014 to 2019, there have been several increases as follows (see Table 1):

Table 1 Contribution rates (per-month) 2014 – 2019

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Source: Prabkharan et al. (2019)

The UHC membership premiums have undergone several increases as can be seen in Table 1. Presidential Decree 19/2016 stated the need for a rise of UHC premium borne by the Government from the equivalent of £1.00 to £1.17 per person per month which increased the informal sector premium level. Under UHC, informal sector workers can access health care at different hospitals depending on their premium level (refer to page 3-4).

Meanwhile, the total private sector worker contribution as a percentage of salary was unchanged at 5%, but the distribution of contribution between the members and their employers shifted from employers contributing 3% and employees 2%, to 4% and 1% respectively (Prabkharan *et al.,* 2019).

Presidential Decree No. 75 of 2020 again increased UHC premiums. The Government contribution beneficiaries increased from the equivalent of £1.17 to £2.14 per person per month. The same also applied to Government Contribution Beneficiaries' recipients paid by the regional and the central government. BPJS public sector paid workers, which consist of civil servants/Armed Force/Police members, had original contributions of 5% of the basic salary and family allowances, with 3% borne by the government and 2% by the workers. The latest policy changed this to 5% of basic salary, family allowances, job allowances or additional income for regional civil servants, with a ceiling limit of IDR 12 million per year of which 4% is paid by the government and 1% by the workers.

BPJS informal sector workers are classified into three groups with associated premiums: Class 1 increased from £4.10 to £8.14 per person per month, Class II increased from IDR 51.000 (£2.62) to IDR 110.000 (£5.09) and Class III increased from 1.30 to £2.14 per person per month. Universal Health Coverage membership targets were to be completed by mid-2015. By 2017, all big and medium enterprises -

were expected to implement the scheme. By 2018, small businesses were encouraged to join. By 2019 it was hoped that 95% of Indonesian citizens would be covered by UHC as well as non-Indonesians who have resided in Indonesia for at least six months (Mutiarin et al., 2019).

After explaining the contribution levels of the various premiums to BPJS Kesehatan, further information on the health service package for BPJS participants can be seen more clearly (BPJS Kesehatan, 2019; Yusriady 2019) below:

a. BPJS Kesehatan provides health services that include primary care health facilities, advanced healthcare services in secondary and tertiary health facilities:
    1. Primary care facilities in the form of essential health services provided by community health centres, clinics or general practitioners or primary health care facilities.
    2. Secondary health care facilities are the health services provided by specialist doctors or specialist dentists.
    3. Tertiary health facilities are for patients in need of further medical treatments or special treatments with specialist doctors and/or advanced specialist equipped hospitals.

b. BPJS Ketenagakerjaan (Welfare benefits for workers and retirement scheme)
    1. Old Age Protection/Jaminan Hari Tua (JHT) - this kind of protection provides benefits once the workers leave the company because of retirement or due to loss of work. Usually, workers will get the maximum benefits after working for 10 years or more in the same company.
    2. Working Accident Protection/Jaminan Kecelakaan JKK) applies if the workers experience any kind of accident whilst working for the company. The workers will receive compensation for any injury or medical treatment performed.
    3. Death Protection/Jaminan Kematian (JK), as the name suggests, applies if the workers die while serving in the company.
    4. Pension Protection/Jaminan Pensiun (JP) applies when the workers reach the retirement age. At that point, they will receive some compensation via this kind of protection.

In essence, the benefits covered by BPJS Kesehatan include public health, curative personal health care and rehabilitative services. Medical and non-medical services, such as ward accommodation and ambulance services are also covered. For primary health care, the health providers are public clinics, private clinics and general practitioners that collaborate with BPJS Kesehatan. The secondary and tertiary health care providers are both public and private hospitals that have established collaboration with BPJS. The Ministry of Health (MoH) is responsible for setting regulations on health service delivery as well as the tariff for services, medical prescriptions and medicines. The MoH collaborates with the Ministry of Finance and the National Social Security Council and is also responsible for regulating, monitoring, and evaluating the UHC policy. The BPJS is responsible for registering health beneficiaries (i.e. members), administrating memberships, supervising health-care providers, and managing claims and complaints (Mutiarin et al., 2019).

In the first year of UHC implementation in Indonesia in 2014, the GoI faced many challenges and endeavoring to successfully implement UHC. This is not unusual for any country that is trying to implement a new (universal) health system. As such, Indonesia has had various issues to overcome, such as how to ensure that the UHC covers the informal sector workers, the UHC`s premium and benefits are in balance, how to ensure “supply-side readiness” in terms of the adequate supply of good quality services, which is an essential condition for successful implementation of UHC (see Bradenkamp *et al.* (2015). Permatasari and Ernawati (2019)

The target population to be covered by 2019 was 257.5 million of the Indonesia population. However, the actual number of UHC members in January 2019 was 215.784.3 million; with 53.755 million (19%) population still to be covered by the UHC programme. At the time, the costs of diseases such as heart disease, kidney failure, cancer and stroke rose significantly (BPJS Kesehatan, 2017). The increasing incidence of degenerative diseases and the ‘diseases of healthcare’ have certainly

affected the health finances during the implementation of UHC, as the data in Table 2 below indicates:

Table-2 Catastrophic Diseases and Cost

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Source: BPJS Kesehatan, 2018

In Table 2 it shows that non-communicable diseases such as heart disease, kidney failure, cancer, and stroke continue to increase in the number of cases and have an impact on increasing health care costs. Related to this, it means that the Indonesian government has needed to continue to make promotive and preventive efforts for these non-communicable diseases. Therefore, BPJS Kesehatan needs to evaluate the promotive and preventive benefits in this UHC package, such as cervical cancer prevention efforts by doing a Pap-Smear. The implementation of the promotive and preventive benefits of BPJS Kesehatan can be undertaken if BPJS Kesehatan works with health service facilities or integrate its programs with the Ministry of Health, such as the Healthy Community Movement Programme (GERMAS), or the SDGs programme.

The referral system is also problematic, as the BPJS Kesehatan (2015) data shows; there were 14,619 million visits to primary health care facilities in the first quarter of 2015. The Referral Return Programme or PRB also is not optimal because several things need to be evaluated further by BPJS Kesehatan and health providers. Permatasari and Ernasari (2019) further stated that PRB is still rarely conducted because some health workers lack understanding of the Referral Return Programme and treatment limitations in primary health care facilities. Thus, this has sometimes resulted in patients who should ideally seek treatment at primary health care facilities

instead, incorrectly referred to secondary and tertiary health facilities. The lack of understanding of BPJS Kesehatan by health workers about PRB has resulted in different perceptions and experiences that have hampered the successful implementation of PRB.

Permatasari and Ernawati emphasise (2017) that more than 2,236 million visits were referred from primary to secondary health care facilities, and 214,706 visits were non-specific referrals that should not have been referred and should have been resolved in primary health care facilities. The referral system does not only concern non-specialist referrals, but also with inadequate form filling. Pre-referral contact is often not carried out to its full potential. Only 15% of patients with 155 diagnoses should be referred to secondary health care facilities, yet this has not happened. Not only from the viewpoint of the community, but even from the standpoint of health care professionals, there are also limitations. Since some primary health care facilities have insufficient medical staff, facilities, infrastructure, medication, and medical equipment supply, they are unable to serve as gatekeepers. The referral system is not functioning properly due to the lack of training of health care staff in the hospital. It should be a referral scheme that has been in place since 2012 and is constantly tracked, reviewed, and implemented under the oversight and direction of the authorities. As a result, there are implementation constraints that must be overcome to ensure that the correct referral mechanism can be established, and solutions identified.

Furthermore, the transformation system before and during the implementation of UHC brings about some impacts on regulations, such as regulations that BPJS Kesehatan and the MoH should implement as the aspects of improving healthcare services. The lack of synchronisation between relevant stakeholders in implementing UHC also needs to be addressed. Prior to UHC, a region's role was very dominant in overseeing the success of social health insurance programmes, such as the implementation of District Health Insurance, which was under the management of the local government. However, at the same time that the District Health Insurance was being intensively implemented, the transformation to UHC was declared by the central government.

In contrast, after UHC, local stakeholders felt that their rights had been fully transferred to BPJS Kesehatan and, therefore, to the central government. Local stakeholders still need to be truly relevant in supporting the success of UHC by participating and encouraging the implementation of the UHC programme in their areas, especially related to UHC participation for vulnerable communities and low-income groups. So, the transformation does not mean that the centre takes over the regional functions. Resolving the misunderstanding between the local and national level is essential; coordination is needed between the central and provincial governments to support the sustainability of UHC in overcoming the obstacles that affect each region.

A great deal of effort is still needed by BPJS Kesehatan and other stakeholders to provide the socialisation of UHC. Socialisation is not only at the level of health services providers but also the community (Permatasari and Ernawati, 2019). This study shows that patients or the community lack awareness of UHC changes and often compare their experiences between UHC and the preceding social health insurance scheme, Askes (Social Health insurance for Civil Servants). Unfortunately, the role of UHC has not been effective in helping patients understand the UHC transition objectives and the new role of primary care services. From the beginning of the transformation of social health insurance, from the previous scheme to the UHC. Many changes to the rules and conditions of service have changed. For example, the location of a health service referral after UHC is more determined explicitly by BPJS. Referral is based on the closest distance from the patient's residence. This regulation aims to make it easier for patients to get access to the nearest health services. Still, sometimes they do not feel that they are compatible with the health services that BPJS Kesehatan has approved. Therefore, BPJS Kesehatan and health providers still need to continue to ensure effective socialisation with the public regarding the referral mechanism. Thus, it is essential to have a broader public information campaign on TV, radio, and at community events to help people understand what UHC entails, what it covers and what it does not cover.

Implementing UHC to various population groups, as revealed by Bredenkamp et al. (2015), faces challenges in terms of the equitable distribution of UHC in Asian countries. The primary health care services need to have administrative capacity and

supply side readiness. Often, government leadership and political priorities are more important than the technical solutions. Furthermore, government needs to consider how to arrange coverage of full package of health benefits to all the population, as well as what the reasonable cost should be and how to address various diseases linked to cost-effectiveness. As to the findings, certain solutions will depend on the government's political will, such as leadership and the management and administration of health care system. In Indonesia, the implementation of UHC is closely related to political conditions and government policies (this is explored in Chapter Two of the thesis: The Socio-political Context of Implementing UHC and the Drive behind UHC).

Referring to the above, at the beginning of UHC implementation, some challenges emerged in terms of UHC memberships as the total population in Indonesia is more than 250 million people. Meanwhile, the target to be achieved by 2019 is that 100% of the population was to be covered, including the low-income group and the informal workers. The latter will find it difficult to pay UHC premiums every month because they do not have a fixed income. This is different from civil servants who have a regular income which means that BPJS Kesehatan premiums can be deducted from their salaries.

The readiness of UHC supplies has also highlighted the supply of health service facilities, human resources, health costs in terms of supply side, provision of medicines, and the strengthening of the referral system (National Team For The Acceleration Of Poverty Reduction/TNPK, 2015: Rolindrawan, 2015). During the transition period, UHC regulations need to be further evaluated such as coordination with stakeholders at the regional and central levels including the socialisation of regulations, including access to health services at the primary health care level and the referral hospitals. Socialisation is crucial for all the stakeholders, including health service providers and the community as a whole. Better socialisation is likely to increase the understanding of all parties regarding the objectives, benefits, roles, and functions of UHC.

As indicated by various previous studies, including those referred to above, evaluations are needed to explore more about UHC implementation. This thesis will do this in terms of the CIPP process of analysis; context, inputs, processes, and outputs of the social health insurance scheme before and during UHC implementation in Indonesia; as well as the extent to which the UHC policy aims had been achieved by 2019. As such, the output of this research is expected to be useful for improving the implementation of social health insurance in Indonesia and its sustainability.

1.3. Research Objectives

The overall objective of this study is to examine the effectiveness of the implementation of the Indonesian social insurance model of health care including, its input, process, and outcome. The specific objectives of this study are stated in the research questions section below.

1.4. Research Significance

Previous researchers have carried out research on and around social health insurance systems. None applies the implementation and effectiveness of a mixed-methods approach for collecting data and undertaking analysis. This research uses mixed methods to provide an evaluation that can contribute to policymakers' understanding of how to improve the implementation of UHC in Indonesia. In addition, this study applies a comprehensive Contexts, Inputs, Processes, and Outputs (CIPP) Model of Evaluation to provide an evaluation that can assist policymakers to consider, further assess, develop, and ensure UHC sustainability, particularly by key stakeholders, i.e., the Board of National Security (DJSN), BPJS Kesehatan, MoH, Ministry of Social Welfare and Ministry of Finance.

1.5. Research Questions

Therefore, the research questions examined in this study are twofold:

R1: What have been the various impacts of implementing the chosen methods via UHC in Indonesia?

This research question focuses on the use of UHC as the social health insurance model that has been implemented in Indonesia and examines the effectiveness of that implementation, including by examining the population that are covered, which services are covered, its financing, who is required to pay out of pocket expenses as well as the overall sustainability of UHC in Indonesia.

R2: How successful has the introduction and implementation of choosing the UHC been before and during the implementation of the new scheme in Indonesia?

The second research question comprises an examination of what has worked well and supported the implementation of choosing the UHC since the GoI declared this programme in January 2014 until the target of achieving 95% population coverage by 2019, as well as an examination of what aspects of implementing this programme have been less successful and what the barriers have been.

Due to the nature of the research objectives and associated research questions, a mixed method approach was applied to this study. Quantitative data was obtained based on secondary data from the 2012-2018 Indonesia Socio Economic Survey National (Susenas). The qualitative data were collected based on focus group discussions (FGDs) and in-depth interviews. Data were analysed based on the context, inputs, processes, and outcomes (product)/CIPP analysis model (Stufflebeam, 2003).

1.6. Thesis Structure

This thesis is divided into eight chapters. Chapter One has presented a general introduction to UHC in Asia and Indonesia, including UHC as reflected in the UHC implementation in Indonesia since 1st January 2014. In addition, the research objectives and specific research questions have also been presented in Chapter One.

Chapter Two explores the socio-political context of implementing UHC and the drive behind UHC, as well as the differing context of welfare regimes, including in Indonesia and ASEAN countries.

Chapter Three explores the health system, health financing and social health insurance in Indonesia and in different countries. Furthermore, this chapter also describes the development of UHC in Indonesia, its philosophical context, history, and progress.

Chapter Four describes the research methodology and methods used in this study and covers research philosophy; research design - incorporating an exploration of the qualitative and quantitative approaches used in this study; the characteristics of the sampling size; an examination of validity and reliability; an analysis of the research plans; as well as a discussion of acquiring ethical approval for the research.

The qualitative and quantitative results and findings are presented in Chapter Five. Qualitative primary data was gathered through in-depth interviews and FGDs. Qualitative data analysis was undertaken using CIPP Model analysis through the use of N-vivo. Quantitative data was undertaken using correlation regression as well as 'Different in Differences Analysis', using STATA.

The mixed methods Concurrent Embedded Design results are explored in Chapter Six. Following that, discussions of the research findings as a whole are explored in Chapter Seven. Finally, conclusions and recommendations, limitation and my reflections on this study are presented in Chapter Eight.

In summary, this research uses mixed methods and CIPP Model Evaluation to examine the effectiveness of the implementation of the Indonesian social insurance model of health care. It is hoped that this contributuion to new knowledge will help policymakers and other key stakeholders (including the Board of National Security (DJSN), BPJS Kesehatan, MoH, Ministry of Social Welfare and Ministry of Finance) to consider and further assess, as well as to futher develop UHC in Indonesia in order to ensure UHC sustainability.

CHAPTER TWO
THE SOCIAL POLITICS OF IMPLEMENTING UNIVERSAL HEALTH COVERAGE: THEORITICAL BACKGROUND AND REVIEWS

2.1. Overview

This Chapter illustrates the socio-political context of implementing UHC and the drive behind UHC globally, the different welfare regime theory, applied in ASEAN countries, including Indonesia application and implementation into UHC.

2.2. Establishing Universal Health Coverage

The aim of Universal Health Coverage is that all individuals and communities receive health services without having financial difficulties (WHO 2020; United Nations 2020). There are three main goals of UHC that include equal and fair access for everyone, sufficient health care quality and no undue financial risk (WHO 2020; United Nations 2020). The UHC, “universal” mean “for all” with no prejudice and no one left behind. Everyone is deemed to have the right to access the health care they need without falling into poverty because of its use. The concept of universal health coverage is based on the WHO Constitution of 1948, which declares health to be a basic human right, as well as the Alma Ata Declaration's Health for all Agenda of 1978. In addition, as part of the Sustainable Development Goals, all United Nations (UN) Member States have reaffirmed their commitment to achieving UHC by 2030 (A/RES/74/2, October 2019) (United Nations, 2020).

Referring to the UHC objectives described by WHO and UN (2020), access to health services includes all individuals and communities irrespective of any difference in social status. As encapsulated by Margaret Chan as WHO Director-General "The Universal Coverage is the most powerful unifying single concept that public health has to offer, because you can realise the dream and aspiration of health for every person irrespective of what class you belong to, whether you are men or women, or whether you are poor" (Holmes, 2012). Access to health services includes primary health care such as those obtained at primary health services, general practitioners, and primary care clinics. While for referral health services, the community can of

course be provided with specialist services including access to secondary and tertiary health care and medical services.

The second objective is of sufficient quality, which means that the community has the right to access quality health services following their health needs (WHO, 2020). Appropriate and competent health and care personnel with a proper skill mix at the institution, outreach, and community levels, equally distributed, supported, and enjoying acceptable work, are required to perform these services. Universal Health Coverage (UHC) method enables everyone to access services that address the leading causes of disease and mortality while also ensuring that the quality of those services is sufficient to improve the health of those who receive them.

The third goal undue financial hardship; is that the community can take advantage of quality health services without burdensome costs. Good health is essential to sustained economic and social growth as well as poverty reduction. At the same time, society needs to be protected from being pushed into poverty because of the individual cost of health care. This is also in accordance with what was stated by WHO (2020) that good health is essential to sustained economic and social growth as well as poverty reduction.

Although the objectives of UHC as mentioned above seem comprehensive, there are some exceptions that are not included in the scope of UHC, considering the different capabilities of each country in terms of resources, as follows:

- UHC does not necessarily suggest universal coverage for all health interventions, regardless of cost since no country can afford to offer all care for free on a long-term basis.
- UHC is about more than just health care funding. Health care delivery systems, the health workforce, health facilities and communications networks, health technologies, information systems, quality assurance processes, and governance and regulations are all included.
- UHC is about providing not only a basic health care, but also includes ensuring progressive expansion of social health insurance coverage and financial protection as more resources become available.

- UHC encompasses not only individual treatment services, but also population-based services such as public health campaigns, fluoridation of drinking water, controlling mosquito breeding grounds, and so on.
- UHC contributes not just to health; taking step to achieve UHC means a step towards equality, development priorities, as well as social inclusion and cohesion.

Universal Health Coverage is concerned with preventative public health, cure, and society's economic and social welfare. In addition, there are other aims such as ensuring that will cover the entire population, how to set suitable and affordable premiums and benefits. Premium is a sum of money that is paid regularly by participants, employers, and/or the government. Indeed, for low-income people, the premium is usually subsidised by the government, as in Indonesia. However, there is a premium paid regularly per person per month with varying package benefits for those who can afford to pay. Also, it is necessary to pay attention to people who do not have permanent jobs. If the government does not subsidise the premium payment, it is feared that this group will not access health services properly due to obstacles in paying premiums. The availability of reasonable funding from various resources, such as tax, is essential for the government to be aware of it. Regarding the benefits package for participants` access to primary, secondary, and tertiary health services, further description of the premiums and benefits of BPJS Kesehatan has been mentioned in Chapter One, pages 3-9.

Regarding the benefit of UHC, Bredenkamp et al. (2015) underline that designing premium and benefits packages need to be concerned with the outcomes, such as improving social welfare to the low-income people and marginalised regions. This programme also aims to attain a healthier population with a positive impact to increase economic growth. This programme needs the government's effort with a good system of transparency; accountability in terms of allocation processes, although many different societies or groups are covered in this programme.

2.3. The Socio-political Context of Implementing UHC and the Drive behind UHC

As stated in the objectives of implementing UHC, everyone, including individuals and communities, has access to the health care they need without facing financial hardship. It includes a complete range of critical and high-quality healthcare services, from prevention to treatment, rehabilitation, and palliative care throughout the life course. UHC is also a manifestation to implement social protection and health for all Indonesian people. Therefore, the government needs to work hard in finding strategies to achieve UHC successfully.

The results of research conducted by Pisani at al. (2012) show that domestic political issues shaped Indonesia's path to universal health coverage, with different groups gaining access to healthcare as their socio-political prominence expanded. Following the Asian financial crisis of 1997, a key turning point occurred. For a variety of reasons including a desire for a more cohesive society and to prevent social unrest, the government for the first time gave health coverage to the low-income groups, resulting in dependency in getting subsidies that influenced later policy decisions.

The government implemented its version of UHC at the time when Indonesia was still experiencing the effects of the financial crisis in 1997. The government made many efforts to provide subsidies to the community, including health protection. However, after the monetary crisis began to subside, the Indonesian government was able to be more dynamic in distributing subsidies. Since the inception of the UHC era, the government has prioritised UHC premium subsidies for low-income groups, with the data verification process from the Ministry of Social Affairs.

The termination of this initiative corresponded with decentralisation, allowing for the testing of a variety of health-care initiatives were successful in the importance of policy experimentation as well as a through grasp of the contextual and political aspects that drive effective UHC models at a local level. While technical considerations took a back seat to political priorities in building national health care structures, they will need to be addressed in the future to ensure that all Indonesian have access to affordable social health coverage.

The role of the government cannot be separated from UHC implementation, also political influence in Indonesia, because UHC is a programme with great potential to attract all policymakers' attention and the community. The implementation of UHC reflects the government's efforts to create a welfare state that prioritises the welfare of its people. The concept of the welfare state is related to efforts to improve the welfare of society in a country.

The concept of a welfare state acquires various aspects in different countries according to its cultural, social, political, and economic heritage and historical development. The “Welfare state” aims to provide for the welfare of individual citizens (Aravazik, 2019). As pointed out by Asa Briggs, 1967; Aravazik, 2019). "This is a kind of country where consciously organized public power is used to reduce the role of market forces" accepted within the scope of the role of the welfare state to provide minimum social security income to individuals and families, to facilitate the prevention of certain social risks, and to offer good living conditions to individuals in society through social welfare. As emphasised by Deacon (2002) that welfare state is a society in which the government accepts responsibility for ensuring that all citizens receive a minimum income and have access to highest provision in the fields of health care, housing, education, and personal social services.

Indonesia is often referred to as a country that carries the idea of welfare state as mentioned in the Preamble to the 1945 Constitution of the Republic of Indonesia which contains the formulation of the goals of the Indonesia and Pancasila states that the Indonesia was formed "... to protect the entire Indonesian nation and the entire homeland of Indonesia and to promote public welfare, educate the nation's life, and participate in carrying out world order..." After that statement, the Pancasila text states, "social justice for all Indonesian people" (Efendi, 2017).

The GoI efforts to implement and realise a Welfare State based on the 1945 Constitution:

1. The social security system, as the backbone of the welfare programme
2. To fulfil the fundamental rights of citizens through development based on productive economic resources, particularly health and education, as a support for the social security system, creating broad employment

opportunities as a starting point for development and compiling economic strength through cooperatives as the most dominant form of business entity.

3. As to economy; equitable economic distribution because of production redistribution and joint control of production through cooperatives,
4. Bureaucratic reform creates a responsive and robust government as an agent of development and a broad provider of public goods and services and natural resource management as a supporter of the Welfare State to uphold social justice (Kresno, 2019).

The discussion about the welfare state theory, the difference between the welfare state regime and its implementation in Indonesia will be discussed in the next parts.

2.4. The Context of Welfare Regimes Theory

As explored by the following references (Gough 2004; Powell and Barrientos 2004; Taylor-Gooby 1991): a welfare regime is a consequence of political, economic, and social structures that impact how public goods are created and managed by a group of welfare actors before being delivered in the form of social policy within a specific welfare system. Esping-Andersen has classified welfare regimes into three types: Social-democratic, Liberal-Anglo-Saxon, and Corporatist. The liberal welfare model described is practised by the United States and Britain. Germany, France, and Belgium practised conservative and Continental European models. Social Democratic Model practised by Sweden and Denmark (Aravazik, 2019). The Welfare models are further outlined as follows:

First, the Liberal or Residual Model *(Anglo-Saxon)* has characteristics that include:

1. Means-tested, or limited, or conditional social support and more of a safety net.
2. Greater state efforts are focused on creating financing schemes so that citizens can participate (again) in large flows of employment.
3. Simultaneously, industrial development and trade are developed. The first *(precursory) is to* create access to goods and services and sustainable purchasing power.

The United Kingdom uses as an archetypical example of this welfare regime model to illustrate better access to this welfare state regime. Nevertheless, it is previously described as more of a hybrid-liberal regime. Unlike traditional liberal countries such

as the United States (which is seen as the model for a liberal regime), the United Kingdom has a National Insurance System, which Beveridge established in 1942 (Spicker, 2012). The National Health Service (NHS) is part of this system, and it is offered free of charge to all citizens, which is not typical of a liberal regime. Furthermore, the United Kingdom comprises four constituent countries, each having its autonomous self-government, such as Scotland, which has a different educational framework than the rest of the country. This is also one of the main criticisms of Esping-welfare Andersen's system because it is rarely found in its purest form, as in this example. The United Kingdom, on the other hand, can still be classified as a liberal government because the country typically only provides social security to its citizen's basic needs, which can be referred to as a safety net. Furthermore, the state's social security programmers, funded by taxes, are limited and stigmatised due to their means-tested distribution, such as the Working Tax Credit, even though they assist those who need it the most. In other words, working tax credit is a means-tested government subsidy that assists low-income workers with day-to-day expenses.

The UK has the National Health Service (NHS) as its publicly funded healthcare system. The NHS is mostly funded from general taxes (including a portion of National Insurance payments). It is one of the largest and oldest single-payer healthcare systems in the world. The NHS provides the majority of healthcare in the UK, including primary care, inpatient care, long-term health, ophthalmology and dentistry. The National Health Services Act 1946 came into force on July 5, 1948. Private health care continues to be parallel to the NHS, partially paid for by private insurance: used by about 8% of the population, generally in addition to NHS services. In the first decades of the 21st century, the private sector began to be increasingly used by the NHS to increase capacity.

On the other hand, the United States (US) is often portrayed as the arcetypal liberal welfare regime where the expectation is that indiviudals make their own arrangements for welfare protection, including healthcare. However, even in the US, employer-based health insurance as well as a residual safety net (Medicare and Medicaid) are key parts of its ‘liberal’ market-based system. And, an issue that often dominates in the US is the debate about choice and personal responsibility, the

desire for a small state, and concerns over the deserving and undeserving (free-loading) poor.

The second welfare regime is Conservative and Continental European models practised by Germany and France explained by Spicker (2020) that the pre-war German settlement as based on the idea of a `social state` sometimes interpreted as a `social market economy`. Germany's economic order is labelled 'Social Market Economy' to indicate that the economic system has both an economic and a social dimension. Its purpose is to reconcile efficiency goals and social responsibility. The concept of the Social Market Economy is based on central values such as freedom or justice. Under the label Social Market Economy, Germany has become an extensive social welfare system. Furthermore, the German economy and welfare system are developed based on a capitalist system. Bismarck developed this principle based on the existing mutual assistance association, which remained the basis of social protection. Social insurance, which might cover health costs, some social care and most of income-maintenance system, is managed through a self-funded basis. Moreover, there is a concern on the principle of "subsidiarity". This principle applied in Germany defines that service must be decentralised or managed independently. The level of state intervention must be residual, which means limited to circumstances not covered in other ways. Those with higher incomes are not covered by the primary social insurance system but are left to themselves.

Furthermore, as described by Nadal (2005) after World War II, France constructed a well-developed social security system based on an egalitarian welfare state model cantered on equality, fraternity, and solidarity. The health-care system can be described by an ideology of national solidarity based on "both mutual dependency and national obligation!" At its best, the feeling of state and public duty encapsulates everything that is beautiful about French civic rights and responsibilities, but it can also breed complacency via insularity.

In contrast to the British NHS, which focuses on providing services rather than reimbursing costs, health care in France is characterised by a national social health insurance (NHI) programme. The NHI is nearly entirely handled by the state and funded by employee and employer insurance contributions and targeted taxes.

Medical goods and services are not free at the point of delivery for most patients. Still, the innovative introduction of the "Carte Vitale" has changed that (which approximates a credit card identifying your national health insurance right). Ensures that patients obtain the appropriate degree of reimbursement nearly immediately afterwards, such as 70% for visiting your doctor or 100% for treating a specific dangerous illness (Britnell, 2015).

In addition, the French system has established an ideal balance of health insurance, patient choice, professional autonomy, central control, and a mixed provider economy that results in positive health outcomes. It is the Republic, not Bismarck or Beveridge, who is responsible for its legacy. However, it can no longer ignore its shortcomings, and the healthcare system will need to be better integrated to increase efficiency and effectiveness.

The third model of welfare regime described by Esping Anderson (1990) is a Social democratic model. The degree of the-commodification is high in this model—the social-democratic principle of stratification. Social stratification describes the welfare state role concerning the structure of the society (Schidt, 2010). Social stratification aims to produce a system of generous, universally, and highly distributive. The benefits are not reliant on individual efforts; therefore, social stratification is ideally low. Within this welfare state concept, social policy is focused on maximising personal autonomy. Women are encouraged to participate in the labour market, particularly in the public sector, regardless of whether they are responsible for providing childcare. To fund the welfare state, this form of the welfare state system is usually committed to providing full employment to its entire population. Only by ensuring that as many people as possible are employed can a high-level unity welfare system be maintained, as proposed by Arts and Gelissen (2002). In other words, the principles of the social-democratic notion are universalism, where there is no duality between the state and the market, and there is high social equality. Individual and family welfare requires social services for all classes and the full participation of the working class.

Esping Andersen study is to ensure that every citizen and their family earn a minimum income according to standard appropriateness- providing social services

for any problems experienced by citizens (whether due to illness, elderly, or unemployment) and other conditions as the economic crisis. They also ensure that every citizen gets their right regardless of status, economic class, and other differences. In addition, the concepts of the welfare state seek to measure the extent of inter-relation between state apparatus (state), individuals and communities (social), and the business sector (market/corporation) in the governance of a country.

However, Esping-Andersen's concept of the welfare regime discussed above has been criticized (e.g., Gough 2004b; Holliday 2000). As further explained by Sumarto (2017), One of the criticisms argues that Esping-Andersen's categorization cannot be used to build the typology of social policy in developing countries. Therefore, welfare regimes need to be examined within the local context, namely, social policy systems in developing countries (Wood and Gough 2006). Democratic institutions, moral systems, and capitalistic models in Asia have various historical ancestors, as explained by (Walker and Wong 2005; Fleckenstein and Lee 2017; Gough 2004; Holiday & Wilding 2003, Hong 2008). It contains, for example, the nation of social solidarity without equality, the rise of patron-client politics, laissez-faire without libertarianism, and the rise of family economy-based capitalism (Papadopoulos and Roumpakis 2017). One focuses on Asian society's social structure, which includes institutionalized obedience to hierarchies, collectivism, and kinship. This fundamental premise is the architect of the state-citizen power relationship, elevating the state leader to the status of a de facto God. At the same time, citizens must be faithful and obedient to the government.

Furthermore, informal institution such as kinship-based institutions continue to play as essential role in social welfare provision alongside state and market institutions (Chan 2008; Walker and Wong 2005; Shin and Shaw 2003; Croissant 2004). These situations can be demonstrated in the East Asian region (Japan, South Korea, China, and Hong Kong Special Administrative Region) and some sections of Southeast Asian region (Singapore, Thailand, Malaysia, and Indonesia). After the global monetary crisis in 1997-1998, Asia's welfare system saw a discursive change from productivist welfare to universal, redistributive, and inclusive welfare. For economic progress, a productivist welfare regime prioritises the development of a

high-quality labour force. The subordination of social policy to monetary policy is the most noticeable element of this welfare paradigm. As a result, social rights are limited, and welfare is designed to boost production (Wen et al., 2021). Typical characteristic of universal welfare regime is if the state budget is allocated more to social programmes to meet the welfare of the community. As to the UHC concept, this is the government's effort to provide health insurance protection to its entire people without exception. The redistributive model entails government policies that are centred on income redistribution. In contrast, inclusive refers to a welfare model that focuses on social inclusion (Lin and Wong 2013). which is achieved via universal social investment programmes (Kwon 2005). This transition was further aided by widespread transmission of the Millennium Development Goals (now known as Sustainable Development Goals/SDGs) discourse, which was injected globally via international agencies (Kühner 2015; Mok and Hudson 2014).

In the context of Indonesia, the emergence of the National Social Security System, which later was implemented in BPJS, "is a mark of a major transition in the Indonesian welfare regime toward the universal model" (Yuda, 2018), will explore the welfare regime in Indonesian and Its implications for the national security system in Section 2.5.

2.5. The Different Context of Welfare Regimes in ASEAN Countries including Indonesia and its Implementation

There has been considerable debate about the characteristics of welfare regimes and regime transition in the developing world over the last three decades. Gough et al. (2004) give a transcontinental map of African, Asian, and Latin American welfare regimes. Welfare regimes have received significantly greater attention in Asia, particularly in Southeast Asia (SEA) and East Asia (EA), than in other regions (Mok and Hudson 2014). Most researchers (e.g., Gough 2004a; Holliday 2000; Mok and Hudson 2014; Powell and Kim 2014) believe that the SEA and EA welfare regimes are not included in Esping-regime Andersen's types (1990), as well as the fact that regimes have changed (Abrahamson 2017; Mok and Hudson 2014). The precise course of these modifications has remained a point of contention. This is mostly since the present categorization of welfare regimes is 'blooming,' with concepts such

as productivist (Holliday 2000), developmental (Kwon 2005), redistributive (Lin and Wong 2013), inclusive (Lin and Wong 2013), or protective (Kühner 2015) emerging.

Initial explorations of Indonesia's welfare system are provided by comparative studies on welfare regimes in SEA and EA, including Indonesia (Hort and Kuhnle 2000; Croissant 2004; Gough 2004a). According to this research, Indonesian social policy, like that of South Korea, Malaysia, and Thailand, can be classified as a productivist welfare regime. These studies may provide insight into Indonesia's welfare regime, but they do not indicate how the regime is currently evolving. The Indonesian government established a succession of social safety net (SSN) programmes from 1998 to 2004 to ameliorate the consequences of the Asian economic crisis, which hit Indonesia in 1997. The Indonesian government is now implementing a universal health insurance programme. These programmes induced a shift in Indonesia's welfare system, resulting in a regime that differed dramatically from previous descriptions.

In the discussion above, the Indonesian welfare regime appears to be changing like a chameleon. Powell and Kim (2014) coined the term “chameleon” to represent the Korean welfare regime’s continual transformation. They examined twenty-six articles and discovered that the Korean welfare regime might be divided into six categories: liberal, conservative, hybrid, East Asian welfare model as a fourth regime, East Asian welfare model as a distinct regime, and underdeveloped. In Indonesia, the term “chameleon” is used to describe a regime that thrives and changes rapidly within a brief period. Indonesia has had four different sorts of regimes since 1945: precarious, productivity, informal-liberal, and informal-quasi-inclusive. Political-economic, volatility, fluctuating growth, global pressures, and social policy “universalisation” all are linked to the welfare regime’s thriving development and rapid adjustments.

The GoI strives to achieve prosperity for all Indonesian people, as stated in the 1945 Constitution, which places social welfare as the main goal of state public policy. Social welfare is contained in the 1945 Constitution, which states; the economy is based on kinship, finances basic education, and develops a social security system for all Indonesian people in addition to empowering low-income and underprivileged

groups of people and provides health services: proper and public service facilities. The Indonesian government is mandated to place the community's interests above individual interests (Kresno, 2019).

Establishing the National Social Security System (SJSN) is one of the efforts of GoI to implement the welfare state concepts. SJSN is a state programme that aims to provide protection and social welfare for all Indonesian people. Through this program, every resident is expected to meet the basic needs of a decent life if things happen that can result in loss or reduction of income due to illness, accident, loss of job, entering old age, or retirement.

Literature written Alfitri (2012), the basic formulation of the ideology of the welfare state is contained in Pancasila. Pancasila is a way of characterising the values of the Indonesian people. These include those related to culture, customs, and national character and are based on cooperation and high national solidarity (Hidayat et al., 2021).

Following the fifth precept of Pancasila, the welfare state, “social justice for all Indonesian people,” is then embodied in the body of the Indonesian constitution and used as a guide for the life of the nation and state. Article 34 of the 1945 Constitution pre-amendment states that the state is responsible for caring for poor and neglected children. After the fourth amendment, it expanded the state`s task in social welfare with additional responsibilities to develop a social security system, empower-income communities, and provide health services and public service facilities for its people. The development of the welfare state regime in Indonesia is described in the section below.

2.5.1. The Change and Trajectory of the Indonesian Welfare Regime

The main characteristics of Indonesia's welfare regime in 1945-1966 were ones of risks, vulnerability, and uncertainty and precariousness. This was because the Indonesian regime was affected by war, political instability, and limited government support. At the same time, international support was limited because Indonesia had exited from United Nations membership

Within this context, when Indonesia was in the precarious welfare era, the Indonesian government was trying to rebuild the economy after achieving independence in 1945. The political situation was unstable and still anxious due to prolonged colonialism. This precarious regime persisted until 1966 when it, arguably, moved into a more 'Productivist Regime'. From the mid-1960s, Indonesia continued to build the economy and develop a welfare system, including protecting some Indonesian citizens (particularly state/public sector employees and the military) via public state-based health insurance schemes.

A precarious welfare regime refers to a set of welfare arrangements in which citizens face risks, vulnerabilities, and uncertainties due to political instability, war, conflict, economic hardship, limited community-based welfare, and the absence of international support. In the Meta welfare regime developed by Gough (2004b), the precarious welfare regime can be classified under the unsafe welfare regime. As summarized by Sumarto (2017), trajectory, changes and characteristics of Indonesia's Indonesian welfare regime can be seen in the following table:

Table-3 Characteristics and Trajectory of Indonesian Welfare Regime

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Sumarto, 2017

By 1966, the welfare system had shifted from a precarious to a productivist one. Given the opposing traits of these two regimes, a strong state and a stable political system are required for this regime change to occur. This is frequently linked to

authoritarian government. Indonesia was viewed as an authoritarian state like Singapore, South Korea, and Taiwan when it built its productivist welfare regime under Soeharto's presidency (Holliday, 2000).

A precarious welfare regime refers to a set of welfare arrangements in which citizens face risks, vulnerabilities, and uncertainties due to political instability, war, conflict, economic hardship, limited community-based welfare, and the absence of international support. The most prominent welfare Productivist model is the subordination of social policy to economic policy. Consequently, social rights are minimal, and welfare provision supports productivity.

The Indonesian welfare regime altered to resemble the liberal-informal welfare regime after the productivist welfare regime collapsed owing to the Asian economic crisis. The government became liberal because of pressures from global market institutions (Wood and Gough, 2004) to smooth the transition from a centralised to a liberal political-economic system. Following the liberal philosophy of the World Bank, the Indonesian Social Safety Net programme recommended by the Bank was targeted only at the low-income group. The regime was also informal because *gotong-royong* provided a source of income for community members.

The commencement of enormous social protection programmes for the low-income group under the Social National Programme and poverty reduction programmes, as well as the continued responsibility of communities in dispensing informal social protection, demonstrate the regime change to an informal-liberal welfare regime. Because the impoverished was included in the Social National Programme programmes, there appeared to be an inclusion. However, the model is not fully inclusive because the goal of inclusion is to meet the needs of those who are excluded, whereas the goal of the Social National Programme programmes was to encourage political-economic transformation that would lead to a market economy. As a result, the programmes portrayed a liberal institution.

The informal-liberal welfare system has been transitioning into an informal-inclusive one (or into an informal-quasi-inclusive one) since 2014. The significance of informal welfare services has grown, yet social policy has remained mostly ineffective. The

goal aspires to include "all" population through the UHC programme, indicating that the government is transitioning to one that is inclusive. According to Kwon (2005), a regime is inclusive if it performs a universal social investment in which the government incorporates all citizens in the UHC (JKN) programme.

The fundamental motivator of the last regime shift was the ‘universalization' of social policy. This time, both local and global institutions are involved. Locally, trade unions and civil society organisations pushed the GoI to implement the National Social Security System statute, which resulted in the UHC (JKN) programme. The WHO, the World Bank, and other international agencies are supporting the UHC on a worldwide scale, advocating for all countries to participate in the "universalisation" of health insurance approach to horizon analysis (Mahoney and Thelen, 2010). Indeed, because most emerging countries have their own versions of the local *gotong-royong,* this method is critical. There is a significant requirement to use such technique when analysing a welfare regime with a "thick" *gotong-royong,* such as Indonesia.

As stated by Sumarto and the previous literatures, community-based welfare arrangements are one example of informal welfare provision. The welfare arrangements play a key role in assisting the low-income group to cope with social risks. This welfare provision is mostly conducted through gotong-royong. The Javanese phrase gotong-royong means "many people carrying things together" or in another words (Bowen 1986: 546). In other words, gotong royong is a philosophy whereby a community supports one another.

Gotong royong is a mutual help involving moral obligation, generalised reciprocity (Bowen 1986), and group action (Seavoy 1977). During these periods, *gotong royong* manifests itself in the form of collective activity to build temples and donations to sustain collective activity (Kartodirdjo 1987). *Gotong royong* is a 'thick' welfare institution in that it offers a variety of informal social protections to community members, including:

a. *Gotong-royong* as multi-purpose insurance

   Gotong-royong is a type of insurance that can be used for a variety of purposes. *Arisan* is a type of multi-purpose insurance. *Arisan* is a credit lottery in which *arisan* members contribute and each member receives the gathered contribution in turn. *Arisan* funds can be used as a source of funding to respond to unexpected situations such as illness (Geertz 1962) and social risks, making them a type of social insurance.

b. *Gotong-royong* as sickness insurance

   Community members provide sickness insurance in the form of cash money to sick members to access healthcare services. Members reciprocate by providing the same insurance to individuals who have insured them.

c. *Gotong-royong* as healthcare

   Gotong-royong also offers healthcare through Pos Pelayanan Terpadu, an integrated health service (Posyandu). Posyandu strives to promote the health of children and breastfeeding mothers by reducing infant mortality. Posyandu also tries to help the elderly retain their health. This healthcare is coordinated by the Posyandu cadres, a volunteer group, and is funded by community-based financial resources.

d. *Gotong-royong* as death insurance

   Gotong-royong can also serve as a form of social insurance for death, known as *layatan*. *Layatan* is a Javanese term that refers to a community member's reciprocal donation to assist those whose family member has died. Moral support, financial assistance, and unpaid work for funerals are all examples of contributions.

e. *Gotong-royong* as income maintenance

   This role is demonstrated in *sambatan,* a labour exchange in which people help each other with agricultural tasks including hoeing, planting, and harvesting (Koentjaraningrat 1974). This transaction enables peasants to produce rice as their major source of revenue at a cheap cost of production, which is viewed as a means of maintaining revenue. Farmers need this cash to stay afloat because they cannot afford the hefty production costs.

f. *Gotong-royong* for housing

   Gotong-royong also helps neighbourhood members who are building or renovating their homes (Kartodirdjo 1987; Koentjaraningrat 1974). In *gotong-*

royong, male members of the community assist in house construction, while female members assist a house owner in preparing lunch for construction workers.

g. *Gotong-royong* as food security

In terms of food security, *gotong-royong* takes the shape of the village barn (l*umbung desa*), which is used to deal with food scarcity. People borrow rice from *lumbun*g desa for seeds or to eat during a rice shortage, and then return it with interest at harvest time. However, due to rural development, the relevance of *lumbung desa* has diminished significantly.

h. *Gotong-royong* as neighbourhood security

To keep communities safe, *gotong-royong* might also take the shape of a neighbourhood security watch (*ronda*). *Ronda* is run by a group of about five family leaders who patrol the neighbourhood at night to protect it from danger. As a location of duty and *ronda* coordination, some communities use *pos ronda*, a security station erected with local funding. Furthermore, the welfare regimes in Indonesia changes as illustrate bellow:

Table-4 Displacement and layering in the Indonesian welfare regime change.

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Sumarto, 2017

As seen in Table 4, both the productivist to informal-liberal and informal-liberal to informal-inclusive regime shifts resulted in layering, with the government launching social protection programmes on top of the informal welfare provided by cooperation. All selected social protection programmes, which had been overlaying the informal welfare structure, have been layered. The Indonesian example demonstrates that institutional layering occurs throughout time without resulting in significant changes to both existing and new institutions. When the subsidised rise for the poor programme was launched in 1998 the programme coexisted alongside gotong-royong. When the informal-liberal regime ended in 2014, the programme, along with cooperation, did not undergo any significant changes, owing to the Government's refusal to reform, revise or add to cooperation (Mahoney and Thelen 2010; Streeck and Thelen 2005).

People believe that cooperation is an essential source of livelihood for community members, thus it is doubtful that the government or interest groups would wish to change it. The only advancement that can be envisaged in this situation is the slow expansion of the new institution without causing any change to the old one. This, however, may not be effective. The health insurance programme, for example, is the only one of the five SSN programmes that has grown significantly. This is because the government created these programmes on an as-needed basis. Ad hoc arrangements discourage policymakers from developing long-term plans that could lead to innovative changes. Ad hoc arrangements, on the other hand, are an insecure intuitional structure that may encourage the government to continue or stop the programme more quickly. The government is less likely to eliminate the programmes without replacing them. Politicians have tended to extend rather than restrict social programmes throughout the last decade to increase their political appeal and win votes in elections (Sumarto, 2014).

The continuing of the informal-formal layering is counterproductive. Interactions between informal and formal welfare systems arose because of institutional stacking, and these institutions may injure each other. On the other hand, community members' collective behaviour, as the basic logic of cooperation, undermines the government's selective approach to social assistance. Consequently, community members believe that regardless of their socioeconomic condition, they have the

same right to obtain government social protection. If one member of the community receives social protection, others in the community may demand it as well. This collective behaviour forces the Government of India to distribute selective social safeguards to all individuals; otherwise, non-recipients will suffer. On the other hand, the layering may erode cooperation because jealousy and protest deteriorate collective action and reciprocity as the features of cooperation (Sumarto, 2017).

Referring to the discussion above, the Indonesian welfare regime appears to be changing like a chameleon. Powell and Kim (2014) coined the term “chameleon” to represent the Korean welfare regime’s continual transformation. They examine twenty-six articles and discover that the Korean welfare regime may be divided into six categories: liberal, conservative, hybrid, East Asian welfare model as a fourth regime, East Asian welfare model as a distinct regime, and underdeveloped. In Indonesia, the term “chameleon” is used to describe a regime that thrives and changes rapidly within a brief period. Indonesia has had four different sorts of regimes since 1945: precarious, productivity, informal-liberal, and informal-quasi-inclusive. Political-economic, volatility, fluctuating growth, global pressures, and social policy “universalization” are all linked to the welfare regime’s thriving development and rapid adjustments.

Other perspectives by Alfitri (2012) emphasise that based on Pancasila as a state, Indonesia is considered a country between socialism and liberalism. Regarding the welfare state’s ideology, the Indonesian state does not have a clear position whether it will be institutionalist or residual in the welfare state until the government ratifies its Law Number 40 of 2004 concerning the National Social Security System. After the law declared the goal, the government introduced UHC as social insurance based on the social security programmed applied to all Indonesian citizens. For the low-income group, subsidies are made available to pay premiums for health insurance and social welfare insurance. This system makes the Indonesian state leaning towards a Conservative-institutionalist welfare state.

By adopting a social insurance system, Indonesia tends to the institutionalist welfare state model of the Conservative regime because the social security programme is not fully submitted to the (private) market mechanism. Based on the decision of the

Constitutional Court in the 2005 case, the government remains responsible for social security for all citizens by organising programmes; social security is managed by a legal entity formed by the government based on the law. In addition, the principle of subsidies that characterises the Conservative regime is also applied where the government is responsible for citizens who are poor or unable to pay contributions. Compulsory social welfare insurance (vide Article 10 (1-2) of Law No. 11/2009 on Social Welfare) and health insurance (vide Article 17(4), 20(1), and 21(1) (3) Law No. 40/2004 on the National Social Security System). The court turned out to justify the government's version of the interpretation of the welfare state ideology which tends to conservative institutionalist policies.

In my view, all these changes are related to socio-political conditions and economic growth, as explained by Sumarto in table 3 that applies to precarious, productive, informal-liberal, and informal-quasi-inclusive regimes. At the stage of the change in the welfare regime, the concept of *gotong royong* applied by the Indonesian people became one of the foundations of the welfare state in each period. Why is *gotong royong* or cooperation one of the reflections of the welfare state in Indonesia? This principle is closely related to the culture of the Indonesian people who have high empathy to help each other and ease the burden of people who are stricken by disasters or various life difficulties. The culture of cooperation applied in multiple sectors, including the economy and health, and can overcome the gap in the socio-economic strata in Indonesia. As in the social health insurance system, the difference in premiums for those who can afford to pay more than the lower-income group manifests through cross-subsidy efforts. However, it is hoped that this system will not trigger discrimination in health services. Those who pay more contributions, for example, will get the best health services. This mindset must be changed in society, especially among health care providers, to avoid discrimination in health services.

For example, in Indonesia, health services in hospitals are divided into classes according to the contributions paid by social health insurance participants. For those who can afford choose class one, the middle economy group chooses class two, and those with low-income choose class three. This phenomenon triggers health services to become discriminatory, prioritising the class with the highest premium contribution

whereas in the Social Security System, there should be no disparity in health services. Hospitals should be of the same class, not divided into first, second or third grades. In 2021, the discourse for BPJS Kesehatan membership will change from a three-class system into a standard one. This change means that there will be no more division of membership based on classes; 1, 2, and 3.

According to the Secretary-General of the Ministry of Health, Oscar Primadi, the application of the standard class for participants will take effect gradually starting in the early 2021 until the end of 2022. Oscar also emphasises with this change that there will be no difference in services based on the category of inpatient rooms to the fees paid. However, the Ministry of Health are formulating the detailed rules. The formulation includes concepts and standard class criteria that will apply in UHC.

Indonesia is a dynamic legal state (welfare state) with legal principles, including the regulation of implementing to the public interest. Based on this principle, government officials are required to carry out activities that lead to the implementation of the public interest which can provide legal protection for the community, as stated in the section of the BPJS Law, “that the national social security system is a state programmethat aims to provide certainty of social protection and welfare for all people” (Yustina, 2019). This means that it is mandatory for the government to provide comprehensive health insurance protection for all Indonesian society without exception.

The implementation of UHC in Indonesia is also in line with changes in the welfare regime in Indonesia. In the era before UHC or JKN, the model and management of social health insurance varied; some were managed directly by the government, such as social health insurance for the low-income group. The government managed some through the Ministry of Health, through the regions and BPJS Kesehatan. However, after 2014, social health insurance is more centralized in its management. Everything is centred on one agency or body, namely BPJS, which is directly under the Indonesian government even though in conducting its obligations, BPJS was then divided into BPJS Kesehatan and BPJS Ketenagakerjaan (refer to Chapter One, page 36-37).

The UHC system currently implemented by the Indonesian government regulates BPJS Kesehatan to pay every sick person, which is as much as in the countryside. Because later BPJS will pay the economic price, so the people in the village will also be served to the maximum and paid by BPJS Kesehatan. Therefore, there will be a natural redistribution of energy and health facilities. The key is BPJS Kesehatan should pay for health facilities at economic prices where the private sector will be challenged to serve and cover the costs of production. So, to realise the welfare state, the government must take a role by making health and employment insurance as public goods that must be fulfilled by the state in its function as a good social security, and the private sector will be reluctant to enter the region if the incentives are insufficient. To fill this void, it is expected that the state must be more responsive in taking over the responsibility of servicing and providing solutions from the implementation of the programme.

In relation to the implementation of BPJS Ketenagakerjaan, membership must be able to cover all citizens with ease of registration. In mid-2012, 151.5 million (63%) Indonesian residents already have health insurance in various forms and extent of guarantees. Based on the data obtained, the population in 2012 reached 239.7 million people, so the efforts to expand membership will also be accompanied by the equalisation of health care packages that are still very varied. For the health sector, this is quite supported by previous initiatives such as Social Insurance for Low-income Group and District Health Insurance. However, in BPJS Ketenagakerjaan, Indonesia will still face obstacles to expand participation for workers in the informal sector such as farmers, fishermen, motorcycle taxi drivers, labourers, and other low-income communities (Fajarni, 2015).

No less important to be considered for the realisation of welfare state through this BPJS programme is the increase of the State Budget in the coming years that is expected to continue to contribute significantly to social security funding (BPJS Kesehatan and BPJS Ketenagakerjaan) in Indonesia to create a healthy society protected from socio-economic risks who can prosper.

The parties who are the key actors in the implementation of UHC other than BPJS are the National Social Security Council; this institution has the authority as the

supervisory board of the implementation of UHC in Indonesia, Ministry of Social Affairs, one of which responsibilities is to verify data on people entitled to be subsidised by the government. The Ministry of Health is responsible for providing health care facilities and quality health services from primary to referral levels. The cooperation of all the main actors is essential to ensure the sustainability of UHC in the future.

CHAPTER THREE
UNIVERSAL HEALTH COVERAGE IN INDONESIA, PHILOSOPICAL CONTEXT, HISTORY AND PROGRESS

3.1. Overview

This Chapter briefly describes the demographics of Indonesia as well as health status, health system, health financing, the establishment of Universal Health Coverage (UHC) in Indonesia, the philosophical context, history, and progress. There is a philosophical context to the implementation of social health insurance in Indonesia. This philosophy is one of cooperation and underlies the establishment of social health insurance in Indonesia, for example, the principle of gotong royong is taken from the 'local wisdom' of the Indonesian people. This principle is used as one of the foundations for implementing social health insurance because it is considered compatible with Indonesia society's culture and human values.

3.2. Population Dynamics and Demographic Changes in Indonesia

The Republic of Indonesia is one of the world's largest archipelagos, consisting of more than 17,000 islands. It is also the fourth most populous country after China, India, and the United States (based on 2018 data). Indonesia had a total population of 259.5 million in 2019; 66.5% were aged between 15 – 64 years, 25% between 0-14 and just over 6.1% were over 65 (World Population Review, 2019).

Indonesia is a lower-middle-income country with a gross domestic product (GDP) of about US$ 3927 per capita per year (Ministry of Health Republic Indonesia, 2019). Based on the World Population (2019) data, Indonesia has more than three hundred distinct ethnic groups. Javanese is the dominant ethnic group in Indonesia (40%), Sundanese (16%), another major ethnic group, and Indonesians of Chinese origin of about 1%.

In addition, Indonesia has seven hundred vernaculars. Even so, Bahasa Indonesia is the national language used primarily in education, media, commerce, and administration. Indonesian language is also a unifying and formal language used by the Indonesian Government to communicate in official forums and interact with the entire population of Indonesia. The demographic trend of the total

population/demographic indicators in Indonesia from 2017 to 2019 is demonstrated as follows:

Table-5 the trend of the total population/demographic indicators in Indonesia from 2017 to 2019

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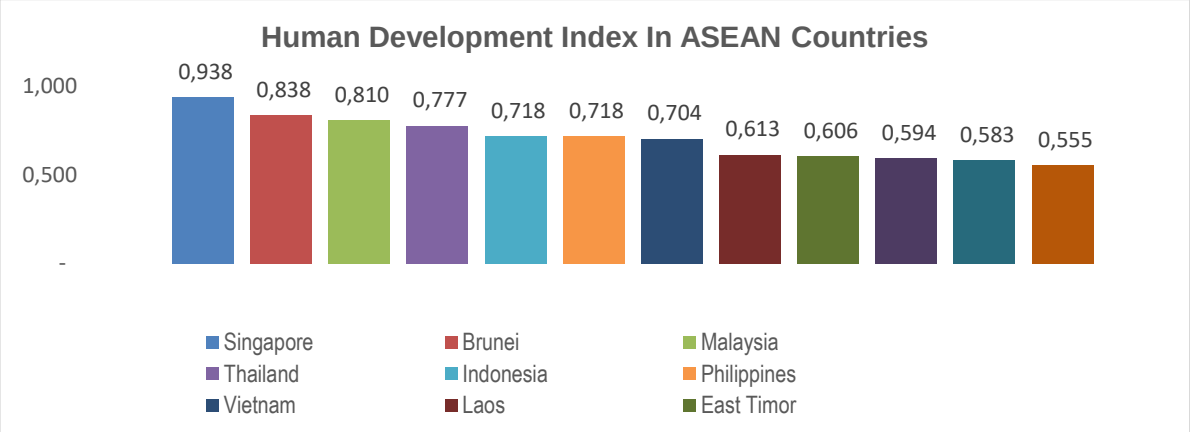
Source: Mahendradhata et al. (2017)

The total population increased gradually from 2017 to 2019 where the population aged between 15 and 64 saw the biggest growth rate. The population density of Indonesia increased from 146 in 2017 to 149 people per sq. km in 2019. The fertility rates in total slightly decreased to 2.29% in 2019. The birth crude rate (per 1,000 people) was constant, i.e., 18.3% from 2018 – 2019. The death rate was stable, i.e., 7.20 in 2018 – 2019. The dependency ratio is an age-population ratio of those typically not in the labour force (aged 0 -14 and 65+), whilst those typically in the labour force (the productive age from 15 to 64) also rose gradually from 2018 to 2019. In contrast, the population living in urban areas increased from 2017 to 2019.

In this thesis, demographic factors such as population size, gender, age, education, and occupation, urban and rural area are part of the measured variables. The

measurement of these variables aims to determine the number of populations covered by UHC from 2012 – 2018, in addition to knowing whether these variables affect UHC participation in Indonesia.

Based on the 2019 Human Development Index (HDI), Indonesia, compared to other ASEAN countries, is ranked fifth. Indonesia and the Philippines both joined the ranks of countries with a high development index in terms of education, health status, and living standards after Singapore, Brunei, Malaysia, and Thailand with the value of 0.718. Further details on Indonesia HDI compared with ASEAN countries are shown below:



UNDP (2019)

Figure-1 Human Development Index (HDI) ASEAN Countries 2019

The HDI is a summary measure to evaluate long-term progress in three basic dimensions of human development: a long and healthy life, access to knowledge, and decent standards of living (UNDP, 2019). HDI covers three dimensions used as a base:

1. Knowledge is measured by length in formal education.
2. Longevity is measured by the life expectancy rate at birth.
3. Quality of life is measured by gross national income per capita.

Health Development Index (HDI) is closely related to the UHC in Indonesia, on life expectancy and quality of life as the latter is included in the UHC objectives to be achieved by the Indonesian government.

3.3. Indonesia's Health Status

Health status is measured by life expectancy at birth. The OECD (2019) and Mandal (2014) defined life expectancy as how long, on average, a new-born is expected to live if the current death rates do not change. Life expectancy at birth is one of the most frequently used health status indicators, primarily due to its relationship with various signifiers of health development, such as increasing standard of living, improved education, greater access to health care, and reductions in infant mortality. Deonandan (2015) emphasises, that life expectancy is one indicator to measure a population's health. However, scientists are aware of these measures' limitations even frequently as a proxy for overall health. The life expectancy for measuring populations has been calculated reasonably and rigorously for decades, thus providing a ready method for comparing health trends over time. Goldsmith (1972) states that mortality and morbidity as both measurements of health status. Regarding the critical indicators of population health, Indonesia data such as life expectancy and mortality in recent years are shown below in Figure 2.

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Source: Statista, 2019

Figure-2 the Life Expectancy in Indonesia, 2009-2019

The statistic shows the average life expectancy at birth in Indonesia from 2009 to 2019 by gender. In 2019, life expectancy at birth was about 73.97, and men were approximately 69.57 years on average. The life expectancy for women is longer than men in Indonesia. Lifestyles such as smoking habits for men are one of the reasons why women live longer. As Retrine et al. (2010) state, that smoking is among the leading causes of preventable mortality worldwide. The proportion of smoking among

men has declined in most countries. Still, it has increased in the most populous countries, such as China, from 4.6% to 7.3%, increasing the impact of tobacco on life expectancy. The World Population Review (2021) reported that in many South and Southeast countries, men`s smoking rates are high, while women`s rates are low. The male smoking rate in Indonesia, for example, is 76.20%, whereas the female smoking rate is 3.60%.

Besides life expectancy, the mortality rate is also used as one measurement in health status indicator in Indonesia. The mortality rate is the number of people who die, divided by the total number of people at risk of dying. Two crucial demographic-specific indicators are the infant, and child mortality rate (Deonandan, 2015). In Indonesia, the mortality rate can be viewed as follows:

Table-6 Infant and Adult Mortality Rate in Indonesia 2014-2019

Mortality Rate Indicator	Year					
	2014	2015	2016	2017	2018	2019
Mortality rate, infant, male (per 1,000 live births)	26,80	25,80	24,90	24,10	23,20	22,50
Mortality rate, infant, female (per 1,000 live births)	21,40	20,60	19,90	19,20	18,50	17,90
Mortality rate, adult, male (per 1,000 male adults)	206,94	205,46	203,99	202,51	177,54	175,78
Mortality rate, adult, female (per 1,000 female adults)	147,89	145,66	143,44	141,21	125,67	123,88

Data analysed from The World Bank, 2020.

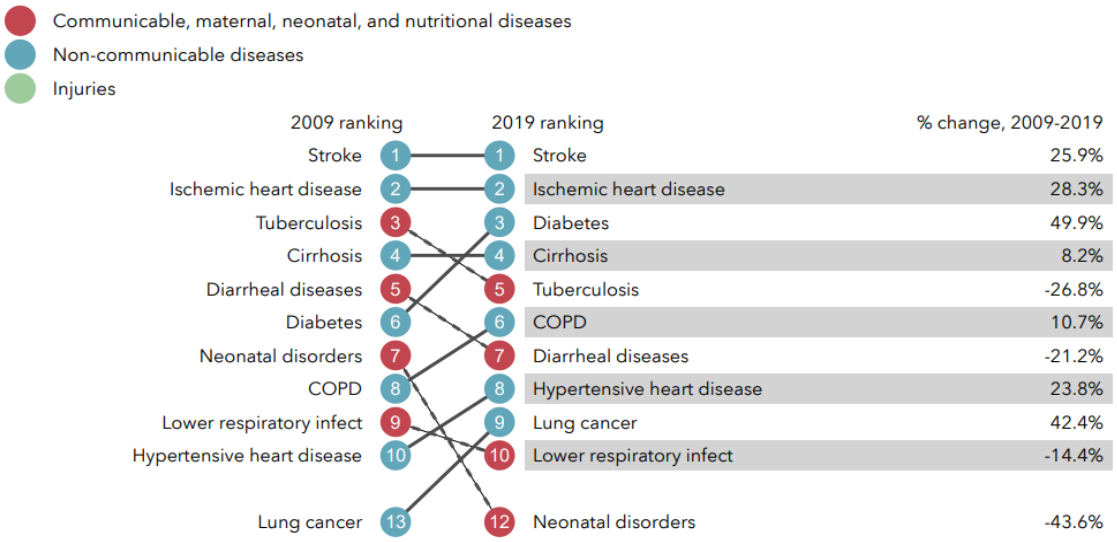
The statistic shows the infant mortality rate in Indonesia from 2009 to 2019. In 2019, the infant mortality rate in Indonesia was at about 20.2 deaths per 1,000 live births. Likewise, the male adult mortality rate declined from 2014 to 2019, but the number was higher than the female mortality rate in the same year. Other factors need to be considered in measuring the mortality rates indicator; maternal mortality ratio, which is the number of women who died during pregnancy and childbirth per 100,000 live births. In 2019, the new-born mortality rate in Indonesia was 12.4 deaths per thousand live births. Between 1970 and 2019, the neonatal mortality rate in Indonesia declined at a moderate rate until it shrank from 48.1 deaths per thousand live births in 1970 to 12.4 deaths per thousand live births in 2019 (Konema, 2019).

Although Indonesia was able to reduce its Maternal Mortality Rate (MMR) by almost one third between 1990 and 2015, well below the target set by the Millennium Development Goal 5 (ASEAN, 2017), MMR is still high despite remarkable

improvements in critical health and economic indicators. Sustainable Developmental Goals (SDGs) point three targets a reduction of the global MMR to less than 70 per 100 000 live births. The WHO's Ending Preventable Maternal Mortality target is for no country to have an MMR greater than 140 (WHO, 2018). Sustainability Development Goals, point three also targets a reduction in neonatal mortality to at least as low as twelve per one thousand live births (United Nations, 2018).

The accelerated pace of maternal and neonatal deaths declines to be needed if these SDGs 3 targets are achieved. Improving timeliness and quality of routine and emergency obstetric and neonatal care and ensuring access to these services for all women and new-borns, will be essential (Stanton et al., 2018).

The mortality rate in Indonesia is also influenced by communicable and non-communicable diseases as can be seen from the following Global Burden Diseases (GDB) data, the top causes of death in 2009-2019 in Indonesia for all age categories are as follows:



Source: Institute for Health Metrics and Evaluation (2020)
Figure-3 The 10 top causes of death and disability (Daly`s) in 2009 - 2019

Global Burden Diseases (GBD) provides a tool to quantify health loss from various kinds of diseases, injuries, and risk factors. Consequently, the health system might be improved, and disparities reduced (Institute for Health Metrics and Evaluation/IHME, 2019). Figure 3 shows the ten top causes of death and disability

(Daly`s) in 2019 and the percentage change during 2009 – 2019 for all ages combined.

The leading combined of disability causes during those years are the non-communicable diseases of stroke (increases more than 50% during 2009 to 2019), Diabetes (49.9 %.) and Lung Cancer (42.4%). Tuberculosis and diarrhoea are the leading causes of communicable diseases in 2009 – 2019. Neonatal disorders increased significantly in 2019. Road injuries also contributed to the death and disability during 2009 to 2019. Regarding the Indonesia`s health status, the government's efforts to improve the quality of its health services and widen the coverage of health insurance for the Indonesian community will be discussed in the next sections.

3.4. Indonesia`s Health System

The Indonesian Health System is a mix of public and private health providers. Following the decentralisation of the national health system, the health-care service and management system is organised into three administrative levels: central, provincial, and district (Ministry of Health Republic Indonesia, 2019). Since 1999, health services have been decentralised to provincial and district governments under the Ministry of Home Affairs (Mahendra et al. 2017).

As stated by Heywood and Choi (2010) the decentralisation had an impact on the low performance of public health funding and the lack of discretion for the district health system. In 2001 Indonesia experienced radical decentralisation which significantly increased the transfer of funds from the central government to districts to improve the performance of the health system. Therefore, the impact of decentralisation, especially in the health sector, has provided opportunities for districts to improve health services in their respective regions. After decentralisation, Social Health Insurance (Jamkesda) was established in several districts to improve access for the low-income group who are not covered by the central health insurance.

During the district health insurance there are 460 districts in Indonesia which have implemented this health insurance scheme with a total of 13.85 million members

participating. However, in 2014 the Indonesian government launched UHC/JKN which is managed by the central government through BPJS so that all health insurance before UHC is gradually integrated into UHC. The transition period lasts from 1st January 2014 to 2016.

According to Mahendra et al. (2017), after decentralisation, health services at the local government level have been divided between provincial and district/municipality levels. Provincial governments are responsible for provincial hospitals and managing health services through the provincial health offices (PHOs). The PHOs are tasked with coordinating health regulations within the province/region and across the districts. The district government has its own district hospitals and coordinates health services through the primary health centres/Puskesmas and its network, but the relationship between MoH, PHO and DHO is not a hierarchical one. The district/municipality government is not under the provincial level. Every level has its own responsibilities and areas of authority. The hospitals are not subordinate to the health offices, and the DHO does not report to the PHO. Consequently, the PHO is not solely responsible to the MoH. Nonetheless, the provincial government is accountable for health programmes both at the provincial and district levels, like the immunisation programmes.

The Ministry of Health is responsible for the operational aspect of referral and specialist hospitals. Nonetheless, many of its functions have been replaced with regulations to ensure the availability of resources, including increasing a more fundamental role in the oversight of social health insurance schemes. Besides the MoH, other actors engage in the health sector, such as the Ministry of Home Affairs, the Social Security Managing Agency, and the National Family Planning Coordinating Board/Badan *Koordinasi Keluarga Berencana Nasional* (BKKBN). The structural organisation in figure 4 illustrates that there are three health departmental bodies with responsibilities at the central level as follows:

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Source: Mahendra et al. (2017)
Figure-4 Organisation of health system in Indonesia, 2014

The district government has its own district hospitals and coordinates health services through the primary health centres/Puskesmas and its network, but as already stated the relationship between MoH, PHO and DHO is not a hierarchical one. The district/municipality government is not under the provincial level. Every level has its own responsibilities and areas of authority. The hospitals are not subordinate to the health offices, and the DHO does not report to the PHO. Consequently, the PHO is not solely responsible to the MoH.

The structural organisation in Figure 4 illustrates that there are five health and other departmental bodies with responsibilities at the central level as follows:

a. Ministry of Health (MoH)

   The Indonesian Ministry of Health is responsible for assisting the President in carrying certain government affairs in the health sector. Based on the Ministry of Health`s Decree (Permenkes) Number 64, 2016, Article 3 on performing its duties, the MoH conducts the following functions:

   1. Formulation, stipulation, and implementation of policies in the field of public health, disease prevention and control, health services, and pharmaceuticals and medical devices.
   2. Coordinating the implementation of tasks, coaching, and providing administrative support to all elements of the organization within the Ministry of Health.
   3. Management of state property which is the responsibility of the Ministry of Health.
   4. Implementation of research and development in the health sector.
   5. Implementation of the development and empowerment of human resources in the health sector, as well as the management of health workers.
   6. Implementation of technical guidance and supervision for the implementation of the affairs of the Ministry of Health in the regions.
   7. Supervision of the implementation of tasks within the Ministry of Health.
   8. Implementation of substantive support to all organizational elements within the Ministry of Health.

b. Ministry of Social Welfare

The Presidential Decree Number 46, 2015 concerning the Ministry of Social Affairs stated that the Ministry of Social Affairs has the responsibility for conducting affairs in the field of social rehabilitation, social security, social empowerment, social protection, and ensuring adequate care to assist the President in organising the government of the State.

In conducting the tasks as referred to above, the Ministry of Social Affairs performs the following functions:

1. Formulation, determination, and implementation of policies in its scope; social rehabilitation, social security, social empowerment, social protection, and the support of low-income group.
2. Determination of criteria and data of low-income group.
3. Determination of social rehabilitation standards.
4. Coordination of the implementation of tasks, coaching, and providing administrative support to all elements of the organisation in the Ministry of Social Affairs.
5. Management of state property/wealth that is the responsibility of the Ministry of Social Affairs.
6. Supervision over the implementation of tasks within the Ministry of Social Affairs.
7. Implementation of technical guidance and supervision on the implementation of the affairs of the Ministry of Social Affairs in the region.
8. Implementation of education and training, research, and development of social welfare, as well as social counselling.
9. Implementation of substantive support to all elements of the organization within the Ministry of Social Affairs.

c. The National Population and Family Planning Board is a government agency responsible for three programmes: family development, demography, and family planning. It aims to benefit Indonesian families by achieving harmony, congruency, and balance in terms of quantity, quality, population distribution, and living environment, as well as improving family quality to foster a sense of peace and hope for a better future in terms of attaining physical well-being

and inner happiness (BKKBN, 2021). Family Programme set by the government suggests two children per family. The number of children is recommended so that the community could be optimal in improving the quality of the family in terms of education, economy, health, and harmonious family relationships.

d. The Social Security and managing Agency (*Badan Pelaksana Jaminan Social*/BPJS), is the Social Security Agency for National Health Insurance Programme under the Indonesian government. The responsibilities include managing memberships, collecting premiums, administrating contracts with the providers and paying the providers. BPJS KIS is a programme while BPJS Kesehatan is the agency assigned to run the programme. BPJS is supervised by Dewan *Jaminan Sosial Nasional* (DJSN), the National Security Board. DJSN members consist of government officials and community members, as well as representatives of employees and employers' associations.
e. The Food and Drug Supervisory Agency, hereinafter abbreviated as *Badan Pengawas Obat dan Makanan*/BPOM is a non-ministerial government agency that conducts government affairs in the field of drug and food supervision. BPOM is under and responsible to the President through the minister who conducts government affairs in the health sector. The main responsibility of this department based on Article 2 of Presidential Regulation Number 80 of 2017 concerning the Food and Drug Supervisory Agency is as follows:
    - BPOM has the task of performing government duties in the field of drug and food supervision in accordance with the provisions of the legislation.
    - Drugs and Food as referred to in paragraph (1) consist of drugs, medicinal ingredients, narcotics, psychotropics, precursors, addictive substances, traditional medicines, health supplements, cosmetics, and processed food.

Referring to Article 3 of BPOM Regulation Number 12 of 2018, the BPOM Technical Implementation Unit has the task of conducting operational technical policies in the field of Drug and Food supervision in accordance with the provisions of the legislation.

3.5. Health Financing System in Indonesia and Other Countries

A health financing system is a fundamental component that impacts the entire health system`s performance, such as the delivery and accessibility of primary health care (Joint Learning Network, 2017). The objective of health financing is to provide funds and establish appropriate financial incentives for providers to ensure that all individuals have access to effective public health and personal health care (WHO, 2000). This reference is in lines with (Joseph and Rhatigan, 2020) who explain that health financing is essential to implement the health system. Most healthcare systems' main expenses include human resources, health care services at hospitals, and drugs.

Health care financing in most tropical nations is provided by a mix of government spending, private (mostly out of pocket) spending, and external funds (donors). Puteh and Almualm (2017) mention, the main financing methods includes government through taxes, social insurance through payroll, taxes or direct contributions, private insurance and out of pocket.

In Indonesia, health financing cannot be separated from the health service process. Health costs are the amount of funds that must be provided to manage various health efforts needed by individuals, families, groups, and communities. Based on that definition, health costs can be classified into two as follows:

- Health service provider refers to the amount of funds that must be provided to conduct health efforts, meaning health costs from the provider’s perspective. The latter represents the main issue for the government and/or the private sector and other related parties. The amount of funds for health care providers primarily refers to all investment and operational costs.
- Health consumers refer to the number of funds that must be allocated to use health services. Health cost is the main issue for health consumers. The government also takes part in ensuring the availability of health services for those in needs.

Health financing in Indonesia has three basic functions: revenue collection, risk pooling, and services purchasing (Claudia *et al*., 2009). Health revenues are collected to provide enough sustainable funds in an efficient and accountable system

that provides individuals with a basic package of essential services to increase health outcomes, financial protection, and community satisfaction. Revenue collections are an effort to collect sufficient and sustainable health funds to finance "basic health services" and protect the risk of illness, especially catastrophic diseases that require expensive financing because of long-term therapy and care, also used to finance accidents. Revenue collection can be sourced from the government such as direct/indirect taxes, non-tax income, compulsory insurance contributions and salary deductions, premium payments to the government, grants/donors. Revenue collection sourced from the community through the pockets of individual patients and humanitarian foundations.

The principle of risk pooling refers to the health financing system in Indonesia to manage “health funds” in an efficient and equitable health risk pool. The collected funds will be paid to the health providers, while the pooling is through central or local Government budget, social insurance, and private health insurance. As explained by Setyawan (2017), types of health services (though the risk is low and uneven) can be expensive for example, haemodialysis, specialist surgery (coronary heart) and cannot be covered by individual savings (risk spreading). In simple term, a financing system will calculate the costliest health issues in a community then split it among its members.

As a result, the expense of costly health treatments is shared by the community, rather than being observed by individual savings. In this sense, social health insurance is an example since it uses risk pooling to recognise that people who are at risk agree to pool their resources to decrease the burden that each person must bear. Pooling risks is the essence of insurance and occurs when individuals at risk agree to pool risks to reduce the burden borne by everyone. Risk pooling increases the probability of obtaining a "moderate" outcome and avoiding extreme effects while reducing the cost of risk, namely financial losses associated with the risk of the event (Murti B, 2000). This happens because most illness events are independent events, so the law of multiplication of probability (Multiplication Law of Probability) applies. The law does not apply if an illness is a dependent event, such as an infectious disease.

Relating to health financing is service purchasing. This function is payment mechanism to health facilities and health service providers. Purchasing components include resource allocation, benefit packages and payment mechanism for health services providers. Conceptually, a health financing system based on social health insurance is a more appropriate choice to implement in Indonesia. This system is also appropriate with the culture of Indonesian people who implement a cooperation system *(gotong royong)* whereby the rich help the low income, the healthy help the sick people. Yet there are important things that still need to be undertaken by the Indonesian Government, such as the mechanism for determining premiums and health insurance packages that fit the needs of the Indonesian society.

Related with health financing as service purchasing, this function is payment mechanism to health facilities and health service providers. Purchasing components include resource allocation, benefit packages and payment mechanism for health services providers. The health financing system in Indonesia is certainly different from other countries in its implementation. In detail, Mukti (2007) explains that health financing system can be divided into four groups:

- Funding system that relies on tax like in the UK or Malaysia will be difficult to implement because only a small number of Indonesian people are taxpayers, only a limited number has a Tax Registration Identity Number/NPWP.
- The second group, the health financing system which is left to the market mechanism with profit-commercial health insurance as its main pillar as in United States of America. This system is not efficient and not equitable. America as a country that implements this system, allocates the highest health costs per person with the lowest level of public health outcomes among other developed countries. Even though in terms of micromanagement, hospitals in America are quite reputable, yet the overall health outcomes in America are behind those of other advanced countries. If this system were to be implemented, a kind of programme for the low income like Medicaid in United States of America needs to be included.
- The third group, the social health insurance system such as in Germany, the Netherlands, France, Japan, Korea, and Taiwan.
- The fourth group, the socialist health financing system implemented in socialist-communist countries such as Russia and China. This system is not suitable for

Indonesian society. In addition, this system has started to be abandoned in some Eastern Europe countries.

The payers and providers of health services in relation to the government and the private sector can be in the form of government payers and implementers of government health service providers, government payers and private health service providers, private payers and private health service providers and private health service providers. In addition, there is a mixed form between the government and the private sector (public-private mix). Health financing sources can come from various taxes, for instance health insurance, both social and commercial, loans, savings, humanitarian donors, donations /assistance, and others. How to implement health financing through the social security system or UHC in Indonesia will be discussed further.

3.6. Universal Health Coverage in Indonesia and ASEAN Countries

This section will explain the implementation of UHC in ASEAN countries. Seeing the many insurance systems and schemes in various countries can be a lesson for Indonesia in implementing social health insurance which continues to grow. As explained in Chapter Two, every country that applies the concept of a welfare state has a social protection program, with health insurance as one of its components. Every country tries to protect its people with health insurance to access decent and affordable health services.

The ASEAN countries have made satisfactory progress towards UHC, in part because of the sustainable political commitment to support UHC in these countries. However, all ASEAN countries face some common obstacles to achieving UHC; financial constraints, including low overall levels and government spending on health; supply side constraints, among others, the number and density of inadequate health workers; and ongoing epidemiological transitions at various stages characterized by an increasing burden of non- communicable diseases, persistent infectious diseases, and the re-emergence of infectious diseases that have the potential to become pandemics (Minh *et al*, 2014). Referring to the results of the study, it is interesting to find out more about the differences in UHC achievements in

ASEAN countries. To start the discussion in this section, the provisional achievements of UHC in ASEAN countries are as shown in the following table:

Table-7 Comparison of UHC Achievement in ASEAN Countries

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Source: The Lancet (2011)

In the table above, the best estimates of insurance coverage for the country populations are categorised into four relevant groups for 2009, based on survey or administrative data. Because of the different pace of population coverage expansion, the total number of the insured population varies with low coverage in Laos and Cambodia, medium coverage in Indonesia and Vietnam, and high coverage in Thailand and the Philippines. Malaysia is reported to have 100% coverage because of its tax-funded system (although high out-of-pocket payments suggest effective coverage is less than this level). The high percentage of the uninsured population

such as in Laos and Cambodia, combined with the elevated level of out of-pocket payments, put the uninsured people at risk of financial impoverishment or forfeiting necessary health care, resulting in disability or deaths at home. Social health insurance coverage is low because of the small size of the formal sector (Tangcharoensathien *et al*., 2011).

Based on a study on the implementation of UHC in 2016 in Indonesia and the WHO report in (2017), the achievement of UHC in Indonesia is still in the stage of developing systems and policies that support financial protection and health service coverage. Various challenges and obstacles cause UHC implementation has not been achieved. Regarding the aim of this research to focuses on evaluating the implementation of UHC in Indonesia, it is necessary to know how UHC is in Indonesia from the philosophical context, historical, and progress. All these points are discussed in the following section.

3.7. Philosophical Context of Universal Health Coverage in Indonesia

The Collins dictionary defines philosophy as the pursuit of wisdom, the study of realities and the general principles, the system of theories on the nature of things or of conduct, also the calmness of mind. In principle, there is no clear distinction as to what philosophy means, philosophical research can apply to all and in all forms, from religion, morality up to scientific philosophy. Nonetheless, its emphasis indeed varies depending upon the field of discipline. Philosophical research should be based on logic. A thought that connects, analyses an issue or a study applying a certain scheme, which in this case is called logic (Aslasken, 2013). Based on the above definition, if philosophy is integrated into the Indonesian Social Health Insurance, this refers to the values, beliefs, principles which underpin the establishment of the Indonesian Social Health Insurance.

The philosophical foundation of social health insurance in Indonesia refers to the fourth Amendment to the 1945 Constitution in 2002 in article 34 (2), which reads (paragraph 2) "The state develops a social security system for all people… and" (paragraph 3) "The state is responsible for the provision of health services and decent public services" (Putri, 2014a). In connection with the elaboration of this law, the Indonesian government established The National Social Security System

(SJSN). The philosophies that underline the implementation of the national social security system are as follows:

a. The SJSN administration is based on human rights and the constitutional rights of everyone.
b. The SJSN implementation is a form of the state's responsibility in developing the national economy and social welfare.
c. The social security programme is intended to enable everyone to develop themselves completely as a useful human being.
d. The SJSN implementation is based on humanitarian principles and is related to the respect for human dignity.
e. SJSN aims to meet the basic needs of a decent life for each participant, and the members. In addition, the SJSN implementation is based on the following principles:
    - Cooperation: Participant, who are able, help participants who are less fortunate.
    - Non-profit: Management of funds is not intended for profit.
    - Openness, prudence, and accountability: This principle applies to the management of funds.
    - Portability: Provides continuous assurance wherever the participant is.
    - Participation is mandatory: The goal is to protect the entire community.
    - Trust funds: Funds are managed by the implementing agencies as much as possible.

Among the many principles of Indonesia, one is renowned as *Gotong Royong* (cooperation), whereby Indonesians usually raise funds to jointly help people who need assistance due to economic, health, or other calamities. Cooperation has also been explained in Chapter 2 (pages 27, 30-32) on the Change and Trajectory of the Indonesian Welfare Regime. *Cooperation* is one of the foundations used by the philosophy of the Indonesian state in social health insurance. The principle of *cooperation* in social health insurance means that participants will be able to help each other. This principle is called cooperation, whereby healthy participants support participants who are sick or at elevated risk. This is a deliverable because participation in SJSN is mandatory for all Indonesian people (BPJS 2018; Jamsos, 2013).

The objective of cooperation in the SJSN system is expected to create social justice for all Indonesian people, as reflected in the fifth principle of Pancasila. Nonetheless, this principle began to be realised after Indonesia achieved independence from the Dutch on 17 August 1945. The development of social health insurance in Indonesia is discussed further in the section on social health insurance history and progress.

3.8. History of Universal Health Coverage in Indonesia

Indonesia's social health insurance existed before Indonesian independence, but it was developed further in 1949 following Indonesian independence. At that time, social health insurance guaranteed health services for some population, particularly civil servants, and their families. This program initiated by Professor G.A. Siwabessy, the then Minister of Health, proposed implementing a universal health insurance program like that applied in many developed countries.

Social health insurance is a social risk management system such as the risk of losing income or having to meet the cost of medical needs due to illnesses (Mukti, 2017). The risk is pooled or transferred from individuals to groups through mandatory memberships. Rules regarding individual risks and contribution regulate contributions. This social insurance system is not usually for-profit oriented and aims to improve the health and welfare of the community. The system is managed professionally, and the surplus is returned to the community. Puteh and Almualm (2017) also describe that social health insurance as a mechanism to raise and pool funds for health financing. Mandatory contributions are usually made by employees, employers, the self-employed and the government to cover health service package. The government usually bears the responsibility to cover the low-income people or those who cannot pay, such as the unemployed.

In social health insurance programme, membership is mandatory. Therefore, the law of considerable number in insurance terms applies. This means that risks can be distributed evenly, widely and reduced effectively. This principle is a legal consequence of large numbers, the more participants, the greater the risk that can be reduced (Murti, 2000). The concept of health financing system based on social health insurance is more appropriate to implement in Indonesia. This system is also relevant to the culture of the Indonesian people who adhere to a cooperation system

(cooperation), where the rich help the low income, the healthy help the sick. This concept is significantly different from private insurance, which is profit-oriented and does not apply the cooperation principle (Mukti, 2017).

In 1968, the Indonesian government issued a Minister of Health Decree (Number 1/1968 by establishing a Health Maintenance Fund Management Agency (Badan Penyelenggara Dana Pemeliharaan Kesehatan, or BPDPK) which regulates health care for state employees and pension recipients and their families. In 1984 the BPDK changed its status from an agency within the Ministry of Health to a State-Owned Enterprise (BUMN), namely Perum Husada Bakti (PHB). This agency provided health insurance for civil servants, veterans, and their family members. In 1992, PHB status was transformed into the so-called PT. Askes Persero in accordance with Government Regulation Number 6 of 1992. PT. Askes began to cover BUMN employees through the Askes Commercial programme. In January 2005 PT. Askes was mandated the responsibility by the government to implement the health insurance programme for the low-income people. This programme has a target to cover sixty million low-income participants. At that time, the fee was covered by the central government.

PT. Askes also managed the Public Health Insurance Programme or better known as the Managed Care. The target was to reach 6.4 million people in more than two hundred districts/cities. The Managed Care programme realised the principle of cooperation through cross-subsidised premium payments from Managed Care participants. At the beginning of this Managed Care programme, various premiums were set, determined by the Indonesian people's ability and willingness to pay (ATP/WTP). The government covered those who really could not afford the premium. Cross subsidy is targeted to people who can afford more than people who belong to below middle-class level economically speaking.

The Managed Care programme brought benefits for the community, but it also had challenges, one of which was public awareness regarding the benefits of the Managed Care programme. Health insurance is needed when people become ill. Additionally, there was a public distrust of the health insurance administering body related to managing the Managed Care premium funds, as stated in Rosyidah's

(2007) study. The problem of public trust in the Managed Care era is due to poor monetary management, such as fraud committed by individuals or agencies that collect funds from premium payments for Managed Care participants.

Indonesia has undergone a long journey in developing UHC, including before and after the reformation of its system. There are different references that explain the establishment of social health insurance in Indonesia. Agustina et al (2019) explained that health policies and practices of the Dutch colonial administration had impacted the health system in Indonesia, including social health insurance. This relates to the historic background as since the 1800s, the Dutch controlled most of the Indonesian archipelago until Indonesia declared its independence on 17th August 1945 and becomes a democratic country under a presidential system.

3.8.1. Social Health Insurance System in Indonesia before the New Scheme of Universal Health Coverage

Research conducted by The Economic Intelligent Unit Limited began to compare social health insurance in Indonesia from the 1970s until the UHC implementation in Indonesia (2015). However, some references state that social health insurance in Indonesia started to be designed in 1968 (Roxt et al., 2009; BPJS Kesehatan, 2020; UNAIR News, 2021; Askes, 2013).

Indeed, there are differences of opinion about the history of the start of a new era of social health insurance in Indonesia, but this study choses to stick to refer to the official reference of BPJS Kesehatan (2020) which states that the new era of social security in Indonesia started in 1968 through Presidential Decree No. 230 of 1968 concerning Regulations for the Maintenance of Civil Servants with only limited participants for Civil Servants and Military Servants, including retirees. . In that year, social health insurance was started for civil servants and their families and retirees. Over time, the latter has developed and covered a wider scope under different management. The evolution of social health insurance in Indonesia is summarised briefly as follows:

Table-8 Indonesia Social Health Insurance Schemes

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Source: Rokx et al. (2009)

The first programme implemented was Health Insurance for Civil Servants known as Askes (Health Insurance). At that time, the social health insurance funder was PT Askes, a state-owned company (*Badan Usaha Milik Negara*/ BUMN). The health insurance providers were Indonesian public hospitals which provided a free, comprehensive package of benefits. The Askes health insurance scheme had tried to set up a comprehensive healthcare benefit package for its members. Sadly, the quality of healthcare services such as responsiveness, empathy, and assurance of the healthcare providers had to be improved. The assurance of the healthcare

providers and the administrative and referral system had to be improved (Bredenkamp et al., 2015).

Alongside Askes evolution, the Indonesian government declared the Workforce Social Security Scheme in 1992 based on Law No. 3/92 (Social Security Law), Government Regulation No. 14/93 and the Ministry of Manpower Decree No.05/93. The health insurance scheme covers three programmes: provident funds, death benefits, and occupational injury (Thabrany, 2003). The benefit package covered comprehensive health services such as catastrophic diseases, surgery, and medicine. Additional fee for the beneficiaries who used health care services or medicine is excluded from the Social Security for Private Sector Employees benefits. Problems were encountered during the implementation of the Workforce Social Security Scheme, such as complaints from the Workforce Social Security beneficiaries relating to the health service provider, referral system, lack of managerial skills including human resources in the management of Social Security for Private Sector Employees. The Social Security for Private Sector Employees scheme sustained until 2013. At the beginning of 2014 Social Security for Private Sector Employees merged with BPJS under the UHC programme.

In 1997 the Ministry of Health (MoH) introduced and socialised Manage Care programme. The Manage Care programme is based on Law No.23/1992 regarding Health Regulation (Thabrany, 2003). The objectives of implementing the Manage Care were to increase public awareness in mobilising funds for health care access, Rosyidah (2007). The positive impact of The Manage Care programme as explained by Shinta (2017) is that The Manage Care represents a model of managed care applied in Indonesia. The Manage Care comprises four actors, participants, Health Insurance Funder, Health Care Providers, and Board of Trustees. The Government as the Board of Trustees acts as a regulator and is obliged to pay premium for the low-income people. In this regard, the researchers claim that The Manage Care is an option given its mutual benefit to all The Manage Care actors. Along the journey, the Manage Care programme brings benefits to the Indonesian society, even though this scheme needs to be improved in terms of implementation, i.e., socialisation to the Indonesian community regarding its benefits. Likewise, the Manage Care

stakeholders should pay attention in healthcare management, reasonable premium, and benefit packages, including provision of quality healthcare.

Another social health insurance scheme in Indonesia is Social Health Insurance for low-income people. This programme aims to cover 76.4 million low-income people. Members in this programme get total subsidies and comprehensive coverage for public health services and private health care providers in collaboration with the government. On this social health insurance scheme, the provision of health care cost protection to low-income people has become a shared function between the central and regional governments. This means that the responsibility for providing health care coverage is shared between the central, provincial, and district levels of government. Thus, the burden of financing Social Health Insurance for low-income people is divided between levels of government. Most of the funds come from the national budget (APBN), allocated in the Ministry of Health budget. The Social Health Insurance Fund for low-income people from the central government only includes residents who have been determined by a decree of the Minister of Health. Regarding the recipients of Social Health Insurance for low-income people based on the poverty criteria version of the National Statistics Board (Dwicaksono et al*.,* 2012).

Social Health Insurance for low-income people is beneficial for expanding access for low-income people to take advantage of health services at the primary and referral levels. However, the targets in this scheme still need to be evaluated because there are low-income people who have not been covered by this insurance scheme (Sparrow et al., 2017). This problem could be due to low-income people's data that has not been appropriately updated every year. Furthermore, the synchronization of low-income people data between regions that has not been integrated with national data still requires support from policymakers at the regional and central levels, especially the Ministry of Social Affairs.

In 2001, Indonesia evolved into a phase of decentralisation. In this era the law of regional autonomy, including the health sector started to be implemented nationwide. The decentralisation triggered responses and more appropriate policy in some respects, like health services and health insurance. The health insurance scheme in this era was called District Health Insurance (Jamkesda) managed by the district

government. This programme expanded gradually using district budgets. The budget was dependent on the ability of the respective district. The premium and benefit packages also depended on the ability to pay for the social health insurance members. The rich districts covered all health services. Thabrany (2003) underlines this scheme resulted into inequalities between regions. Sparrow et al. (2017) state that the District Health Insurance programme could be a means for local governments to contribute more optimally in terms of health insurance. This regional effort was valuable when the central government faced financial difficulties in covering the national health insurance. However, the constraints of the District Health Insurance programme are because each region has different capacity in terms of financial, human resources, technical and administrative. These barriers affected the quality, design, and implementation of District Health Insurance scheme. Harimurti, et al. (2013) also emphasise that the gap in the District Health Insurance programme is because each district has different budget capacity and regional policy.

Apart from the District Health Insurance programme, the Indonesian government has tried all efforts to promote health insurance to the Indonesian population, especially the low income. Yet, some districts such as Yogyakarta implemented its own regulation to cover the low income not covered by national health insurance. This programme was set up in 2003 and known as Social Health Insurance Programme under Yogyakarta Special Region/Jamkesos. Yuniarti explains that this social health insurance scheme under the Government of the Special District of Yogyakarta (DIY) was coordinated with regencies/city governments (Yuniarti and Mukti, 2013).

The Jamkesos participants are the low-income people in Yogyakarta not yet covered by social health insurance, either UHC, District Health Insurance or other social health insurance. Social health Insurance Programme under Yogyakarta Special Region membership is set under the DIY Governor Regulation Number 63 of 2016. The Social health Insurance Programme under Yogyakarta Special Region is beneficial to the people of Yogyakarta, especially for participants not yet covered by any social health insurance. This programme also states the effort of local governments in protecting the low income to access healthcare services.

In addition to District Health Insurance and Social health Insurance Programme under Yogyakarta Special Region, Universal Delivery Care was also introduced by the Indonesian government on 11th January 2011. This programme aims to reduce maternal and child mortality. Universal Delivery Care is funded from the central government revenues directly integrated from the State Treasury Office (Yuniarti and Mukti, 2013). The Universal Delivery Care benefit package covers pregnancy, delivery, postpartum services, antenatal care, postpartum delivery care, and newborn babies, including family planning. The benefit coverage standards of medicine are based on the national MoH programme. The referral system in the hospital outpatient clinics and class 3 hospitals depends on the income level of patients. Universal Delivery Care guidelines are based on MoH Regulation Number 631/MENKES/PER/III/2011.

Ministry of Health revised this regulation Number 2562/MENKES/PER/XII/2011 issued in 2012 to improve the criteria of the provider's performance. The Universal Delivery Care was also beneficial to increase community participation in social health insurance whilst the UHC programme was still under initiation by the government. However, there are issues to be improved in this programme, such as the commitment of health sector stakeholders to evaluate fund management to reduce the complexity of Universal Delivery Care with other insurances because it affects the reimbursement process. The study reveals that families pay additional out of pocket (OOP) transport costs to health care facilities (hospitals).

As social health insurance schemes progressed in 2012, President Joko Widodo introduced the so-called Healthy Indonesia Card (*Kartu Indonesia Sehat/KIS*), Smart Indonesia Card (*Kartu Indonesia Pintar/*KIP) and Prosperous Family Card (*Keluarga Sejahtera/KKS*). These schemes provide free healthcare for Indonesia`s low-income society and have been realised as a promise by President Joko Widodo during his campaign (President RI, 2011). The providers of this system managed by BPJS Kesehatan have a target of 86.4 million people belonging to the low-income bracket with a plan to extend coverage to new-born babies, 1.7 million homeless and internally displaced people. As the first target, the government aims to cover 432,000 homeless and internally displaced people.

The various cards introduced by President Joko Widodo resulted ambiguity in responsibilities of each stakeholder, its target and management. Previous research conducted by Mukti and Rosyidah (2014) highlights different perceptions between MoH, Social Ministry, BPJS and Fraud Department and related stakeholders on the implementation of Healthy Indonesia Card, the cut-off point like data synchronisation of the low-income people. This research recommends the government to integrate the role and function among related agencies on the UHC, Healthy Indonesia Card, District Health Insurance, and The Social health Insurance Programme under Yogyakarta Special Region. Support from the local and national governments needs to be expanded, including system and data mechanism validation for the low income (PBI).

There are many models of social health insurance in Indonesia before UHC, some are directly managed by the central government such as Social Health Insurance for the low in-come group and Universal Delivery Care whereas District Health Insurance and Social Health Insurance (for the community uncover any health insurance, disabilities, homeless etc.) are managed by local governments. Additionally, there are private health insurance appointed by the government, like Social Health Insurance for the Civil Servants and Social Security for Private Sector Employees. There are also semi-governmental and regional organisations, such as Managed Care. The implementation of social health insurance in Indonesia before and after UHC will be discussed in the following section.

3.9. Social Health Insurance in the Transformation Era

The two articles mandate the formation of the BPJS and the transformation of PT. Askes (Persero) which used to be the provider of social health insurance, PT ASABRI (Persero) which is the provider of the insurance for the Indonesian armed forces, PT Jamsostek (Persero) which is the provider of social security for workers and PT. TASPEN (Persero) as the provider of the civil servants' retirement savings fund. All these national social security administrators were transformed into one social insurance organising body, namely BPJS. The institutional transformation of the four companies was then followed by the transfer of participants, programmes, assets and liabilities, rights, obligations, and employees (Putri, 2014b).

Social Health Insurance all are merged under one National Social Health Insurance funder, i.e., BPJS which includes social health insurance already implemented by GoI nationwide, like Social Health Insurance for the low-income people and Universal Delivery Care. This change happened gradually until 2016 since GoI launched the transformation era on the 1st of January 2014. The transformation of the implementation of social security has brought about significant changes in the philosophy, legal entities, organisations, governance, and organisational culture. The philosophical evolution of the national social security from industrial relations between workers and employers to a form of constitutional relations between the state and citizens. BPJS, in this case, is the organising agency appointed by the Indonesian government to realise citizens' constitutional rights to social security.

In the pre-SJSN programme, the provider of the social security programme was State-Owned Enterprises (BUMN). Therefore, the providers' mission of the social security programme of establishing BUMN Persero was profit oriented because BUMN Persero was accountable to its shareholders. After the SJSN era, BPJS as the provider of the national social security represented the state in realising citizens' constitutional rights to social security and the right to a decent living, as mandated in the 1945 Indonesian Constitution Article 28 paragraph (3) and Article 34 paragraph (2). The transformation of BUMN Persero into BPJS aimed to fulfil the principles of the mandate and the SJSN non-profit principle, in which the fund managed by BPJS is a mandated fund from participants to provide optimal benefits for social security.

In other words, following Law Number 24 of 2011 Article 40, BPJS Kesehatan manages two assets, namely the Social Security Fund assets and the Social Security Administering Agency (BPJS) assets. BPJS Kesehatan is required to separate the Social Security Fund and BPJS assets. The Social Security Fund assets are mandated funds belonging to all participants, which are a collection of contributions and the results of their development which BPJS Kesehatan manages for the payment of benefits to participants and operational financing for the implementation of the social security program.

Regarding changes in terms of legal entities after the transformation, PT Askes, PT Jamsostek, PT. ASABRI and PT TASPEN, which used to be state-owned

enterprises in the form of limited liability companies, were incorporated into private companies. Hence following the transformation of the four BUMN into a specific public legal entity called the Social Security Administering Body (BPJS), the latter becomes a state institution which reports directly to the President. Mahendra, 2011 adds that in the era of transformation, external supervision of the BPJS was undertaken by DJSN and independent supervisors, namely the Financial Services Authority and the National Supreme Audit Board. In accordance with the BPJS Law, post-transformation of BPJS is divided into two, namely BPJS Kesehatan and BPJS Ketenagakerjaan. BPJS manages health insurance programmes and BPJS Ketenagakerjaan provides work accident insurance, old age savings, pension, and death benefits.

The transformation of PT ASKES (Persero) to BPJS took two years from 25 November 2011 to 31 December 2013. During the preparation period, the Board of Commissioners and PT Askes (Persero) were tasked with preparing BPIS Kesehatan operations and planning the transfer of assets and liabilities, employees and rights and obligations of PT Askes (Persero) to BPJS. Operational preparation of BPIS includes: (1) preparation of BPJS operational systems and procedures: (2) socialisation to all stakeholders; (3) determination of the health insurance programme in accordance with the SISN Law (4) coordination with the Ministry of Health to transfer the implementation of the programme Social Health Insurance for the low-income people (5) coordination with the Ministry of Defence, TNI and POLRI to divert the implementation of health service programmes for members of the National Police and civil servants within the Ministry of Health, TNI/POLRI (6) coordinating with PT Jamsostek (Persero) to transfer the implementation of the Jamsostek health care insurance programme (Putri, 2014).

When BPJS Kesehatan started operating on 1st January 2014, PT Askes (Persero) was declared disbanded without liquidation. All assets and liabilities and legal obligations of PT Askes (Persero) became the assets and liabilities and legal rights and obligations of BPJS Kesehatan, and all employees of PT Askes (Persero) became employees of BPJS. At the same time, the Minister of State-owned Enterprises/BUMN as one of the stakeholders ratified the closing financial statement of PT Askes (Persero) at a stakeholder meeting after a public audit was conducted.

The Minister of Finance endorsed the opening financial report of BPJS Kesehatan including the funding for health insurance. For the first time, the Board of Commissioners and Directors of PT Askes (Persero) were appointed as the Supervisory Board and the Board of Directors of BPJS for a maximum period of 2 (two) years following the set-up of BPJS.

Since 1st January 2014, social health insurance programmes implemented by the government have been transferred to BPJS. The Ministry of Health no longer operates the Social Health Insurance for the low-income people programme. The Ministry of Defence, TNI and POLRI no longer manage health service programmes for their participants, except for certain health services relating to operational activities as determined by a government regulation. PT Jamsostek (Persero) no longer manages health insurance programme for workers.

3.10. Social Health Insurance under the New System (UHC/JKN)

The Government of Indonesia has been making efforts to establish a comprehensive system of social protection, which includes health case protection for all citizens. These aims to provide: (1) all residents with access to affordable primary health care, including maternity care; (2) all children with basic welfare security that encompasses access to nutrition, education, and other necessary goods and services; (3) all individuals who are unable to earn sufficient income due to sickness, unemployment, maternity or disability with basic income security, and (4) all senior citizens would receive basic income security through pensions or in-kind transfers (UNDP, 2014).

Members of BPJS are Indonesian citizens and foreigners reside in Indonesia for least 6 months or more. BPJS covers health insurance, employment injury and insurance for the elderly, pensions, and death. There was a long journey between the 1970s and 2013 until the GoI officially declared the UHC. UNDP Indonesia (2014) states that the Indonesian constitution recognises the right to universal social security which is also reflected in the National Social Security Law (No. 40/2004) and the recent Law on Social Security Providers (No. 24/2011).

Universal Health Coverage means that all people would receive health services according to their needs. These health services refer to health initiatives designed to promote better health (such as anti-tobacco policies), prevent illnesses (such as vaccination), and to provide treatment, rehabilitation, and palliative care (such as end-of-life care) of adequate quality. It is expected that the services would be effective while at the same time ensuring that the use of these services does not expose the user to financial hardships (BPJS, 2014).

3.10.1. Premium and Benefits during Universal Health Coverage

Besides exploring the progress of the BPJS programme, this study also compares the target set for health coverage of the low income (Penerima Bantuan Iuran/PBI) and near low income (non PBI) by BPJS with that of the previous social insurance for low-income group programme. Jamkesmas is the health social insurance system applied by the GoI before 2014 (Bredenkamp et al., 2015). BPJS (2014) reports that the target population to be covered in 2019 amounts to 257,500 million (100% population). The updated data of JKN, as reported by BPJS is shown in this figure:

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Source: BPJS Kesehatan 2019
Figure- 5 Participants of HHC/JKN Programme 1st January 2019

The updated data from BPJS on 1st January 2019 showed that the total population covered in UHC programme was 215,784,3 million which means that 53.755.6 million (19%) of the population is still to be covered by the UHC programme. The largest number of participants receiving subsidies by the government amounts to

4.78% whose contribution is taken from APBN and APBD recipients. Classification of memberships in UHC is as follows:

Table- 9 Participant of UHC Programme

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Source: BPJS Kesehatan 2019

Relating to the above, self-employed workers, such as traders, farmers, fishermen and others need to be evaluated by the government to ensure reasonable and suitable premium and benefit package. The previous research was conducted by (Bredenkamp *et al.*, 2015) explored that several Asian countries including Indonesia are progressing towards the goals of Universal Health Coverage (UHC). Nonetheless, there are barriers, such us the countries in question use public revenues to converge the informal sector. In addition, they employ a mixture of tax subsidies, non-financial rewards, and contributory requirements.

Finally, there are many challenges in terms of supply-side readiness, including the availability of equipment, adequate infrastructures, availability of essential drugs, and availability and competence of health staff and workforce able to deliver high-quality care in a UHC context (Bredenkamp et al., 2015). Based on the previous research

premium and benefits needs to be evaluated and improved in the UHC era even though the scheme covers the benefit package for the informal sector. The benefit package after and before the UHC is shown in Figure 6 as follows.

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Source: The Economist Intelligent Unit, (2015)
Figure-6 Social Health Insurance before and after UHC

The benefits of UHC are supposed to be comprehensive, covering treatment for diseases such as influenza as well as expensive medical intervention, like open-heart surgery, haemodialysis, and cancer therapies. Among Asian countries, those implementing an undelivered health insurance system such as China, Indonesia, the Philippines, Thailand, and Vietnam face the same issue of how to cover informal workers, and people who have low income. Employers usually pay social health insurance contribution via monthly salary deductions, whereas the low-income, elderly who have low income are subsidised by the government. However, the problems are complicated for the informal workers because they have various kinds of jobs and no fixed salary every month (Bredenkamp et.al, 2015).

Furthermore, the formal sector in Indonesia has had to increase its contribution, but the government needs to the premium and benefit package of the informal sector-most of whom belong to the missing middle group. Evaluation is needed to ensure that there is a balanced relationship between the employees and employers in the informal sector including increasing the awareness of employers; they need to responsible to cover their employees with proper health insurance. About the benefit package, Wong, and Bitran (1999) cited by Bredenkamp et al. (2015), emphasise that a rational process to determine the benefit package is needed to explain means important to avoid unpredictable services between the provider and the beneficiaries meaning.

Issues that need to be considered to design benefit package has been explored by IHME, WHO (2013) state that non-communicable diseases, aging population, medical technology, hospital class are the key factors. An additional point from Busse, (2013) reveals that technical skills are necessary. It is important that the benefit package is supported by a political commitment to ensure that the outputs cover numerous services. Previous research above reveals important points to design the health insurance benefit package, such as considering reasonable package with the premium setting, avoiding the unexpected services that exclude the benefits, and the various kinds of diseases covered in the benefits. More details of benefits during UHC are illustrated in Figure 7

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Source: The Economist Intelligent Unit, (2015)
Figure-7 UHC Benefits

The UHC scheme covers comprehensive benefit package, although there are benefits not covered, such as medical examination, treatment and medical consultancy, medical treatment not listed in the field of specialist's discipline, blood transfusion, first level laboratory diagnostic supporting examination and in-patient care based on medical indication.

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Source: BPJS Kesehatan 2019
Figure-8 Comprehensive Benefit Coverage

The benefit package of BPJS covers health promotion with the aim to maintain health and personal consultation. The prevention aspect covers the protection from illnesses and consists of three main programmes: firstly, routine immunisation and family planning programme. Secondly, selected screening such as Pap smear test. Thirdly, PROLANIS programme for chronic disease management. The PROLANIS is one of BPJS Kesehatan's programmes for participants with certain diseases that require special treatment such as diabetes, heart, and other catastrophic diseases.

As to catastrophic diseases, BPJS Kesehatan (2018) reports the trends of catastrophic illness costs in Indonesia which have increased every year. Figure 9 lists down the increasing number of catastrophic illnesses and costs from 2014 to 2016:

Table-10 Catastrophic Disease Costs

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Source : BPJS Kesehatan 2104-June 2017

The highest number of uncommunicable diseases in Indonesia is heart disease which has increased from 2014 to 2016. The most expensive cost is IDR 6,491,761,274,870 in 2016. Furthermore, the case of kidney failure increased in 2014, 2015 and 2016 with a total expense of more than IDR 12 trillion. The prevention programme like PROLANIS will be useful to reduce the number of catastrophic diseases and the promotion programme like personal consultation will be worthy for the community to improve health behaviour awareness. Previous research explored by Nafsiah et al. (2016) shows that life expectancy in Indonesia increased from 1990 to 2016 by 8.0 years, 7.4% for male and 8.7% for female. Total DALY`s caused by communicable diseases, maternal, neonatal, and nutritional disorders have decreased by 58.6%.

Nonetheless, the total DALYs from non-communicable diseases has increased. There were three major causes of DALYs in 2016, cardiovascular diseases and diabetes. This reference is linked with Sulivan (2016) which reported that in Indonesia, 67 percent of adult males' smoke cigarettes, and 11.8 million people are expected to have diabetes by 2030. These lifestyle diseases will account for most of the country's deaths. Stroke, ischemic heart disease, and diabetes are the top three causes of death in Indonesia. From 2012 to 2030, Indonesia could lose $4.4 trillion owing to the impact of chronic or "non-communicable" diseases (NCDs). Based on

the data, the Indonesian government should evaluate if the number of catastrophic illnesses keeps increasing significantly from year to year as the latter will have an impact on the health care financing in UHC implementation.

3.11. Demand and Supply in Indonesian`s Universal Health Coverage Context

Demand and supply are the fundamental effort to implementing National Social Security System concept on national health insurance. The term demand is distinguished by the terms needs and wants. Need is an item or service that is considered the best by a health care provider (a doctor) used to improve the health of patients, while want is a product or service desired (requested) by the patients. This distinction is considered important, especially in health economics and public health with the aim at reducing the gap. The Government can influence doctors 'decisions to accommodate patients' wishes through laws and regulations (Janis, 2014).

3.12. Demand in Universal Health Coverage in Indonesia

Demand is a desire for specific products supported by the capabilities and a willingness to pay. The health request is influential on health service utilisation. The utilisation of health services is a behaviour or action owned by individuals in seeking health services (Andersen et al., 1997). Service utilisation Health is essential in society which aims to assist in determining health status.

The relationship of the factors referring to the demand for health services is very varied. The costs of health services have a negative correlation with the demand for health services, the higher the price, the demand for health services decreases. A similar correlation also occurs between the availability of alternative goods and demand for health services, whilst the patient's income and preferences and the price of alternative goods have a positive correlation with the demand for health services. Jack W (1999) mentions that empirical analysis of the demands for health care preferences and requests for health indicates that costs, income, and health status tend to influence health service utilisation, while the existence of such correlation seems reasonable.

Demand for health services in Indonesian community is met through three ways, namely self-medication at home, traditional medicine, and treatment with medical

professionals. Treatment with medical professionals is treatment based on instructions from health workers conducted in polyclinics, health centres and hospitals. Self-medication at home is treatment without instructions from health potentials. Traditional treatment refers to the use of a method, tool or material not included in the standards of modern medical treatment either conducted alone or with instructions from traditional health workers (Kalangie: 994 in Janis: 2014). Demand (realisation of use) for health services in Indonesian society through health workers is currently still exceptionally low. This most Indonesians tend to choose self-medication at home using medical drugs or traditional medicine. The use of this treatment method is conducted to deal with minor ailments and routine treatment of chronic diseases after previously receiving care from health workers. In general, the motivation of treatment in this way is more practical (no need to queue at the hospital), lower costs (the price of health services performed by medical professionals), the long-distance location on the availability of health care professionals and the disappointment with the intended health services (Janis, 2014).

Table-11 Demand for Health Services (in %)

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Source: Janis 2014

The community tends to consult medical professionals in meeting the needs for health services. In addition, the community's preferences indicate that the costs of medical professional health medical services are still not affordable to the community. Therefore, it is assumed that "if the price of health services performed by medical health workers is affordable, the community will choose to use the latter in meeting the needs for health services rather than self-medication". The SJSN and BPJS concept will play a role in increasing the demand (realisation of use) of health services, especially medical professionals.

3.13. Supply of Universal Health Coverage Context in Indonesia

Doctors and health services are crucial which must be considered by health service providers (Jack, 1999). For instance, physicians from all kinds of medical specialities

provide two important roles as health care providers. Firstly, they assess, diagnose, and provide information and advice to the patients on their condition, such as the positive and negative impact of the treatments. The patient requires all information to improve their understanding of the health services. Secondly, the physician also performs surgery, administers injections, writes prescriptions, and so forth. All the physicians should provide better health for the patients, both in terms of information and medical services.

In general, the supply of health services is defined by the provision of health services delivered to patients through a combination of health care workers and health facilities (hospitals, clinics, and clinical laboratories). Factors that influence the supply of health services are Human resources, Money, Material, Method, Market, Machine, Technology, Time, and Information. Explanation and examples of the intended factors are shown below:

Table-12 Factors that influence the supply of health services.

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Source: Jannis, (2011)

From the intended health service supply determinants, human resources are the most dominant determinant. This can be understood because other determinants are provided and managed by the determinant. The condition or quality of the determinant in question will determine the quality of health services. Considering that the success rate of the SJSN concept is also influenced by the performance of suppliers of health services, BPJS needs to control all determinants of health service supply, especially the determinants of Health Human Resources. The health workers in Indonesia reported by Ministry of Health as follows:

Tabel-13 the Health Workers in Indonesia 2018

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Source: Ministry of Health Republic of Indonesia (2019)

The WHO threshold of 2.28 health workers (doctors, nurses, midwives) per one thousand population has played a significant role in determining the minimum sufficiency of health workers stock of developing nations. Indonesia has done tremendous efforts to improve the availability and equitable distribution of health workers across the country regions. As shown in figure 5, the health worker density as reflected from the combined number of registered doctors, nurses, and midwives to population has been significantly increasing in the last decade from 1.28 to 5.25 per one thousand populations between 2010 and 2018. Improving the health workforce information system by using the information technology may contribute to the increased health worker density as health workers' data can be provided more accurately (Efendi, 2019).

Although human resources for health in Indonesia have increased over the last decade, as shown by the data above, but as to the supply of health resources in the

UHC context, this asset is being evaluated to provide health services for the population. The ratio still needs to be improved as well as the demand of the population. The government should consider the distribution across the district, especially in the rural and remote areas. The supply-side readiness of UHC is based on the increasing number of catastrophic illnesses and infectious diseases. The efforts of health facilities are essential, and the efforts of primary health centres to raise health promotion to improve healthy behaviour awareness of the Indonesian society. The primary health centre is a mandatory step of a rapid progress to achieving the UHC. The public health programmes such as prevention, health promotion are the first programmes to be designed. The programmes should be well structured and efficient. Therefore, primary health care services can fulfil most of the health care needs of the communities (Beattie et al*.,* 2016), Based on the data updated by BPJS (2019), there are 9.931 community health centres in Indonesia.

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Figure-9 UHC Health Facilities (Source: BPJS, 2019)

The information in Figure 9 shows that the community health centre has the highest number of UHC health facilities in Indonesia, followed by Clinic Pratama. In contrast, the smallest number is Primary Class D Hospital. Regulation to access the hospitals relating to the referral system is based on Presidential Decree number 12 of 2013-chapter IV on Health Care Benefits. The UHC members can use the benefits of a comprehensive health care service package, including referral health service (Public Disclosure, 2018).

The referral system starts from the first level health facilities (FKTP), such as community health centres or primary health care, and then to the next level in district/city hospitals. At the next level, if the district/city hospital cannot cover the health care because of the unavailability of the facilities or a specialist doctor, can refer a patient to the regional hospital and national referral hospital. In an emergency condition, a patient can access any health facility.

Table-14 Health Facilities

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Source: Mahendradhata et al. (2017)

The community in their respective districts can access the outpatient facilities. The outpatient facilities are authorised to propose a referral to the hospital based on the patient's diagnosis. UHC members can also access the in-patient services at the district and provincial level, as shown in Table 15:

Table-15 In-Patient Health Facilities

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Source: Mahendradhata et al. (2017)

In-patient services in Indonesia are provided by public and private hospitals, including Puskesmas with in-patient facilities, and some private specialist clinics which have an agreement with BPJS. The hospital classification is based on the services provided, human resources, medical equipment, facilities, and administration (Minister of Health, 2014c), type D being the simplest, while type A is the most comprehensive (see Table 15). In terms of quality, all hospitals are required to undertake an accreditation programme. This programme is managed by the Hospital Accreditation Committee (KARS). The 2012 version of the national hospital

accreditation standard is adopted from the JCI standard for hospitals. As of May 2015, only 106 hospitals have been accredited. The development of ideas and goals for the quality of hospitals is getting better, encouraging the KARS Team to develop a national accreditation standard that is applied to all hospitals in Indonesia.

A back referral system from hospital to primary care also exists. Unfortunately, the system is not running well since the availability of certain drugs in primary health care is limited. Homecare is also not popular in Indonesia since it is not covered by the UHC. Another challenge is the Indonesia Case Base Groups (INA-CBGs) implementation. INA-CBG is a system payment with a "package" system, based on the disease suffered by the patient. The hospital will get paid by the INA-CBGs rate which is the average cost spent for a group of diagnoses. For example, if a patient suffers from dengue fever the INA-CBG system "calculates" what services will be received by the patient, along with the treatment, until the patient is cured or one period of hospitalisation (Info BPJS Kesehatan, 2014). In its implementation, research by Astuti et al. (2021) shows that hospital and INA-CBGs rates are different because the calculation of the two rates uses different parameters. However, if there is a significant difference this can have a detrimental impact on the hospital especially for private hospitals that are profit orientated.

The health care facilities at all levels also provide emergency services. The services range from the primary to highly specialised and tertiary facilities. Primary health care without beds only provides emergency services during opening hours. All emergency care units in hospitals or primary health care are expected to provide the emergency services within five minutes upon patient’s arrival (WHO, 2017).

From each period milestone analysis on UHC implementation in Indonesia, there is progress in providing coverage. However, some points need to be evaluated and improved for the sustainability of UHC in Indonesia. This study will further assess how UHC is in terms of regulations, resources, funding, including premiums and health care packages, its implementation, the government's efforts to achieve UHC targets, the obstacles faced and its sustainability.

CHAPTER FOUR
RESEARCH METHODOLOGY AND PHILOSOPHY

4.1. Overview

Chapter Four explores the essentials of research philosophy relevant with my research design, its associated classification and which methods are applied in this study. In this study, the ontological aspect was examined in order to better understand the basis for evaluating the degree of success in implementation UHC in Indonesia. The year 2013 marked the transition period from multi-payer transformation into single-payer under BPJS Kesehatan, when UHC was implemented from 1st January 2014 onwards.

This study also examines the positive and negative sides of UHC implementation and its benefits for the people of Indonesia. As to the provision of comprehensive results of this study, it is not enough to use quantitative data, such as knowing the characteristics of the community social health insurance participation and demographics (rural or urban area). Instead, this study needs to evaluate more deeply how the implementation of social health insurance is before and during the transformation era. Therefore, the researcher chooses the pragmatism paradigm as the epistemological aspect of this study. With this assumption, the researcher can present richer data based on the quantitative and qualitative analysis results relating to the implementation of social health insurance in Indonesia, before and during UHC.

With regard to data analysis, the latter is used to consider whether the method is suitable for analysing the big national data. In addition, the study is limited to knowing the correlation between variables and analyses more closely related to intermediate variables that can affect the correlation results. As for the qualitative data, the researcher used the CIPP evaluation model which, via its stages, allowed for a formative analysis of why the Indonesian government launched the UHC programme, including its objectives, plans, targets and benefits, while the summative analysis evaluate the process and outcomes of the programme of implementation.

As to the axiological aspects of this study, the researcher was aware of applicable research ethics considerations, such as respondents' vulnerability and potentially conflicting positions (and, therefore, the duty of the researcher to protect the respondents' anonymity and confidentiality), the requirement of the researcher to provide information regarding the purpose and benefits of the research, the reasons for selecting the respondents, and so forth. Furthermore, respondents where continually informed of the need for their consent to participate and their right to withdraw at any time from this study.

The use of Mixed Methods was appropriate axiologically as it allowed the researcher to explore (in a sensitive and confidential manner) what the perspectives of various stakeholders were. This, in turn, then provided a comprehensive set of data that was analysed and provided evidence for the improvement and development of UHC in the future as well as input for policyholders and related stakeholders to further increase their attention to findings that require cross-sectoral handling. For example, equity in health services in remote areas is not only the responsibility of the Ministry of Health but also of BPJS Kesehatan in order that BPJS Kesehatan participants are able to access health services in remote areas. Likewise, the role of regional leaders is needed in order to provide support and monitor the progress of UHC in their respective regions. These important findings would not have been drawn out of a research project that had not appreciated the need for an axiologically appropriate approach (that is, one that took account of the underlying vulnerabilities of various respondents and the duty of the researcher to undertake the research in an ethically principled manner).

4.2. Research Philosophy

The essence of research philosophy as explained by Dudovskiy, (2018) is a belief about the ways in which data relating to the phenomenon are be collected and analysed. Furthermore, Saunders et al. (2009) state that various types of research philosophies are important. The researcher can decide on the research philosophy to be used in a study or a dissertation which requires the researcher's awareness to formulate his or her beliefs and assumptions. According to the literature, understanding various types of research philosophy is useful for the researcher to

enable him or her to choose and consider which research approach to be applied to collect data and make analysis.

All research projects are led by a set of beliefs known as a paradigm. A paradigm is a method of thinking about or seeing the world. The researchers' paradigms also serve as the foundation for everything else they accomplish during the study process. Holden and Lynch (2004) and Saunders et al. (2009) both claim that a research philosophy determine one`s approach to developing knowledge that defines philosophical paradigm. The development and belief of the knowledge is dependent assumptions relating to the range of perspectives, including practical considerations when deciding a research topic. Basically, there are many branches in research philosophy relating to a range of scientific discipline. Addressing research philosophy in a research dissertation is reflected in the awareness and the integration of the researcher`s beliefs and assumptions. According to Killman (2013), in order to comprehend research, one must examine the philosophy that underpins it. Researchers need to understand the concepts of Ontology, Epistemology, Axiology, and Methodology in order to comprehend the paradigms. This reference is similar to (Saunders, Lewis and Thom hill, 2009) that state Research philosophy is classified as ontology, epistemology and axiology.

The figure below provides an illustration of the possible philosophy position for different types and research.

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Source: Mark Saunders, Philip Lewis, and Adrian Thornhill, 2015.
Figure 10 Research Union

Figure 10 describes the six layers of research union; research philosophy, research approach, research strategy, research choice, time horizon, research techniques and procedures. The research philosophy is the very first layer of the union. But what exactly does that imply? The research philosophy, on the other hand, is the cornerstone of any investigation since it describes the set of beliefs that the study is based on.

The research approach is the second layer of the research union. The research methodology refers to the general method used in the study - inductive or deductive. It is critical to clearly define research approach because it will influence the data gathering and analysis decisions that the researcher applies in study. In the study of an otherwise unknown isolated group, an inductive technique could be applied. Because there is so little information on this group, research would be required to learn more about it, which would lead to the development of theories. When analysing changes in the physical properties of creatures over time, on the other hand, a deductive approach would be used, as this would most likely be based on

the theory of evolution. To put it another way, the beginning point is a well-established corpus of prior research.

The third layer of the research union is the research strategy that describes how research will be conducted based on the study's objectives, such as experimental research, action research, case study research, grounded theory, ethnography, and archival research. Related to my research, I decided on evaluation research using mixed methods. The case study of this study is to evaluate the implementation of social health insurance in Indonesia, before and during UHC.

The fourth layer of the research union is referred to as "choices." This layer will determine how many different data kinds, qualitative or quantitative, will be used in a study. Mono, mixed, and multi-methods is the three alternatives. I use Mixed Methods Concurrent Embedded Design in this study.

The time horizon is the fifth layer, and it simply states how much data in the time plan need to be collected. The cross-sectional and longitudinal temporal horizons are two alternatives. In my study, the time horizon is the cross-sectional approach.

Finally, the sixth layer is at the heart of the union, where the researcher may get down to the nuts and bolts of the research and make decisions on specific approaches and procedures. Specifically, the stages on my research are as follows:

1. I decide what data will be collected and how I collect it. In my research I collect qualitative and quantitative data. My qualitative data was conducted using In-depth interviews and FGDs. Meanwhile, quantitative data was collected from National Socio Economy Survey.
2. I plan for my research population. For example, for qualitative study I use Stratified Purposeful Sampling - a sample within a sample that suggests which technique can be stratified by selecting units or cases relevant to a crucial dimension. Population in this research is based on the Indonesia National Socio economic Survey data in 2012, 2013, 2014, 2015, 2016, 2017 and 2018.
3. I decide my data analysis in this study relevant with the data collection methods. Quantitative data was undertaken using Correlation Regression

while Different in Differences Analysis used STATA. Qualitative data analysis was undertaken using N-vivo CIPP Model Analysis.

4. I also design instruments for my primary data with Semi-Structured In-depth interviews and FGDs which includes Input: 23 questions; Process: 6; Output: 6 Items; in total 35 questions. The quantitative data was based on the National Socio Economy Survey.

Research philosophy approaches enable to decide and was adopted by the researcher derived from research questions. There are different types of research philosophy described below:

4.2.1. Ontology

The link between the researcher and the knowledge being discovered is the subject of epistemology. As defined by Killman (2013) ontology is "how we come to know what we know," adding that it "determines the objectiveness of the connection between researchers and what can be known" (objective or subjective). The researcher's belief about the nature of reality is referred to as ontology. In simple words, there are two primary points of view:

1. One reality exists that has yet to be found and is unconstrained by context.
2. Depending on the situation, various realities exist.

When reviewing prior studies and our assumptions, researchers must be aware of the ontology in order to account for the ontological impact on the researcher process. Ontology, according to Snape and Spencer (2003), is the study of the nature of the world and what we may learn about it.

The ontological aspect of this study is the implementation of the social health insurance program in Indonesia, before and during the new system known as UHC or JKN that has been implemented by the Indonesian government. This study was conducted to prove whether social health insurance in Indonesia is running well in accordance with the target of the Indonesian government, one of which is to cover 95% of Indonesia's population in 2019. Is the social health insurance program which later transformed into UHC in 2014 beneficial to the

people? What is the role of the government to make UHC successful and whether UHC will be sustainable in the future? Furthermore, to prove the nature and benefits of UHC, the researchers designed an appropriate research design, including data collection methods. This topic related to the aspect of epistemology will be explained in the following section on Epistemology.

4.2.2. Epistemology

Epistemology is the study of what constitutes acceptable knowledge in a given field of study. There are two types of researchers: resource researchers and feeling researchers. The ‘resource researcher' approaches data from the standpoint of a natural scientist. In the field of study philosophy, epistemology is divided into three categories: Positivism, Realism, and Interpretivism (Saunders at al., 2009).

Research epistemology or paradigms (knowledge claims) point out by Creswell (2014); positivism/post-positivism, constructivism/interpretivist, advocacy/participatory, and pragmatism.

a. Positivism/Post-positivism Paradigm

   Positivism also known as logical positivism relates to the scientific method of conducting a scientific research. Usually, it uses as quantitative methods. Post-positivism is connected to the thinking after positivism which challenges the traditional nation of the absolute truth of knowledge (Philips & Burbules, 2000 in Creswell, 2003). As to the realism philosophy, Dudovskiy, (2018) classifies it into two groups: direct and critical realism philosophy. Direct realism is known as naïve realism-it refers to what you see and get. On the other hand, Grix (2004) emphasises that criticism on the positivist paradigm has influenced the development of post-positivism which refers to the positivist and interpretivist’s paradigm. The ontology of post-positivism is critical realism.

   Positivism research often relates to the quantitative method Rehman and Alharthi (2016). The latter applies quantification to describe and analyse features of social reality referring to positivist epistemology. This epistemology assumes that social content can be isolated and

conceptualised as variables. These can also be expressed on a numerical scale. According to the positivist approach, qualitative data can be collected and analysis using internal, external validity, reliability and objectivity.

Natural scientists' philosophical approach can be seen in positivism, as their work is based on observable social entities. Data gathering and hypothesis building are the foundations of research strategy. These theories will be investigated and confirmed, and the results will be used in future studies. Another element of this theory is that positivist researchers use a highly structured technique to aid hypothesis testing. Furthermore, positivism is based on quantifiable observations, which leads to statistical analysis (Thakurta and Chatty, 2015).

Slightly different stated by Broom and Willis (2007) Positivism is a complex and loaded philosophical concept, but it remains the paradigmatic basis for much health research today. Within the social sciences, the term positivism has been used to criticise natural sciences and scholars who advocate a scientific model. With default, a positivist believes that reality is tangible and that objectivity is possible; as a result, the idea that science is ideologically driven is replaced by the idea that science transcends ideology - a pretty circular reasoning.

b. Constructivism or Interpretivism Paradigm

The Interpretivism paradigm was “response to the dominance of excessive positivism” (Grix, 2004). This paradigm refutes the idea that a single, verifiable reality exists that relates to our senses. Interpretative Ontology is anti-foundation. That is an approach in which believe that there is some fundamental belief or principle which is a basic foundation approach as the where of inquiry and knowledge. Colin (2010) states that Interpretivism relates to the philosophical position of subjectivism and is applied to classify various approaches, including social constructivism, phenomenology and hermeneutics; these approaches refuse the

objectivists' view that resides within the world of independent consciousness.

Constructivists or interpretivists, Khawulich et al. (2012) underline that reality as being constructed on the assumption that there are many realities. Knowledge is subjective and idiographic and truth is dependent upon the context. This paradigm is value-led and focuses on the fact that values influence how we think and behave and what we find important.

In addition, Kuwalich (2015) explains that constructivists or interpretivists see reality as socially constructed and view that there are many realities. Knowledge is subjective, idiographic and truth depends on the context. This paradigm is full of values and emphasises that values influence the way to think and behave, as well as the important contribution of the results or findings. Generally speaking, methodology relating to constructivist paradigm applies qualitative assessment methods. This research methodology is divided into certain designs, e.g. phenomenology, grounded theory, ethnography, case study, and biography.

c. Advocacy or Participatory Paradigm

This approach is claimed to begin in the 1980s and 1990s from individuals who felt that post-positivists structural laws and theories did not target marginalised individuals or groups or did not adequately deal with social justice issues (Creswell, 2003). Historically, some of the advocacy or participatory paradigm writers have drawn on the works of Marx, Adorno, Marcuse, Hebermas, and Freire. More recently Kemmis and Wilkinson (1998) can be read on this perspective (Creswell, 2003). These researchers believe that inquiries need to be linked to a political agenda. As such, the research must contain an agenda for action on reform that can change the lives of participants, the institutions where the individuals work or live, and the lives of the researchers. Additionally, specific problems need to be addressed that speak about the important issues of that time, like issues about empowerment, inequality, oppression, domination, and suppression.

Recent writers include Rorty (1990), Patton (1990) and Cherryholmes (1992). There are many forms of pragmatism. They claim that knowledge arises out of actions (as in positivism). There is a focus on what is conducted and on the solutions of the problems (Creswell, 2003). It is very important to be aware of pragmatic paradigm problems and how to resolve them. Researchers can use some approaches to understand the problems in order to observe and analyse. Therefore, the founder of this philosophy believes that mixed method studies are appropriate for this paradigm as cited by Creswell (2003) who explored some opinions of Rosman and Wilson (1985), Tashakkori and Teddlie (1998) also Patton (1990) who captured the essence of concerns on the research problems in social science studies and who applied pluralistic approaches to derive knowledge about the problems.

Pragmatism research philosophies accept concepts that are relevant only if they support their actions. Pragmatics recognise that there are various ways to interpret the world and conduct research, and that no single point of view can provide an overall picture that is rational in their opinion (Saunders, *et.al*. 2012). More details of pragmatism with positivism and interpretivism are described below:

Table-16 Pragmatism Research Philosophy

Research Philosophy	**Research Approach**	**Ontology**	**Axiology**	**Research Strategy**
Positivism	Deductive	Objective	Value-free	Quantitative
Interpretivism	Inductive	Subjective	Subjective	Qualitative
Pragmatism	Deductive or Inductive	Objective or Subjective	Value – Free or Subjective or believe based	Quantitative and or qualitative (Mixed Methods)

As illustrated in Table 16, conducting study with pragmatism research philosophy allows integrating multiple research methods such as qualitative, quantitative and action research methods. Positivism research philosophy is associated with deductive research approach, and interpretivism that relates to the inductive research approach. Inductive research approach as defined by Trochim (2006) starts from specific to

general patterns, whilst temporary deduction begins with general and ends with specifics; arguments based on experience or observations are best expressed inductively, whereas arguments based on laws, rules, or others are broadly best expressed deductively. Creswell and Plano Clark (2007), state that “the deductive researcher “works from ‘top down’, from a theory to hypotheses to data”. Concerning the references, deductive usually applies quantitative research strategy and inductive often uses qualitative research method. Deductive and Inductive research approaches can also be both integrated into the mixed methods study. Even so, the research methodology and methods are illustrated more in details by Creswell (2014):

Table-17 Research Philosophy, Methodology and Methods

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Source: Creswell (2014)

As we are seen for table 17, Research Methods can be classified into quantitative, qualitative and mixed approaches.

1. A quantitative approach is one in which the investigator primarily uses post positivist claims to develop knowledge: the cause and effect thinking, the reduction of specific variables and hypotheses and questions, the use of measurement and observation, the test of theories; the employment of strategies of inquiry, like experiments and surveys and data collection on predetermined instruments that result into statistical data.

2. Alternatively, a qualitative approach is one in which the inquirer often makes knowledge claims based primarily on constructivist perspectives, for example the multiple meanings of individual experiences, socially and historically constructed meanings, with an intent of developing a theory or pattern or advocacy/participatory perspectives (political, issue-oriented, collaborative, or change oriented) or mixed. It also uses strategies of inquiry such as narratives, phenomenologists, ethnographies, grounded theory studies, or case studies. The researcher collects open-ended, emerging data with the primary intent of developing themes from the data.

3. Finally, a mixed methods approach is one in which the researcher tends to base knowledge claims on pragmatic grounds (consequence-oriented, problem-centred, and pluralistic). It employs strategies of inquiry that involve collecting data either simultaneously or sequentially.

   Based on the types of research approaches, one can conclude that there are three broad research methods, quantitative, qualitative and mixed methods. The researcher need to select one of the research approaches which is most appropriate for the research inquiries, objectives and scientific discipline as well as the contribution that it can give back to science and society.

In order to decide on the appropriate methods, Creswell (2003) suggests the use of the criteria as below:

- Match the methods to the research problems; quantitative method is most appropriate for problems where trends or explanations need to be made. Qualitative method are be used for problems that need to be explored to obtain a better understanding.
- Integrate the approach to the researcher`s experience, the method chosen must relate to the personal experience and training of the researcher.
- Finally, it is important to remember the prospective audience who will read and use the findings from the research and to fit the approach with that audience

Referring to the explanation of research philosophy above the ontology aspect in this study refers to determining the implementation of Indonesia's health insurance programme. In this chapter has considered the underlying research philosophy and associated epistemological, ontological methodological consideration that have shaped the thinking on the most effective research methods to employ in underlying this research into the implementation of the social health insurance programme before, and when the new scheme was inaugurated by the Indonesian government.

Furthermore, epistemology aspect is also reflected in the pragmatism paradigm in this research (Dudovskiy, 2018) emphasises that pragmatism paradigm can mix both positivist and interpretivist positions within the scope of a single

research that relates to the nature of the research question. Relating to the reference mentioned by Dudosky, mixed methods design is applied to this study. Primary data is collected using qualitative method, and secondary data collected by quantitative approach.

In my view, Ontology and Epistemology provide a holistic understanding of knowledge is regarded, how we can see ourselves in relation to the methodological strategies we use to uncover or discover. Awareness of philosophical assumption will improve the quality of study and contribute to the creativity of the researcher.

4.2.3. Axiology

Axiology is concerned with the nature of ethical behaviour and what the researchers think to be desirable and ethical. When undertaking research, striking a balance between the research's aims, the values the researcher seeks to attain and any additional ethical concerns that may arise during the research needs to be considered (Killman, 2013).

Axiology is a discipline of philosophy dealing with aesthetics, ethics, and judgments. This method incorporates the social inquiry process. The axiological skill of researchers is used to make decisions about the research subject and methodology. Researchers' philosophical approach, for example, is represented in their values as well as their research activity, particularly in the field of data collecting and data analysis techniques.

According to the concept of Axiology, this research was conducted in accordance with ethics and research procedures, related to the flow and process of ethics researchers discussed specifically in sub Chapter 4.3., Ethics consideration. Ethics research is carried out not only to respect, protect respondents from adverse impacts, even though this research is not harmful. However, the researcher ensures that all information to be extracted is in accordance with correct and human research principles, such as the time of the interview, ethics when collecting data, and the freedom to withdraw if the respondent objected to participating in the research. In this study, validity and reliability tests were also

carried out to ensure the validity and reliability of the data obtained. So that the research results are free from bias, and the results of the contributions from the research can be accepted by stakeholders related to the implementation of UHC in Indonesia.

4.3. Research strategy

Choosing a suitable research strategy is critical to ensure that research questions are answered in a way that is both valuable and consistent with the overall topic, questions, and study purpose" (Walshe et al., 2004). In line with Saunders, et al. (2009), most research methodologies are deductive in nature. While allocating strategies is necessary, the author also noted that it is crucial to remember that there is no superior or worse strategy; all strategies are important to every researcher; nonetheless, their application will be wholly dependent on the researcher's field of study. Research strategies should not be restricted to one strategy per study; it is also possible that survey strategy can be as part of case study.

Related to the research strategy, this research uses a Mixed Methods research strategy. This research uses mixed methods as an attempt to provide an evaluation that can contribute to policymakers' understanding on how to improve the implementation of UHC in Indonesia. Besides, this study applies a comprehensive: Contexts, Inputs, Processes, and Outputs (CIPP) Model Evaluation. So, the findings of this research are deemed to be more inclusive.

4.3.1. Mixed Methods as Research approach and justification

Based on the research philosophy discussed in the previous sections which also refer to the research questions, a mixed-method approach was used in this study. As defined by Creswell (2003), the mixed method is based on a pragmatist approach and is a consequence-oriented, problem-centred, and pluralistic. Mixed methods use both quantitative and qualitative data collection.

Pointing out from Andrew and Halcomb (2006) that the aim of mixed methods studies is not to replace either qualitative or quantitative research but rather to exploit the strengths and minimalise the weaknesses of both approaches in a single

study. The researcher needs to evaluate the most appropriate methodological approach to answer the specific research question which should clearly explain the rationale for using a mixed-methods design, rather than a singular qualitative or quantitative method.

Moreover, mixed methods research is a method which is based upon a pragmatist belief. This method can use quantitative and qualitative approaches. Once the researcher has decided the mixed methods, the next stage is to select the mixed methods model. According to the mixed methods model there are four major types of mixed methods designs: Triangulation Design, Embedded Design, and Explanatory Design and Exploratory Design. Creswell and Plano (2007) describe the types of mixed models approaches as follows:

Creswell and Plano (2007) describe the types of mixed models approaches as follows:

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Figure-11 Types of Mixed Methods Study (Creswell et.al., 2007)

The mixed methods model in Figure 11 can be classified into 4 main designs; each of the models is developed to match some types, such as the triangulation model which can be classified as convergence model, data transformation, and validation of quantitative model. Embedded or Nested model is divided into experimental and correlation model. Explanatory design has two branches: follow-up and participant model. Finally, exploratory design is classified as an instrument development model and taxonomy development design.

a. Triangulation Design

   The triangulation design is the most common and well-known design. This method was previously known as concurrent triangulation design (Creswell. 2003).

   The quantitative and qualitative phases develop simultaneously. Both designs are usually given equal value. The traditional model of triangulation mixed methods design is the convergence model whereby the integration occurs during the data collection and after the preliminary analyses when the data are transformed either by quantifying qualitative data or by qualifying quantitative results. The triangulation design is classified into 3 designs: convergent model, data transformation design and validation of qualitative model.

   Applying the triangulation convergence model, the researcher collects and analyses quantitative and qualitative data separately on the same phenomenon and the different results are converged (by comparing the different results) during the interpretation. This design can be used when the researcher's purpose is to compare results or validate, confirm or integrate quantitative results with qualitative findings. The aim of this model is to come up with a well-substantiated conclusion about a single phenomenon.

   The triangulation transformation model involves collection and analysis of different quantitative and qualitative data. Nonetheless, after preliminary

analysis, the researcher uses procedures to transform one data type into another type of data. This is accomplished by either quantifying qualitative findings or qualifying quantitative results (Creswell, 2006).

Triangulation validating quantitative model is used when the researcher develops the quantitative findings from a survey by including a few open-ended qualitative questions. In this model, the researcher collects quantitative and qualitative data in one survey instrument. Because qualitative points are an add-on to a quantitative survey, the items do not commonly produce a rigorous qualitative data set. Yet, the researcher provides interesting quotes that can be used to validate quantitative survey findings. Finally, the fourth model of triangulation design is the triangulation multilevel model. This model is used in different methods-quantitative and qualitative- to address different levels in a system. The findings from each level are merged into an overall interpretation (Creswell, 2006).

b. Embedded or Nested Model

The embedded or nested model was first explored by Doyle (2009) which explains that there are 2 data collection approaches on this model, one of which is primary and the other one is secondary or acting as a supporting role. Besides, Terrell (2012) underscores that the main purpose of this method is to develop a wider perspective than using only predominant data collection method. This model enables the researcher to address different research questions or to receive information from different groups or levels in an organisation. Embedded or nested model has 2 designs; Experimental model and Correlation model.

Experimental model is the most common variant of the embedded design which focuses on quantitative methodology with the qualitative as a supporting role (Creswell and Plano, 2007). One of the objectives of qualitative approach used in this model is likely to examine the process

of intervention. The embedded experimental model was formerly known as the concurrent nested mixed methods design (Creswell, et.al. 2003).

Additionally, the Experimental model of the mixed methods design focuses mostly on the quantitative methods rather than qualitative design. This model can be used in research intervention process, like in a programme or organisation. On the other hand, the correlation model addresses qualitative data embedded within a quantitative design to support or explain the outcomes of correlation model.

c. Explanatory Design

The explanatory design defined by Creswell, *et.al.* (2003) as sequential explanatory design, reveals that there are 2 phases in this model: the quantitative phase conducted first then the qualitative phase whose purpose is to explain or enhance the quantitative results. Explanatory design is useful when a researcher needs to develop and test a new instrument (Creswell, 1999; Creswell et al., 2004) or identify important variables to study quantitatively when the variables are unknown. This design is also appropriate when a researcher generates the results from different groups (Morse 1991) to test aspects of an emergent theory or classification Creswell (2006) or to describe a phenomenon in depth and then measure its prevalence.

The explanatory design consists of two models: follow-up model and participant selection model. In the explanatory follow-up model, the researcher identifies specific quantitative findings, such as unexpected results, outliers or differences between groups that need further explanation using qualitative methodology (Creswell, 2003). In the Participant Selection Model, the qualitative phase has priority over the participant selection model, whereby the aim of the quantitative phase is to identify and intentionally select participants.

d. Exploratory Design

The exploratory model is a sequential design whereby the first phase, qualitative, supports the development of quantitative phase. This design is applied for developing and testing instruments (Instrument's development model) or evolving taxonomy (taxonomy developmental model). Priority refers to the quantitative entity of the instrument of development model.

Based on the theories and types of mixed methods model, my study chooses the mixed methods design applying the concurrent embedded model. This design provides a supporting secondary role in studies that are based mainly on other data types (Creswell et.al., 2003). Likewise, Creswell (2009) explains that the embedded concurrent strategy of mixed methods research can be identified using the data collection phase, where both quantitative and qualitative data are collected. In contrast to the traditional triangulation model, a concurrent embedded design employs primary methods that guide a research project and secondary methods that provide a supporting role. Concurrent Embedded Strategy Design is illustrated in the figure below:

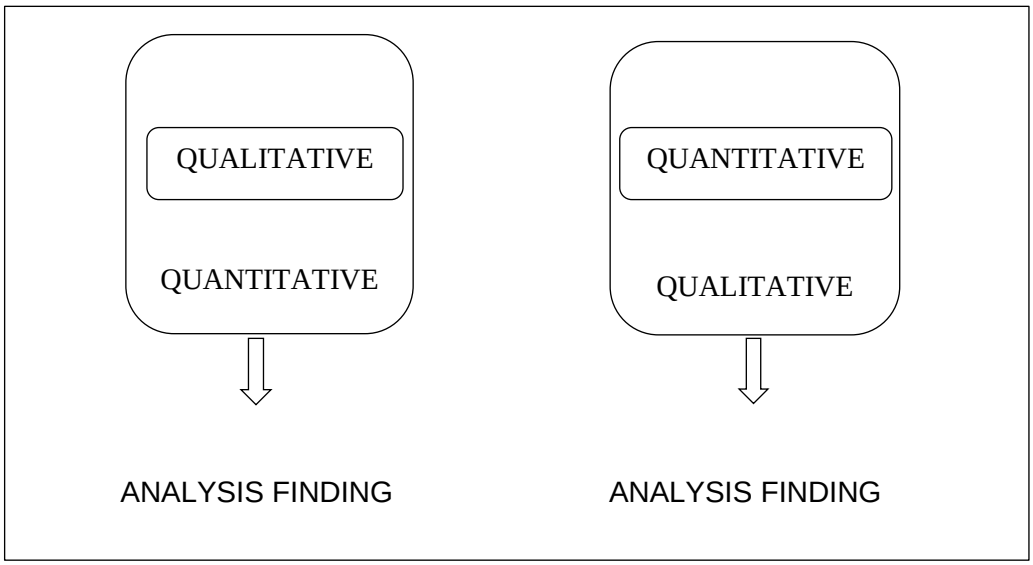

Figure-12 Concurrent Embedded Strategy Design

Concerning the references as illustrated in the diagram (Figure 12) the researcher selects concurrent embedded strategy model in mixed methods study based on these reasons:

- The research in this study is an evaluation research with mixed methods study design
- This study has different research questions and refers to different answers which relate to qualitative and quantitative data
- Data in this study are quantitative and qualitative. Quantitative data is secondary data that the researcher collected through national data access in 2012, 2013, 2015, 2016, 2017 and 2018
- The primary data in this study are qualitative collected through structured in-depth interviews and focus group discussions/FGDs
- The qualitative data in this research are more dominant which steer the research project whereas the quantitative data serve as secondary method that provides a supporting role.

Classification of quantitative and qualitative methods will be discussed further in the next sections.

4.3.2. Research techniques

The research technique in this study is to use quantitative and qualitative methods, to answer the research question with the following description: In more detail, data collection using quantitative, pilot qualitative, sample determination, instruments, validity, reliability, pilot studies to data analysis can be seen in the next section.

4.3.3. Quantitative Method

Quantitative method was used in this study defined by Creswell (2003), Wahyuni (2011) and Burian et.al. (2010). These researchers mainly employ post positivist claims to develop insights, i.e., cause and effect thinking, choosing specific variables, hypotheses and questions, using measurements and observations, and conducting statistical tests of the theories.

In my research quantitative data are obtained using secondary resources on the Indonesia Socio Economic National Survey (Susenas) data that are related to independent and dependent variables. Independent variables include age, gender and educational background, formal and informal employment, economic status, urban and rural region, frequency of illness, and health insurance membership. Dependent variables comprise outpatient and inpatient utilisation. Quantitative data are analysed through correlation regression statistical test and software. The quantitative research design in this study is discussed as follows:

4.3.4. Population and Sample

Population in this research is based on the Indonesia National Socioeconomic Survey data in 2012, 2013, 2014, 2015, 2016, 2017 and 2018. To carry out an analysis of the differences in health insurance membership before and after the JKN era, a series of National Socioeconomic Survey data from 2012 to 2018 is needed, the data record for seven years of data is 7.7 million data, and the variables used in the analysis are 23 variables. To process the data, a capable statistical processing application, such as statistical version 16, is required.

Table-18 the Total population based on the Susenas data in 2012-2018

Year	Total Population
2012	1.114.445
2013	1.094.179
2014	1.098.280
2015	1.097.719
2016	1.109.749
2017	1.132.749
2018	1.131.825
Total	**7.778.946**

The sample was taken from Indonesia National Socioeconomic Survey data in 2012, 2013, 2014, 2015, 2016, 2017 and 2018. The research started in 2012 because that year marks the start of social health insurance transformation- the Indonesian government's National Health Insurance/UHC. The single-payer system began in 2014, therefore this

research evaluates the social health insurance implemented before and after UHC, until 2019 at the time when the road map of UHC achieved 95% coverage of the Indonesian population.

Regarding Indonesia National Socioeconomic Survey data strength; each sample is collected from each regent/city (over 1 million respondents) and is designed to reflect the situation in Indonesia up to regent level. Indonesia National Socioeconomic Survey data is undertaken yearly hence we can see the trend from year to year. This data also has some Weakness; the main objective is to get an overview of the national economic social status hence other measurements are optional. As a consequence, data collected for other issues does not cover everything. The cross sectional study design applied instead of longitudinal results into data trend to be much influenced by respondents' characteristics.

4.3.5. Independent Variables

As explained by Shone (2015), an independent variable is an explanatory variable that is assumed to cause variations in other explanatory variables. The Independent variable in this study is Indonesia's social health insurance programme before and after UHC has been implemented.

Table-19 Defining variables and parameters of Independent variables

Independent Variables	Definitions	Instruments	Parameters	Scales
Social health insurance era	Social health insurance implementation in Indonesia, before and after UHC has been implemented	National Data	0. 2012 – 2013 prior to UHC era 1. 2014 – 2018 UHC era	Nominal

4.3.6. Dependent Variables

Dependent variables are explanatory variables which are assumed to be influenced by independent variables (Shone, 2015). Dependent variable in this research is the social health insurance membership

Table-20 Defining variables and parameters of dependent variables

Dependent Variables	Definitions	Instruments	Parameters	Scales
Health Insurance Membership	This variable is seen from the membership of social health insurance (BPJS *Kesehatan*/other Schemes of Social Health Insurance)	National Data	0. Not covered by National /Out of Pocket 1. Covered by social health insurance	Nominal

4.3.7. Intermediate variables

Intermediate variables serve as a causal link between other variables. The latter can play a role on the dependent variables to make a change (Ananth et al., 2017). Intermediate variables in this research are classified as follows:

Table- 21 Defining variables and parameters of intermediate variables

Intermediate Variables	Definitions	Instruments	Parameters	Scales
Gender		National Data	1 Male 2 Female	Nominal
Age Category		National Data	1. Young age 0-14 2. Productive age 15-65 3. Elderly 66 above	Interval
Educational Attainment	Education classified by formal education level in Indonesia	National data	0. Never attend formal education 1. Elementary school 2. Junior high school 3. High school 4. Higher education/University	Ordinal
Employment Status	Employment of respondents, unemployed and employment	National Data	0. Unemployed 1. Employment	Nominal
Household income	Economic status categorised by quantum matrix with 5 categories:	National Data	1. Quantile 1 2. Quantile 2 3. Quantile 3 4. Quantile 4 5. Quantile 5	Interval

Intermediate Variables	Definitions	Instruments	Parameters	Scales
Territorial status	Respondents living in an urban or rural area	National Data	1. Urban 2. Rural	Nominal
Access for health care service	Respondents who have access to outpatient and inpatient facilities	National Data	1. Outpatient 2. Inpatient	Nominal

The classification of the Independent and the Dependent variables are summarised in this figure below:

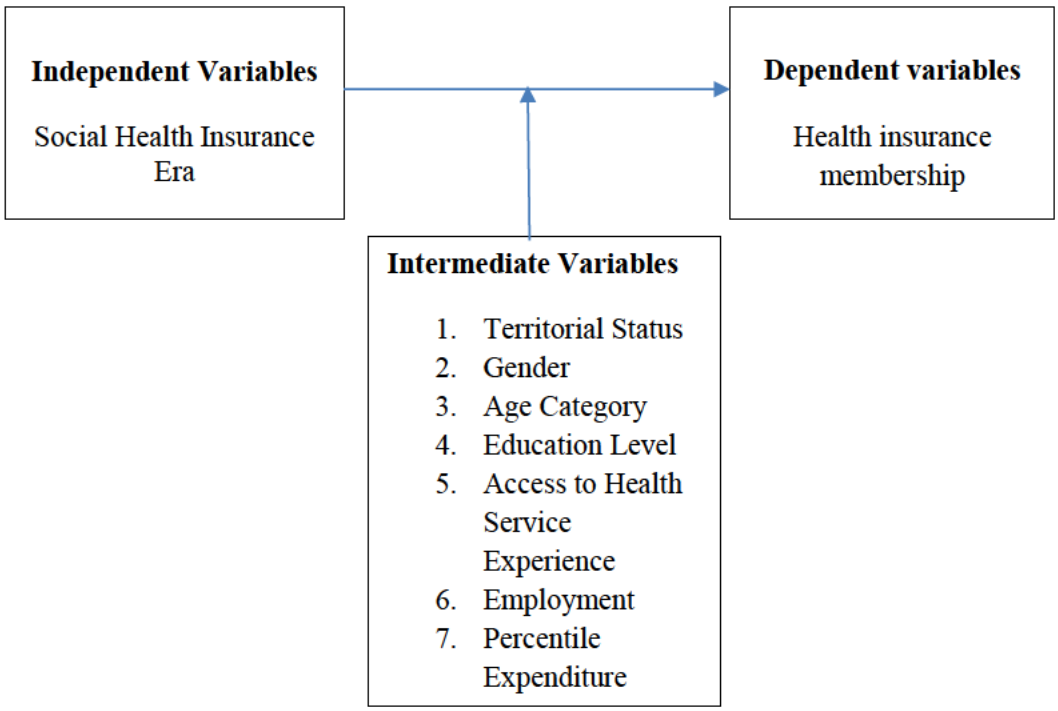

Figure-13 Quantitative Research Design

4.3.8. Quantitative Data Collection and Analysis

Quantitative data in this research are obtained using secondary data resources on the Indonesia National Socioeconomic Survey data 2012 – 2018. Quantitative data are analysed through correlation regression statistic test and STATA software. The STATA application type is special edition,

licence Single-user perpetual with the serial number 12345678910. Quantitative data collection process at a glance is shown in Figure 19:

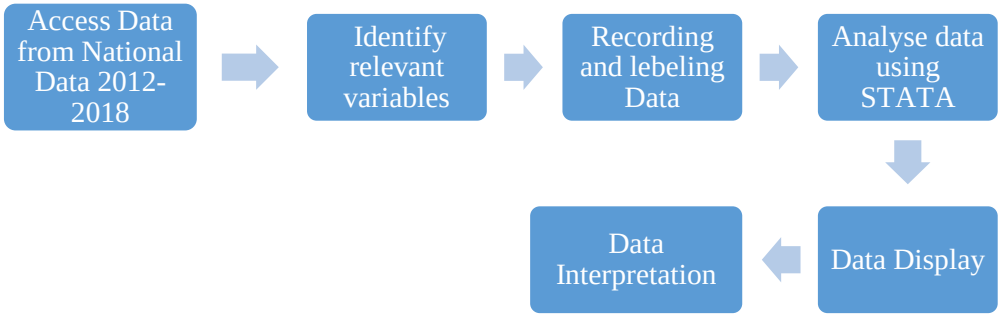

Figure-14 Quantitative Data Collection

Quantitative data are accessed from Indonesia National Data (Susesnas) in the year of 2012 – 2018. Data are clasified based on research variables such independent, dependent and intermediate. Once data have been compiled, these data are sorted based on research variables, then the researcher coded the data, input them into the STATA software programme followed by data analysis using Deference in Differences Analysis (DID). This analysis is generally used to recover interesting causal effects from observational research data - where the experimental design is beyond the control of the researcher (e.g. natural experimentation) and is usually subject to unobserved confounders and some form of selection bias Finally, the data are interpreted and explained based on quantitative results (Kandker et al., 2010).

4.3.9. Qualitative Method Using Context Input Process and Product (CIPP) Model

Evaluation is the assessment to measure the process of a programme or an activity. The result is essential to improve the programme Lopez *et al.* (2007a) explains in more details the concept of evaluation which includes:

- Evaluation is to compare between results and expectations of the programme
- It is to find out the benefits or gains and obstacles during the programme
- It is to find out the solutions to improve programme and achieve positive contributions to the organisation

There are various models of evaluation to review a programme, such as Discrepancy Model, Responsive Evaluation Model, Summative and Formative Models, including the CIPP Model. The qualitative method in this research uses evaluation of Content, Input, Process, and Product/Outcome (CIPP) model of assessment. This model is an evaluation model where the assessment is conducted as a system. This model is a concept proposed by Stufflebeam whereby the critical purpose of the evaluation is not to prove but to improve both formative and summative approaches that are applied (Stufflebeam and McKee 2003). More in details, Stufflebeam explains the CIPP Model component as follows:

- The aim of context evaluation is to provide information systematically that can be used by decision makers to make decisions relating to the establishment of new goals, modification of existing objectives or as a confirmation of present goals. Input evaluation purpose is to identify and assess alternative programme strategies to achieve given objectives and to provide information to assist in designing strategy.
- Input evaluation purpose is to identify and assess alternative programme strategies to achieve given objectives and to provide information to assist in designing strategy.
- Process evaluation is performed to provide information during the implementation stages of a project or programme. In addition, it describes actual activities to achieve targets and objectives of the programme.
- The aim of the product evaluation is related to the outcomes, to obtain and evaluate the overall benefits of the process relating to the impact of the programme.

Context, Input, Product, and Process (CIPP) model is a process that focuses on evaluation model that can be applied at any stage of programme development (Ferris and Devaney, 2017). Evaluation of these results can be divided into assessment of impact (impact), effectiveness (sustainability) and

adaptability (transportability) (Stufflebeam et.al., 2003). The evaluation variables in this study are explained below:

Table-22 Evaluation variables and definition

Context Variables	Definition	Parameter	Data Collection Method	Data Analysis
Government policies and regulations on social health insurance programme	All regulations and policies that have been formulated, agreed by the relevant stakeholders and have been officially endorsed by the government or related agencies (institutions)	The availability of regulations or policies on the implementation of social health insurance in Indonesia at the central, regional and local levels (related institutions)	Documents observation	Formative
The goals of social health insurance programme	The goals that have been formulated by the government and related parties about social health insurance in Indonesia. These objectives are made to be agreed, implemented and achieved	There are clear objectives on social health insurance programme implementation	Documents observation	Formative
Planning of social health insurance programme	Planning of social health insurance programme before and during UHC	Availability of roadmap of social health insurance programme before and during UHC	Documents observation	Formative

Input Variables	Definition	Parameter	Data Collection Method	Data Analysis
Government policies and regulations on social health insurance programme	All regulations and policies that have been formulated, agreed by the relevant stakeholders and have been officially endorsed by the government or related agencies (institutions)	Availability of regulations and documents about social health insurance in Indonesia, before and after UHC - Central level - District level - Internal (institution) regulations	Documents observation In-depth Interviews Focus group discussions	Formative
Demands on social health insurance programme	The terms and needs of the society on social health insurance programme	- Ability to pay (ATP) and willingness to pay (WTP) conducted by DJSN or related stakeholders - Properly premium and benefit package on social health insurance programme	Documents observation In-depth Interviews Focus group discussions	Formative
Supply of social health insurance programme	The efforts of the government and related stakeholders to provide human resources in health sectors, health facilities and	- Adequate human resources in health sectors (primary health facilities, hospitals)	Documents observation In-depth Interviews Focus group discussions	Formative

	infrastructure, including adequate medicine, and health information system	- Facilities based on referral system (inpatient, outpatient) - Enough health facilities (number of primary health service facilities, number of hospitals) - Availability of health service equipment - Adequate medicine - Adequate health information system		
Equity in accessing health service facilities	The terms and needs of the society on social health insurance programme	- The number of community /members of social health insurance - The number of poor people who can access social health insurance	Documents observation In-depth Interviews Focus group discussions	Formative
Enough funding and financial protection	Enough funding for social health insurance programme and the number of people who pay for health services using out of pocket	- Enough funding on social health insurance programme - Number of people who pay health	Documents observation In-depth Interviews Focus group discussions, quantitative method	Formative

	system	service using out of pocket system		
Quality of health services	Appropriate quality of health services by health providers	- Accreditation of health service institutions - Licences of the institutions who have partnerships with BPJS *Kesehatan*	In-depth Interviews Focus group discussions	Formative
Government policies and regulations on social health insurance standards and implementation	All regulations and policies that have been formulated, agreed by the relevant stakeholders and have been officially endorsed by the government or related agencies (institutions)	Implementation of the regulations about social health insurance in Indonesia, before and after UHC • Central level • District level • Internal (institution) regulations	Documents observation In-depth Interviews Focus group discussions	Summative
Demands on social health insurance programme	The terms and needs of the society on social health insurance programme	• The government conducting Ability to pay (ATP) and willingness to pay (WTP) • Properly premium and benefit package on social health insurance programme	Documents observation In-depth Interviews Focus group discussions, quantitative method	Summative

Process Variables	Definition	Parameter	Data Collection Method	Data Analysis
Supply of social health insurance programme	The efforts of the government and related stakeholders to provide human resources in health sectors, health facilities and infrastructure, including adequate medicine, and health information system	In implementing social health insurance, health providers must have: • Adequate human resources in health sectors (primary health facilities, hospitals) • Facilities are based on referral system • (inpatient, outpatient) • Enough health facilities (number of primary health service facilities, number of hospitals) • Availability of health service equipment • Adequate medicine • Adequate health information system	Documents observation In-depth Interviews Focus group discussions	Summative

Output/Product Variables	Definition	Parameter	Data Collection Method	Data Analysis
	for health services using out of pocket system	• Appropriate premium and benefit package	discussions, quantitative method	
Equity in accessing health service facilities	Health services can be accessed by all levels of the Indonesian community including poor people	Health services can be accessed by all levels of the Indonesian community including poor people	Documents observation In-depth Interviews Focus group discussions, quantitative method	Summative, quantitative
Enough funding and financial protection	The cost does not put people at risk of financial hardship	- Providing enough funding on social health and insurance programme for the poor - Appropriate premium and benefit package	Documents observation In-depth Interviews Focus group discussions	Summative
Quality of health services	Appropriate quality of health services by health providers	Patients' satisfaction	Documents observation In-depth Interviews Focus group discussions	Summative

The evaluation of CIPP Model in this study is shown in Figure 14 as follows:

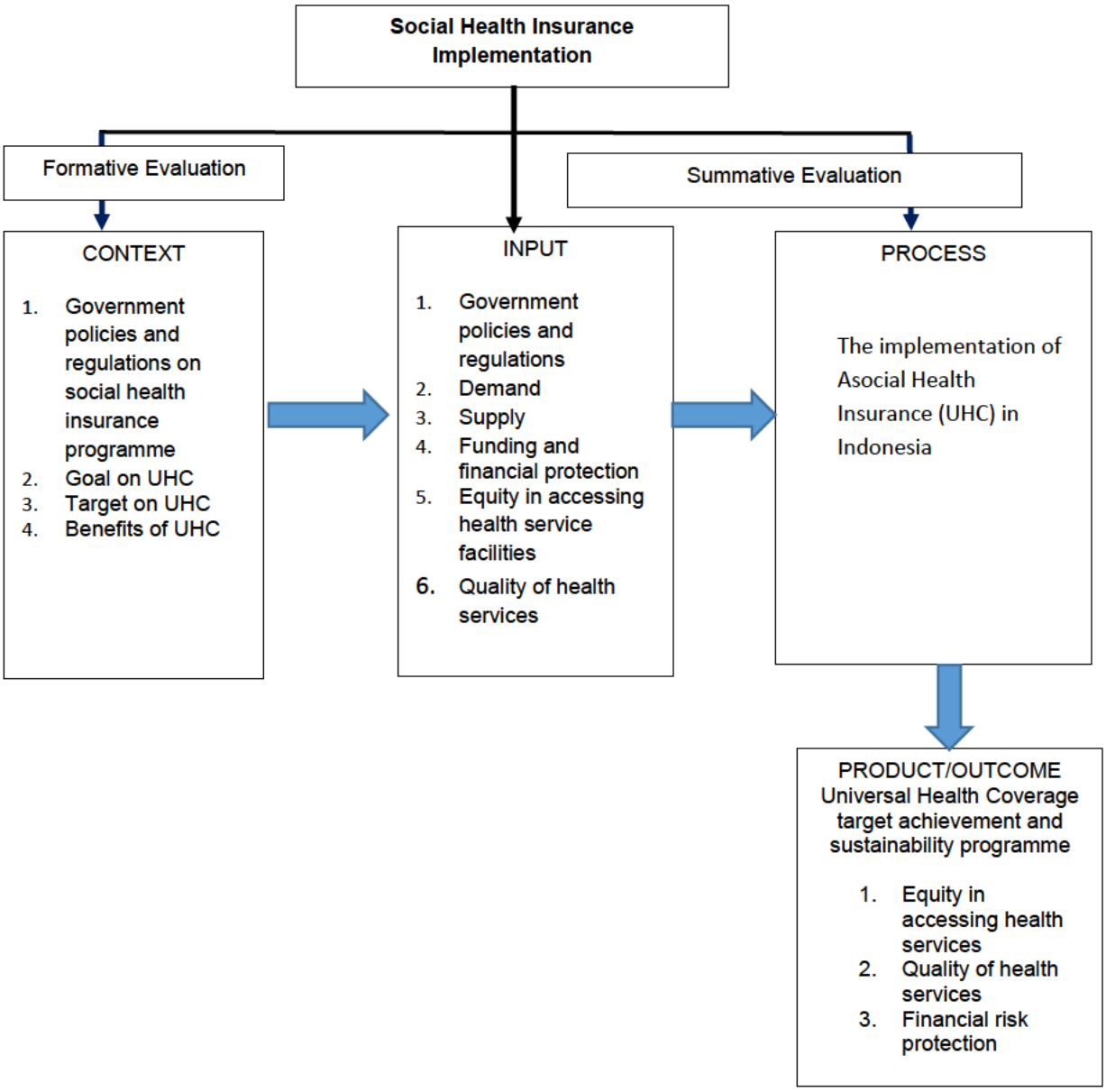

Figure-15 Evaluation Research using (CIPP Model)

The CIPP model evaluation in this study focuses on the Context of Universal Health Coverage UHC (health insurance model of health care in Indonesia) with formative evaluation and inputs of the UHC. The processes and outputs of the programme are evaluated through a summative evaluation.

4.3.10. Research Informants Criteria and Recruitment Process on In-depth Interviews

The informants on this research have been chosen by Stratified Purposeful Sampling. Stratified Purposeful Sampling is a sample within a sample that suggests that technique can be stratified by selecting units or cases relevant to a crucial dimension Patton (2001).

The key informants in this study include members of Health Financing and Health Insurance of the Ministry of Health (MoH), members of the Directorate General of Social Protection and Social Insurance of the Ministry of Social (Welfare), National Security Council (DJSN) and BPJS *Kesehatan* and the health providers from primary health care, public and private hospitals that are knowledgeable about social health insurance schemes and regulations.

Related to the provision of research ethics, respect for the privacy and confidentiality of research subjects is essential. Therefore, for collecting qualitative data in this study, the researcher used a unique code to maintain the confidentiality of the subjects involved in in-depth interviews as follows:

Table- 23 In-depth Interviews Informants' Code

Informant's Code	Representative
S.1.Indepth.DJS	The Board of National Security (DJSN) Stakeholder
S.3.Indepth.HSP.A	Legal Compliance and Inter-Agency Relations (HARLEG) BPJS Kesehatan Stakeholder
S.3. Indepth.HSP.B	The Referral and Health Care Assurance (JPKR) BPJS Kesehatan r Stakeholder
S.3. Indepth.HSP.C	Health Financing Assurance (JPKP) BPJS Kesehatan Stakeholder
S.4.Indepth. MoH	Centre for Health Financing and Insurance Ministry of Health R. I Stakeholder
S.5.Indepth. MoS	Directorate General of Social Protection and Social Insurance Ministry of Social Welfare Stakeholder
S.6.Indepth.DHY	Yogyakarta District Health Office Stakeholder

Total of In-depth interviews respondents include 7 people. The criteria of informants in this study include:

- The informants' experience in social health insurance before and after UHC
- The informants' involvement in social health insurance programme before and after UHC
- The informants' understanding of social health insurance schemes and regulations

Apropos the criteria of informants, the researcher selected the informants and contacted the institutions to apply for a research permit. The researcher explained the aims of the informants' research, attached all necessary documents, such as research proposal, ethical clearance, and key points of in-depth interviews in the covering letter.

4.3.11. Research Informants Criteria and Recruitment Process in Focus Group Discussions (FGDs)

Besides in-depth interviews, data collection was conducted through focus group discussions. Marshal et.al. (2016) states that focus group discussion is the process of interviewing informants in a focus group which normally consists of 7 to 10 people, minimum is 4 to as large as 12 people. Langford and Donagh (2003) also define focus group discussion as one of the strategies to collect qualitative data based on discussions to find out perceptions of several groups of members relating to specific objectives.

Nineteen people are participating in this study in total. The same as in-depth interviews to respect the confidentiality of respondents' data. Researchers categorize respondents with a unique code as follows:

Table- 24 Focus Groups Discussions Informants' Code

Informant`s Code	Representative
FG.01.STK.D.H.O.Y	District Health Office representative
FG.02.STF.D.H.O. Y	Secretary of District Health Office
FG.03.STK. D.H.0.Y	Health Care Service Devision
FG.04.STK.D.H.O. Y	Section Head of Assurance and Quality Improvement of Health Care
FG.05.STK.D.H.O. Y	Section Head of Primary Health Care Service and Referral
FG.06.STK.D.H.O. Y	Section Head of Family Health and Nutrition (integrated programme)
FG.07.STK.D.H.O. Y	Section Head of Health Administrator of Primary Health Care Service and Referral
FG.08. STKD.H.O.Y	Section Head of Health Administrator of Assurance and Health Quality Improvement
FG.18.STK.U2.PR.H.Y	The Integrated Service Unit (UPT) Puskesmas Umbulharjo
FG.19.STF.U2.PR.H.Y	Insurance and Referral Service Staff of UPT Puskesmas Umbulharjo
FG.16.STK.U1.PR.H.Y	Head of UPT Puskesmas Tegalrejo
FG.17.STF.U1.PR.H.Y	Insurance and Referral Service Staff of UPT Puskesmas Tegalrejo
FG.15.STK.PR.H.Y	The Integrated Service Unit (UPT) Primary Hospital
FG.11.STK.D.H. Y	Yogyakarta District Hospital (RSUD Jogja) representative
FG.12.STF.D.H. Y	Health Insurance Staff of Yogyakarta District Hospital (RSUD Jogja)
FG.09.STK.G.H. Y	DR. Sardjito Public Hospital
FG.10.STF.G.H. Y	Health Insurance Staff of DR. Sardjito Public Hospital representative
FG.14.STK.P.H.Y	Pembina Kesejahteraan Umum (PKU) Muhammadiyah Yogyakarta Hospital representative
FG.14.STF.P.H. Y	Health Insurance Staff of *Pembina Kesejahteraan Umum* (PKU) Muhammadiyah Yogyakarta Hospital

The participants of focus group discussions have been chosen by Stratified Purposeful Sampling. The research subjects are representatives of the Yogyakarta District Health stakeholders and staff and health providers from primary health care (*Puskesmas),* public hospitals (RSUD) and *Pembina Kesejahteraan Umum*

(PKU)/Board of Trustees of General Welfare of Muhammadiyah Yogyakarta Private Hospital and Yogyakarta Public Hospital (RSUP) DR. Sardjito.

4.3.12. Facilitators in the Recruitment Process

There are 3 facilitators who helped the researcher coordinate the FGDs. The criteria for the facilitators in this study are as follows:

1. The facilitators have experience as a researcher especially in qualitative study
2. The facilitators have conducted research on social health insurance programme or health policy programme
3. Have experience as a facilitator in an FGDs
4. The facilitators attended the training programme and the FGDs simulation

After a selection process, three facilitators met the criteria to facilitate FGDs as part of qualitative data collection in this study.

The research coordinator conducted training to the facilitators who had passed the recruitment process. This training was run to explain and coordinate between the research coordinator with the facilitators so that the data collection meets the research procedures, criteria and the research variables.

The training programme was delivered for 4 days from 1:00 PM to 3:00 PM. In the first day; the research coordinator introduced the research programme and distributed the FGDs Guidelines. In the second day; the research coordinator discussed the ethical clearance, such as the participant information sheet, informed consent and instruments. In the third day; the research coordinator discussed the FGDs instruments. In the fourth day the Research Coordinator conducted the FGDs simulation and preparation. Once, the research training had been completed, a simulation was held to ensure that facilitators understood the instruments and were ready to conduct the FGDs.

4.3.13. Validity of Data

The data validation is achieved through triangulation qualitative data sources. Patton (2002) states that triangulation sources is a method of comparing and cross-checking the consistency of participants at different times and by different means within the qualitative method. On this point, the research uses internal and external validity:

- Internal validity within triangulation data sources is comparing perspectives of key informants from different points of view such as how the Ministry of Health key informants expressed the social health insurance programme. The same applies to the Ministry of Social Affairs, DJSN, BPJS *Kesehatan*, and the health care providers. Consistency of what the key informants expressed is one important indicator in this method.
- External validity is ensured through existing documentation description based on in-depth interviews. In addition, external validity is achieved during the triangulation process and confirmation from various sources of references and feedback from experts.

4.3.14. Pilot Study Process

The pilot study was undertaken through in-depth interviews with three people with experience in research methodology and social health insurance in Indonesia. Apart from interviews, experts provided some feedback on the research instruments used. The feedback from the informants is as follows:

Table- 25 Instruments feedback from experts on Social Health Insurance

Informants Code	Feedback
S.1.PS	• Time management to conduct in-depth interviews and FGDs. The informants recommended time span between 30 - 45 minutes for in-depth interviews and maximum 60 minutes for FGDs. • Make the instruments easy to understand, i.e.: In-depth interviews and FGD sub-topic: Sub-topic A, Input **on Social Health Insurance (A1-A3) question no 3.** Add people who were involved in coordination when conducting planning on UHC

	implementation. The question should be clearer: **How did DR. Sardjito public hospital coordinate the planning of the implementation of UHC? Who was involved in such activity?** In-depth interviews sub-topic **Process (Implementation) of Social Health Insurance Programme,** question no. 3; "Please explain the relevance of social health insurance programme to other programmes implemented by DJSN *Kesehatan.* Give an example, like Sustainability Development Goals/SDGs". The question should be revised as follows: **"Please explain the relevance of social health insurance programme to other programmes implemented by DJSN *Kesehatan* (such as: Sustainability Development Goals/SDGs)"** • Give an example also in In-depth Interviews, **Sub-topic B. Process (Implementation) of Social Health Insurance Programme, Question no.4** about BPJS *Kesehatan* mechanism to conduct monitoring and evaluation on social health insurance programme • The question should be revised as follows: "Please explain the mechanism of BPJS *Kesehatan* in monitoring and evaluating social health insurance programme (such as: Utilisation Review)" • **Regarding FGD instrument Sub B. Process (Implementation) of Social Health Insurance Programme, question no 2 about social socialisation on health insurance implementation in the society.** This question is difficult to answer by the interviewees from hospitals, because they usually give socialisation only to patients. Hence, make a clear context to the community.
S.2.PS	• Provide key points relating to the questions Sub-Topic A, Input **on Social Health Insurance (A1-A3) number 2** about the transformation era. Number 4, process transformation before and after national health insurance implementation (UHC) in Indonesia. Sub-topic B, question number 1 regarding the efforts of the institution to implement social health insurance • Inform the institution (interviewees) before the in-depth interviews or FGDs to bring or check secondary data, such as, inpatient or outpatient utilisation, referral data, kinds of diseases, such as sub-topic, **A.2. Demand on Social Health Insurance Programme questions number 4, 5, and 6.**

	• Inform the interviewees before the researcher conducts the in-depth interviews or FGDs. The interviewees to check secondary data relating to the Quality Adjusted Life a years (QALYs) and Disability Adjusted Life a years (DALYs) secondary data. This data is relevant to the in-depth interview and FGD **sub-topic c. Outcome on Social Health Insurance Programme; questions no 3 and 4** • Probe the question regarding funding, such as in sub-topic **A.3. Supply on Social Health Insurance Programme, question number 1 about the** terms of financial resources in the implementation of social health insurance prior to and after the implementation of UHC. Also, question number 1b about funding on social health insurance. Questions that relate to finance are difficult to be answered openly.
S.3.PS	• Manage the time carefully in sub-topic **B. Process (Implementation) of Social Health Insurance Programme, question number 1 and sub-question number 1a, b, c, d, e, and f regarding** the efforts of the institution to implement social health insurance and the sub question about the supply context. • Consider the same questions with the same points as in sub-topic A. **Regulations and Policy on Social Health Insurance Programme, question number 3** about the planning of implementation of social health insurance programme**.** This question is like s**ub- topic B. Process (Implementation) of Social Health Insurance Programme,** question number 1 that relates to the implementation programme before and after UHC. This question enables the interviewees to provide the same explanation. • Ensure the outcome questions of in-depth interviews and FGDs **sub- topic C. Outcome on Social Health Insurance Programme, match** the research questions and programme outcomes to achieve health insurance membership targets, access to health services and facilities, health care quality, and financial risks. • Probe **sub-topic C. Outcome on Social Health Insurance Programme question number 6** relates to the sustainability programme of social health insurance in Indonesia, suggestions and expectations.

Feedback from the experts was very useful in develop these appropriate instruments. Therefore, the researcher revised some questions of the in-depth interviews and FGDs to incorporate the experts' feedback particularly on time management, overlapping questions, giving examples on points that had to be

explored more in depth by the interviewees. After adjusting a few points following the inputs from the experts, the researcher asked the supervisors to review the instruments in more detail. Once, the supervisors agreed then the instruments were submitted to the Ethics Committee for approval. The researcher then applied for a research permit and data collection process in Indonesia once the Ethics Team at Coventry University had approved the ethical clearance.

4.3.15. Qualitative Data Collection

"The qualitative data collection conducted during in-depth interviews and FGDs Catherine et.al. (2016) describe In-depth interviews as a construct site knowledge", where two or more people discuss the same topic of interest. In-depth interviews in this study were conducted with members of Health Financing and Health Insurance of the Ministry of Health (MoH), members of the Directorate General of Social Protection and Social Insurance of the Ministry of Social Welfare, National Security Council (DJSN) and BPJS *Kesehatan,* members of Health Financing and Social Insurance the Provincial Health Office of Yogyakarta Special District. The consideration to choose Yogyakarta is because this province has various policies in implementing District Social Health Insurance Scheme, such as City Health Insurance/*Jaminan Kesehatan Kota* (Jamkesta), District Health Insurance/*Jaminan Kesehatan Daerah* (Jamkesda), and Social Health Insurance/ *Jaminan Kesehatan Sosial* (Jamkesos).

FGDs members in this research are representatives of the Yogyakarta District Health stakeholders including staff and health providers from primary health care (*Puskesmas*), public hospitals/*Rumah Sakit Umum Daerah* (RSUD) and the Board of Trustees of General Welfare/*Pembina Kesejahteraan Umum (*PKU) Muhammadiyah Yogyakarta Private Hospital and Yogyakarta Public Hospital (RSUP) DR. Sardjito.

As explained by Wilig (2008), semi-structured interviews state that these interviews combine features from formal and informal interviews on personal experience that could lead to unexpected results and enhance findings. Process of qualitative data collection was conducted in two provinces in Indonesia; Jakarta and Yogyakarta. The process started in the third week of August 2019, after the research permit from Indonesia had been granted.

4.3.16. Qualitative Data Analysis

Qualitative data was analysed utilising Computer-Assisted Qualitative Data Software (CAQDS). This software can assist the researcher although the researcher also needs to exercise flexibility, creativity, insight and intuition (Denzin & Lincolin, 2005 in Shone 2015). As to the reference, N-Vivo only supports data analysis process that is more structured, but the researcher is responsible for sorting out the data, transcribing, and analysing them systematically. Figure 16 reflects the data analysis process in this study:

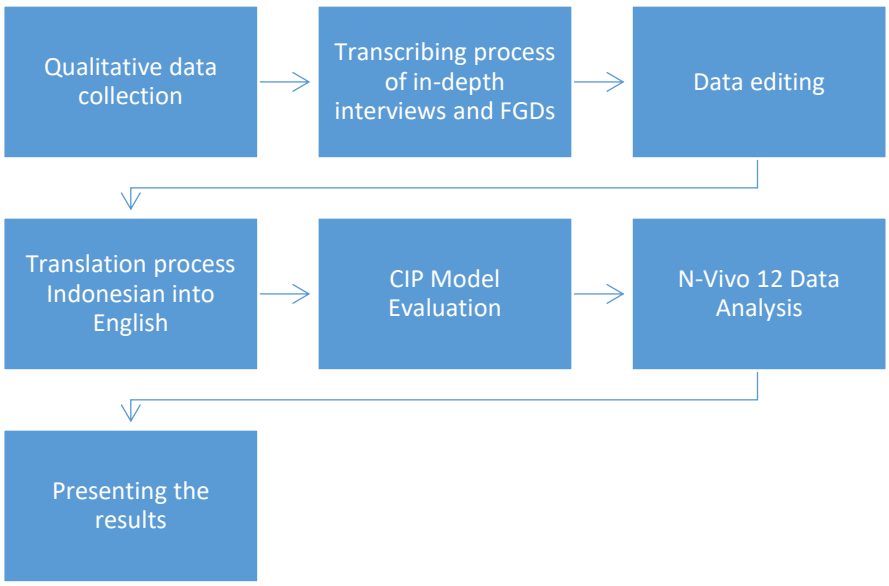

Figure-16 Qualitative Data Collection Process and Analysis

Data analysis in this study was conducted using N-Vivo software, including other processes relating to the data from the beginning of the study: collecting all available data from various sources at the start of study, namely from observations, transcribing

process of in-depth interviews and FGDs, data editing, note taking and documenting the results, checking the validity of the data then presenting them in a narrative form. The transcribing process was very challenging, because many abbreviations needed to be clarified, such as NICU (Neonatal Intensive Care Unit) PICU (Paediatrics Intensive Care Unit), CIC (Consultant Intensive Care), and others. To resolve this, the researcher checked the medical dictionary and other literature which enabled him or her to provide clear definition. Additionally, the translation took more than 3 weeks. The researcher uses the mixed methods concurrent embedded procedure to combine quantitative and qualitative data analysis as illustrated in this table below:

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Figure 17 Concurrent embedded model data collection and analysis, modified from Creswell (2015)

Quantitative data and qualitative data were collected at the same time. Yet, the quantitative data in this study serve as secondary role to the qualitative data which are more dominant. The process analysis of quantitative data through statistical correlation regression and qualitative data is analysed using CIPP

model (Formative and Summative analysis) merging quantitative and qualitative data using the concurrent embedded model.

The research was carried out after receiving the approval from the Research Ethics Committee at Coventry University. Hence, this research was conducted in accordance with scientific principles of accountability. Further explanation regarding ethical clearance will be discussed in the ethical consideration section.

4.4. Ethical Consideration

Ethical clearance is needed to ensure the legitimacy and efficacy of research process, such as accessing and collecting data, involvement of people in the organisation, publication of results or findings, informed consent and confidentiality. Silverman (2000) points out the essentials of ethical consideration for the researcher before and after conducting the research, because when the researcher undertakes his or her project, he or she invades the participants' privacy. Creswell (2003) states ethical consideration as a responsibility of the researcher to respect the rights, needs, values and desires of the participants.

Research ethics has various principles, but four main principles are essential for researchers: respect for human dignity, respect for the privacy and confidentiality of research subjects (respect for privacy and confidentiality), fairness and inclusiveness respect for privacy and confidentiality, justice, and inclusiveness, and considering the benefits and harms (balancing harms and benefits) (Polit and Beck, 2004). In this study, the applications of these four aspects are:

1. The researcher considers the subjects' rights to obtain available information related to the research, has the freedom to make choices, and is free from coercion to participate in research activities (autonomy). Several actions related to the principle of respecting human dignity are: the researcher prepares an informed consent form and participant information sheet consisting of: (1) an explanation of the benefits of the research; (2) explanation of possible risks and inconveniences that may arise; (3) explanation of the benefits to be obtained; (4) the approval of the researcher who can answer every question asked by the

subject related to the research procedure; (5) subject's consent can withdraw at any time; and (6) guarantee of anonymity and confidentiality. In this case, the researcher uses a unique code to ensure the anonymity and confidentiality of respondents.

2. Researcher pays attention to the privacy and confidentiality of research subjects. In its application, researchers do not display information about the identity of both the name and address of the issue in the questionnaire and any measuring tools to maintain the anonymity and confidentiality of the subject's identity. Researchers in this case use coding (initials or identification numbers) as a substitute for the respondent's identity.
3. Regarding respect for justice and inclusiveness, this research is carried out honestly, carefully, professionally, with humanity. It pays attention to accuracy, thoroughness, accuracy, closeness, psychological and religious feelings of research subjects. The research environment is conditioned to meet the principle of justice and inclusiveness, namely the clarity of research procedures. Justice has various theories, but the most important is how the benefits and burdens should be distributed among the community group members. The principle of equity emphasizes the extent to which research policies distribute advantages and disadvantages equitably or according to the needs, abilities, contributions and free choices of society.

The research carried out this study is in accordance with research procedures to obtain useful results for research subjects and could be generalized at the population level (beneficence). Researchers minimize the adverse impact on the subject (non-maleficence). The research procedure in this study refers to the Coventry University Ethic Guidelines with the following flow of ethical submissions:

The ethical process in this study is addressed as follows:

- Creating an account on Coventry University Ethics website (using username and password)
- Completing all forms, including research objectives, descriptions and methodology

- Defining personal data
- Data collection clearance
- Getting informed consent from all participants, respecting confidentiality
- Designing bilingual instruments (English and Indonesian)
- Conducting a pilot study to ensure that the instruments are feasible to use for data collection
- Assuring data security including research data management and protection
- Completing travel assessment documents and making sure that the researcher has his or her own health insurance and travel insurance covered by Coventry University when conducting research in Indonesia.

Once the content details above had been completed, the research protocol was submitted and reviewed by the Ethics Committee at Coventry University. The researcher waited for the review process, revised the research protocols incorporating any feedback. Afterwards, the researcher resubmitted until the results were available and a formal certificate to conduct the research was awarded.

The research was undertaken in Indonesia after obtaining ethical clearance from Coventry University. Next the researcher applied for a research permit in Indonesia. The flowchart for proposing research permit in Indonesia is described as follows:

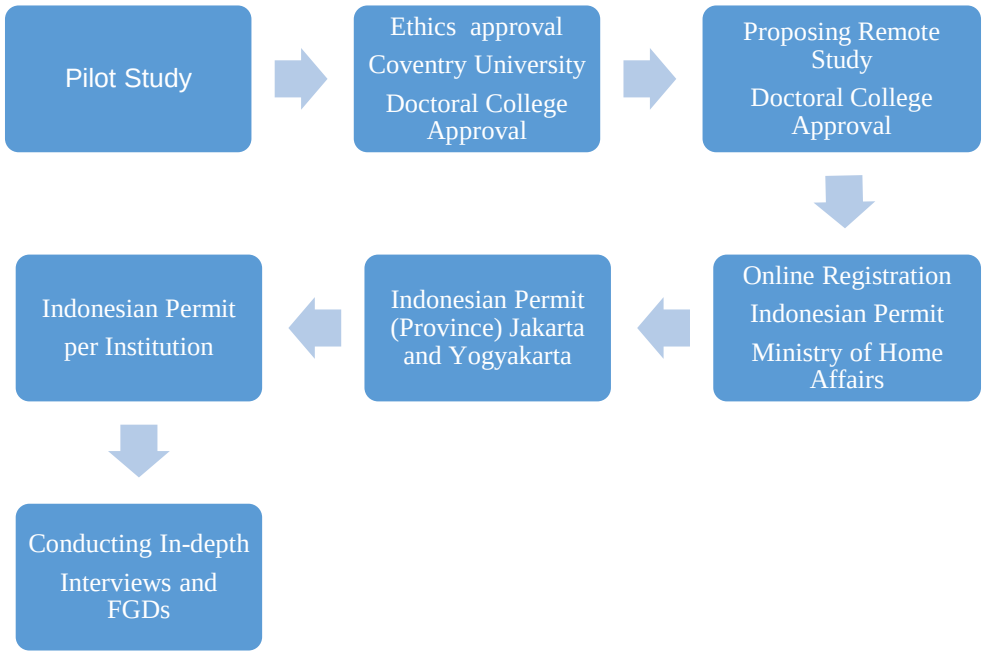

Figure-18 Flowcharts for Proposing Research Permit in Indonesia

Based on Figure 18, the researcher conducted a pilot study before uploading ethical protocols onto the Coventry website. Pilot study had been performed through in-depth interviews with 3 resource persons with experience in health policy and social insurance in Indonesia. Besides the interview, the experts provided some feedback on research instruments. The researcher proposed a remote study with the Doctoral College after ethical clearance had been given.

In addition, the researcher applied for a research permit to the Ministry of Home Affairs of the Republic of Indonesia through online registration at https://ula.kemendagri.go.id. After all the necessary documents are in order, the researcher sent a formal letter requesting a research permit to the Ministry of Home Affairs of the Republic of Indonesia.

4.5. Qualitative Data Collections Process

Qualitative data collection in this study used in-depth interviews and FGDs. The process of qualitative data collection was conducted in two provinces in Indonesia;

Jakarta and Yogyakarta. The data collection started in the third week of August 2019. The process of in-depth interview and FGDs is explained further in sections 5.2.1.

4.5.1. In-depth Interviews

The researcher started to coordinate with the person in charge of the respective institutions to ensure that the participants were ready to be interviewed. The process of recruiting informants for in-depth interviews varies in terms of time. The quickest response was made by the Ministry of Health, then DJSN. Response from the Ministry of Social Affairs and BPJS Kesehatan was delayed for almost three weeks. After the dates for data collection had been agreed by the informants, the researcher conducted interviews at informants' institutions. Before conducting the interviews, the researcher introduced themselves to the informants, then explained the purpose of the interviews and then the participant information sheet and the consent inform were completed.

There were seven participants there were two who declined to be recorded during the interview process. To keep the data from being missed, researchers conducted interviews and made notes of all the information from the participants. The list of informants who agreed and signed the inform consent is as follows in the table 26:

Table-26 In-depth Interview Informants; Characteristics

Gender		**Age Group**			**Length of Experiences in Social health Insurance (Year)**		
Male	Female	30 - 40	41-50	51-60	5-10	11-20	21-30
3	4	1	4	2	3	3	1

The total respondents are 7 people, the majority of informants were 41-50 years old, and has more than 5 years of experience managing a social health insurance programme. All subjects are permanent staff representing their institutions including DJSN, BPJS Kesehatan, Ministry of Health, Ministry of Social Affairs and Health Office.

The total time for conducting interviews varied, but on average they took 30 to 45 minutes. All informants answered the interview questions clearly. After the interview, some informants were still interested in conducting discussions related to the implementation of UHC. The researcher checked the completeness of the results of the interview before leaving the interview room. The researcher also asked permission for additional data to be collected if appropriate and the informants were willing to be contacted again by the researcher. Beside in-depth interviews, the researcher also conducted FGDs in Yogyakarta. The details of FGDs process is discussed in the next section.

4.5.2. Focus Group Discussions

The FGDs started in the first week of September 2019. Facilitators' recruitment took more than one week. Training and briefing were carried out in the fourth week of September (facilitator's recruitment process is explained on page 144). Afterwards, the researcher coordinated with Yogyakarta District Health Office to invite the participants. The researcher assured that the data had been fully collected before the transcription. When the data transcription was finalised, the researcher continued to analyse the data. The researcher conducted this process and combined the qualitative data results with quantitative data and then interpreted the results. The activities and timeline of gathering data in Indonesia is attached in appendix.

4.5.3. Research Training for The Facilitators

As mentioned previously, in Chapter Four, after a selection process, three facilitators met the criteria to facilitate FGDs as part of qualitative data collection in this study. The researcher conducted training to the facilitators who had completed the recruitment process. This training was conducted in order to explain and coordinate between the research coordinator with the facilitators so that the data collection fills the research aims and the research variables. The training programme was delivered over 4 days from 13pm to 15pm.

Table-27 Training Programme Activities

Date	Venue	Topics
Tuesday September 10th 2019 13.00pm – 15.00pm	Hospital Manajemen Meeting Room University of Ahmad Dahlan Yogyakarta	introduced the research programme
Saturday, 21th September 2019 13.00pm – 15.00pm	Hospital Manajemen Meeting Room University of Ahmad Dahlan Yogyakarta	• Ethical clearance • Participant information sheet • informed consent and research instruments
Monday, 23th September 2019 13.00pm – 15.00pm	Hospital Management Meeting Room University of Ahmad Dahlan Yogyakarta	Research instruments
Wednesday 26th September 2019 13.00pm – 15.30pm	GAIA Hotel Yogyakarta Quarter 1 Meeting Room	Focus Group Discussion Simulation

The research training was conducted and a simulation was held to ensure that all facilitators understood the instruments and were prepared to conduct the FGDs.

4.5.4. Focus Group Discussion Process

In the preparation phase, the researcher coordinated with Yogyakarta District Health Office the participants` recruitment, invitation letter, venue and FGD agenda. The researcher also communicated to ensure the attendance of the participants. In the first coordination with the Yogyakarta District Health Office it was agreed that the implementation of the FGD would be held on 20th September 2019. However, this event was postponed because the majority of participant was involved in the accreditation of health services. Therefore, the event was held on September 26, 2019.

The researcher also conducted FGD simulation with the facilitators and checked all the documents such as instruments, attendance, laptop, LCD Projector, and all the equipment. The meeting room was booked and confirmed by the GAIA Hotel Cosmo manager. Focus Group Discussions were conducted at GAIA COSMO Quarter 1

Meeting room Hotel, Jl. Ipda Tut Harsono No 16 Yogyakarta. This location was easy to access by the participants because this location is near to the Yogyakarta District Health Office, and the City Centre.

The informants of focus group discussions have been chosen by Stratified Purposeful Sampling. The research subjects are representatives of the Yogyakarta District Health stakeholders and staff and health providers from primary health care (*Puskesmas),* public hospitals (RSUD) and *Pembina Kesejahteraan Umum* (PKU)/Board of Trustees of General Welfare of Muhammadiyah Yogyakarta Private Hospital and Yogyakarta Public Hospital (RSUP) DR. Sardjito. Details of the informants and characteristic are as follows:

Table-28 the FGDs Informants and Characteristic

Gender		**Age Group**			**Length of Experiences in Social health Insurance (Year)**	
Male	Female	38-40	41-50	51-60	5-10	11-20
5	14	8	8	4	14	5

The total respondents were 19 people. With regards to the number of informants, the researcher divided the research subjects into four groups based on the institutions (role and function). The first group were from District Health Office, the second group from *Puskesmas* (Primary/Community Health Centre), the third group from private hospitals, and the last group from district and public hospitals.

All participants were present and filled their presence. Majority of were the participants were female (74%) and Male (26%). The study indeed involves more women respondents even though the researcher had reminded the importance of gender balance. Yet in reality the number of human resources who is experiences in social health insurance both before and after UHC is limited. Additionally, most of policy makers where the research was undertaken are women. Considering this factor, the researcher decided to continue with the in-depth interviews and FGDs based on the

respondents' level responsibility and this experience in implementing the programme before and after the transition towards UHC as well experience in managing social insurance in their respective institution in accordance with the criteria stipulated in this study. The average ages of the informants were 38 to 60 years old. Most of them were experienced in the social health insurance for more than ten years. This point was important because participants could compare before UHC and after the implementation of UHC program. The current job of the informants was fulltime Job at their institutions; they had been working in their position for more than five years.

The FGDs agenda began with the opening instruction from the researcher and the Head of Yogyakarta District Health Office. Afterward, the participants introduced their selves, and the researcher introduced the facilitators as well. The researcher explained the research aim and objectives, as well as covering the participant information sheet and the inform consent. The researcher gave the opportunity to the participant to assure their willingness to participate in this research. The participants were able and agreed to sign the consent form. Then the researcher divided the informants into four groups. Each group was guided by one facilitator. The FGDs process took around 45 to 60 minutes.

In general, the FGDs process was conducted successfully. There were no participants who complained and they were happy to be able to express their opinions to improve the UHC sustainability. In essence, they were optimistic about the successful implementation of the UHC program, though they believed these needed to be an evaluation of the UHC implementation and a need for improvements in terms of regulations, funding, information systems, regional authority and implementation of referrals. At the closing ceremony, the researchers thanked the informants, and reviewed all the FGD documents including participants' telephone numbers just in case the research need to contact the informants in the future for further clarification.

4.6. Transcription and Translation Process

After the qualitative data collection had been completed, the researcher transcribed and translation from Indonesian to English. Transcription and translation were carried out by the researcher carefully, because there were many terms that need to be considered such as medical abbreviations, names of diseases, programmes and regulations. Furthermore, In Yogyakarta, some of the informants used their local language such as Javanese to express their opinions. Although this process is quite complicated and took more than three months, the researcher managed to complete all of these processes on time.

CHAPTER FIVE
ANALYSIS RESULTS FROM PRIMARY AND SECONDARY DATA

5.1. Overview

Chapter Five describes the process of qualitative as primary data quantitative analysis secondary data in this study. All the data were aimed to respond to the research question. What has been the various impacts of the implementation of the chosen methods via UHC in Indonesia? Impact refers to how many people have been covered by UHC, which services are covered and who pay out of pocket. Quantitative data was conducted to respond these questions. Quantitative data are accessed from the Indonesia National Socioeconomic Survey data in the year of 2012 – 2018. Data are classified based on research variables such as independent, dependent and intermediate. Once data have been compiled, these data are sorted based on research variables, then the researcher coded the data, input them into the STATA software program followed by data analysis using Difference in Differences Analysis (DID). The result of this quantitative data includes knowing the achievement of participation before and after UHC implementation. Also, to find out whether there are confounding variables that can affect the participation variables in participating in the health social security program, as well as the variables of age, education, occupation, access to health services, territorial status, and percentile expenditure.

The results of qualitative data were collected from the Focus Group Discussions (FGDs) and in-depth interviews. Data were analysed based on context, inputs, processes and outcomes (product)/CIPP analysis model. Qualitative data analysis used N-Vivo software. Primary data obtained from in-depth interviews and FGDs are used to answer research questions number one and two; what has been the impact of the implementation of UHC in Indonesia? Although from the quantitative data the percentage of coverage and health services obtained by the community (UHC`s beneficiaries) can be seen, nonetheless the existence of qualitative data relating to the outputs and outcomes of UHC implementation all for deepest analysis. Likewise with

research question number two; how successful has the introduction and implementation of UHC been in Indonesia? The second research question includes what has worked well and supported the implementation of UHC as well as what has not worked well and what the barriers have been, and the efforts to resolve them. The results of data qualitative data include; Context, Input, Process and Product. Also, the quantitative data related to univariate, bivariate, and DID analysis are interpreted as follow:

5.2. Qualitative Data Analysis

Qualitative data was analysed in summative and formative methods based on the evaluation results of the CIPP Model, which consisted of Context, input, process, and output (product). This qualitative analysis was also assisted by using the N-vivo software for the coding process and grouping of the qualitative results as shown in figure 19:

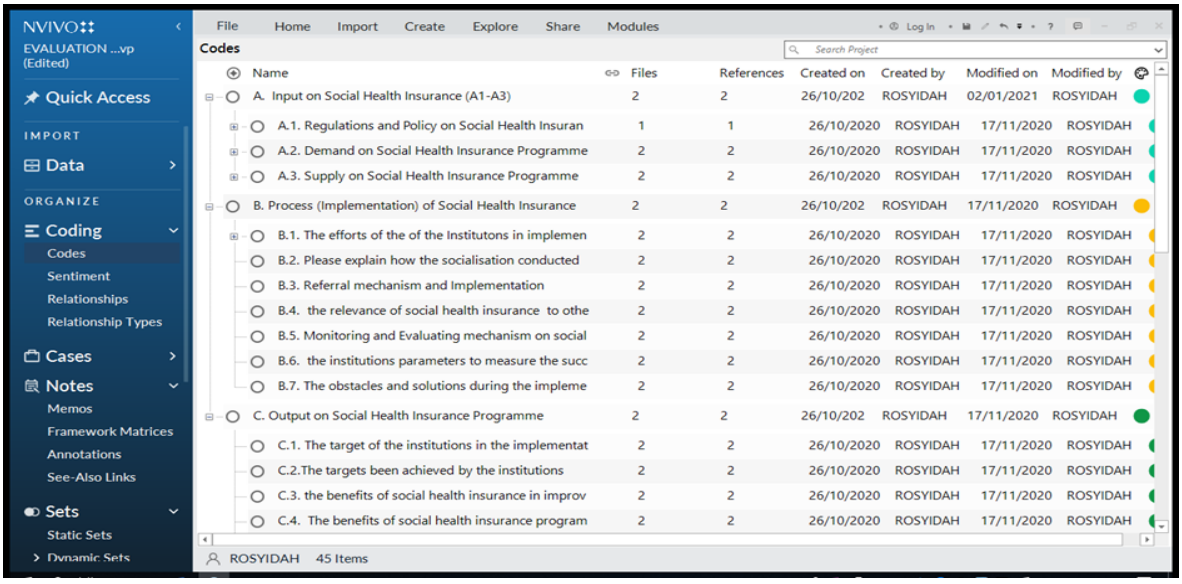

Figure 19 the N-vivo software for the coding process and grouping of the qualitative results

Once coding was done, and then input data process based on the Context, Input, Process and Output components. To simplify the process of searching for documents and interview excerpts, the researcher categorised the menu queries on N-vivo, as shown in figure 20:

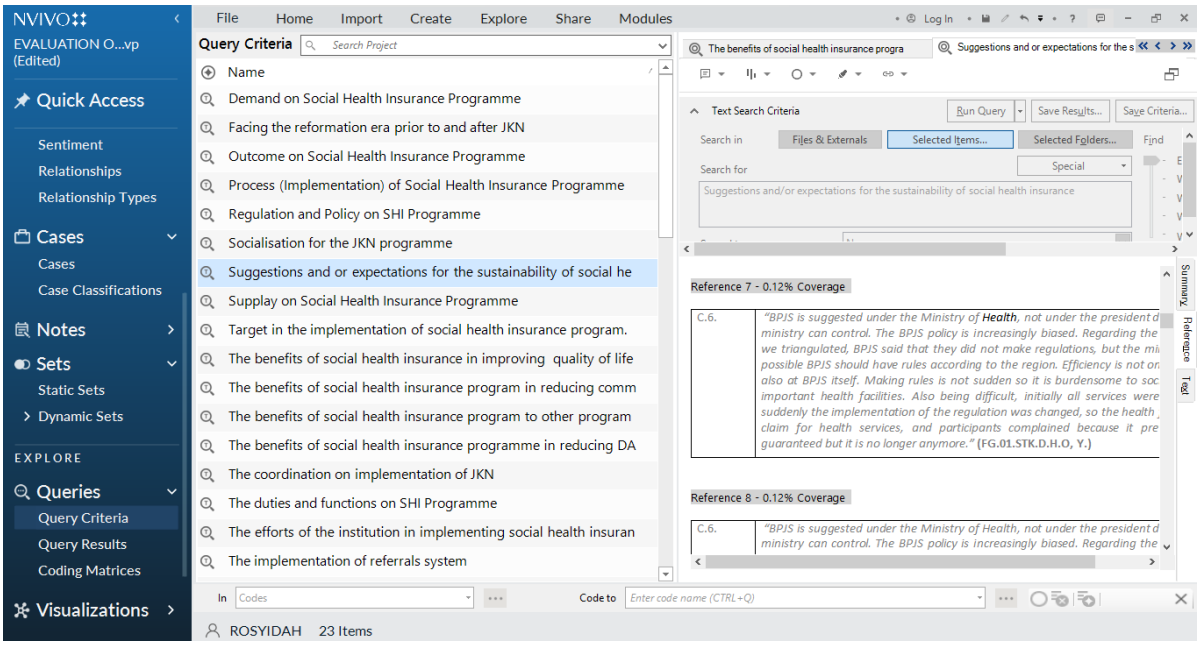

Figure 20 Query Criteria

All documents related to observations, results of in-depth interviews and FGDs are all exported into N-vivo, as the following example in figure 21 shows:

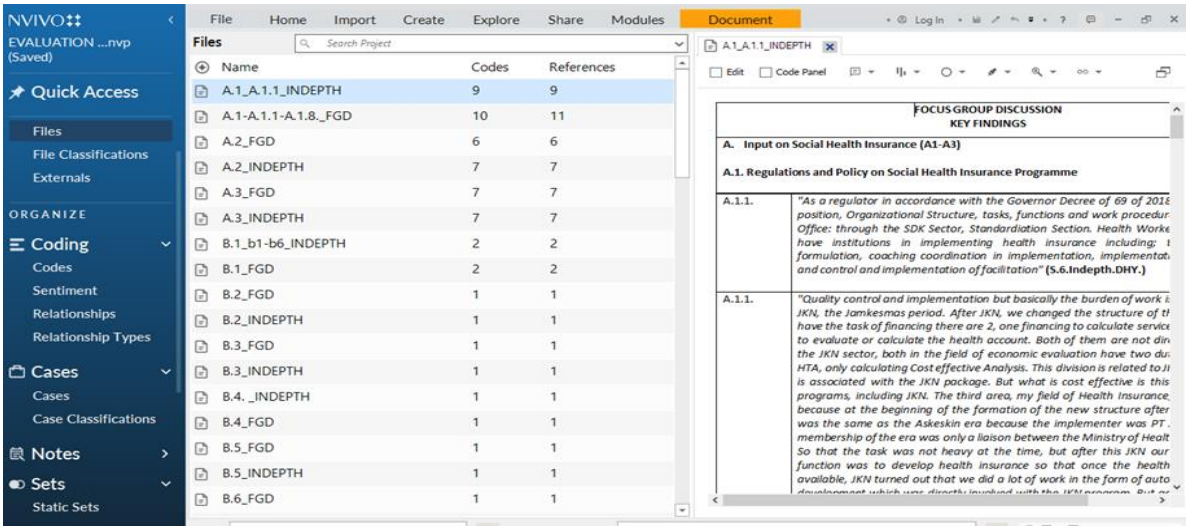

Figure 21 Documents Searching via N-Vivo

Researchers also set up menu queries for each subtitle of each data exported into N-Vivo, making it easier to search when the information is needed. Related to the results

of document observations, interviews and FGDs are discussed in the Chapter qualitative research findings. The results of the qualitative data analysis, it is presented in the following section.

5.3. Qualitative Results Based On Context, Input, Process, and Output (Product) Analysis

The qualitative findings are drawn from the in-depth interviews and FGDs. There are three key points in the interview and FGDs instrument, which includes eight items of questions related to the input, including regulations and policies in the implementation of UHC in Indonesia. There are eight questions about demand and seven items about supply in the era before and after UHC (lists of questions attached in appendix). Furthermore, there are six items in the second key point. The questions related to the process before and after implementation of UHC including obstacles and efforts to solve problems during the transformation. Moreover, there are six questions about the outcome, which include the benefits felt after the UHC program and suggestions for the programme's sustainability

5.3.1. Context before Universal Health Coverage Era

In the evaluation context, document observations related to the goals, targets and benefits and regulations related to UHCbefore the UHC and when the UHC programme has been implementing. The UHC that is observed in this study is UHCwhich is still running in the transition year, namely 2012-2013 before UHC and during this programme is implementing in 2014 -2019. There is an UHC scheme that is intended for low-income people, which is subsidized by the government 100% from regional or central funds. There is UHC which is intended for civil servants, workers, including retirees. As well as UHC for the public whose premium payments varies, for details (see in appendix). UHC in Indonesia before UHC (1968 to 2013) comprised of many schemes. However, all of these schemes can be grouped into insurance that covers civil servants, workers, vulnerable groups, the low income, and the public societies. There is also insurance for pregnant women and delivery. Each health insurance

programme's general objectives are almost the same, namely to provide health insurance coverage for the Indonesian people, increase access to quality health services for all Indonesian citizens and their health standard. For special purposes, the UHCprogramme to improve is depending on the schemes, such as the UHCfor low-income group programmes for the low-income people, the government fully subsidises health care services in primary health care and hospitals, including medicines for the low income people. However, the benefits in accordance with the UHC for low-income group`s scheme, for example, drug standards must be in accordance with the national formulation. The recipients of the UHC for low-income group subsidy are determined based on criteria from the National Statistics Board/ Badan Pusat Statistik Nasional (BPS) data.

While the Universal Delivery Care programme is specifically aimed at pregnant women and childbirth who were not yet covered by any health insurance scheme, the insurance is managed by the regions, such as District Health Insurance and Social Insurance Scheme for Formal Sector Employees. This programme aims to provide health insurance coverage to local or district residents. Especially for people who have not been covered by health insurance from the central government, or have not registered with any health insurance.

In terms of policies and regulations, it can be seen that since 1968 PT Askes has undergone many changes in the government's authority. It starts with the management of UHCfor civil servants and their families. Then the regulations continue to change, along with various social security schemes such as UHC for Civil Servants and UHC for low-income groups. Along with the various UHCschemes that PT Askes has managed, the government has PT Askes, which is trusted to manage health insurance in Indonesia. Because of his experience in managing UHCin Indonesia, UHC PT Askes was trusted as an administrative body called BPJS Kesehatan.

There are still many improvements in each of the UHCschemes implemented by the Indonesian government. However, good things should be appreciated, such as the increasing number of Indonesians covered by health insurance by 60% or more than 237 million people in 2010; these numbers dominated from the implementation of the UHCfor Civil Servant, Social Insurance Scheme for Formal Sector Employees, and UHCfor the low-income group. Regional health insurance also plays an optimal role in covering residents in the region who are not yet covered by the UHC administered by the central government. In 2010, District Health Insurance covered 31 million people or 22.6% (Ministry of Health RI, 2011).

In addition, the number of low income people who were covered by health insurance for the low income continues to receive the government's attention from each scheme. For example, UHC for low-income group which was operational in 2005 covered 36.1 million low income people, and in 2007 the coverage for the low income expanded to 76.4 million people.

5.3.2. Context of the Indonesia Universal Health Coverage Universal Health Coverage Era

Social health insurance continued to evolve until 2014 when the government introduced UHC or often called UHC. Mandate by Law Number 40 of 2004 on the National Social Security System and Law Number 24 of 2011 on the Social Security Administrative Body in 2012. National Social Security Council and the Ministry of Health created a road map to provide systematic direction to outline the necessary coherent and coordinated steps within the stipulated timeframe to prepare the UHC System. The roadmap provides an operational framework for the Social Security Administrating Body (BPJS Kesehatan) to establish UHC by 2014.

As mandate by Law Number 40 of 2004 on the National Social Security System and Law Number 24 of 2011 on the Social Security Administrative Body in 2012. National Social Security Council and the Ministry of Health created a road map to provide

systematic direction to outline the necessary coherent and coordinated steps within the stipulated timeframe to prepare the UHC System. The roadmap provides an operational framework for the Social Security Administrating Body (BPJS Kesehatan) to establish UHC by 2014 (see figure 22).

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Source: National Social Security Council (2012)

Figure-22 Indonesia Universal Health Coverage for operational framework for health insurance in Indonesia

In 2012, brainstorming related to the design for the UHC has started. Stakeholders including by the National Social Security Council, which has the authority as a regulator in terms of national social security. Also, related parties, the Ministry of Health, the ministry of social affairs, local government, private providers, associations of health providers, pharmacies and others built a consensus regarding various agreements to carry out transformation.

The agreements referred to in this UHC roadmap included; agreement regarding the law related to the legal basis for the formation of UHC. How to provide health service benefits, the amount of premium, the stages of expanding membership and the stages of equalisation of benefits, government regulations and presidential regulations, transformation of BPJS Kesehatan, communication of related parties including to the public, plans for socialisation and education of the UHC programme. Regarding the management of the UHC programme see figure 23:

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Source: National Social Security Council (2012)

Figure- 23 the management of the UHC programme

Three main elements in the management of health insurance, namely: Revenue collection, risk pooling and purchasing. Fundraising is the process by which funds must be collected (contributions from participants or taxes can be collected effectively and efficiently from households, employers, government and / or other organizations). Funds raised must be sufficient to pay for health services and sustainable. There are only two possible ways of funding for universal coverage, namely social insurance and taxes. The extent of population coverage determines the adequacy of funds that must be

collected. The existence of an economic-financial system, the existence of formal employment relationships (wage workers), a reliable tax system, adequate benefits and awareness of the population determine the sustainability of fundraising.

Meanwhile, pooling risk is a contribution collected so that health care costs are shared by all (shared) and not borne by individuals when they are ill. Pooling risk requires solidarity within the community (World Bank, 2006). Another definition is that pooling is a contribution used to purchased or provide appropriate and effective health interventions (WHO, 2005). In the Roadmap to UHC (2012), risk pooling (cooperation) is a joint effort so that all citizens contribute (pay contribution/taxes) to pool (pool) funds to pay treatment of anyone who is sick.

In the health financing system in Indonesia, the pooling risk function may involve the ministry of health or national health services, social security organization, voluntary private health insurance, and community-based health insurance (such as District Health Insurance or others). The Government carries out pooling risk in the regional Budget (APBD) and the Central State Budget (APBN) for health services. Preparing the APBN and APBD can determine pooling risk to help people with high risk and can pay low through rational planning.

Pooling at BPJS Kesehatan might not provide a good composition. Non-Government Contribution Beneficiaries participants my come from community groups who are already sick or tend to get sick. Meanwhile, healthy people tend not to enter or have their health insurance outside of BPJS. This can be cited as an example of an adverse selection process. Meanwhile, pooling risk for the health services in private insurance agencies tends to only be for those who are able and healthy. This situation needs attention.

Another health financing function in UHC is purchasing. Purchasing is defined as contributions used to purchase or provide appropriate and effective health interventions (WHO, 2005). Purchases here, sometimes referred to as the supply side of funding,

include several agreements used by health care buyers to pay health care providers (World Bank, 2006). This agreement can consist of various types.

Some government health service providers and social organisations provide health services to public employees with a payment model that can make directly or contractual agreements from private or government-owned providers. Purchasing services must be carried out as carefully and efficiently as possible. The mandate fund is sufficient, and there is no waste (optimal resources). The wider (comprehensive) the health insurance benefits, the more funds are needed. For efficiency in spending on health services, the methods of payment or purchase of health services form public and private health facilities must be regulated so that there is no waste or unnecessary spending on services (moral hazard or fraud).

In the SJSN context, Indonesia has chosen a mechanism social insurance by requiring every citizens who receives wages to pay contributions while those who cannot (low income or unable) receive contribution assistance from Government. Later, when he works and has a wage, he will be obliged to make contributions. The social insurance mechanism guarantees more than enough funds for health services rather than a tax mechanism where funds for health services must be contested annually in the DPR in the form of the APBN Law. Regarding the premium and benefit package towards UHC, it can be seen in the following figure:

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Source: (National Social Security Council, 2014)
Figure-24 UHC in Indonesia, Premium and Benefits

Before UHC implementing 2012-2013 the amount of contributions and payment system offered by previous health insurance also varied. But coverage is become more comprehensive over time. UHC era National Health benefits packages based on the principle equity is in accordance with the mandate of SJSN Law and formulated in the Presidential Regulation on Health Insurance.

The benefits that UHC participants would be receive comprehensive, covering promotional, prevention, curative and rehabilitative services, including the necessary medicines other consumables. For the implementation of the UHC programme in Indonesia, the following in-depth interviews and FGDs are explored bellow.

5.3.3. Input of the Indonesia UHC before and During Indonesia National Health Insurance (UHC) Implementing

In this qualitative study, questions related to Input in the implementation of UHCin Indonesia and the duties and functions of the institutions in relation to the National social health insurance; how is the institutions facing the reformation era prior to and

after UHC**,** and the coordination conducted by related stakeholders in planning the implementation of UHC? Who were involved in such activities?

The following sections present the findings of the qualitative data (from FGDs and In-depth Interviews) in relating to regulations, input (demand, supply) process, and outcome.

5.3.3.1. Regulation and Policy in Social Health Insurance in Transformation Phase

Based on the results of the FGDs, there are many overlapping findings on regulation. Especially, related to the socialisation of regulations and the transformation phase before UHC and after UHC declared on 1st January 2014. Regarding the regulation the Yogyakarta, representatives explained in the FGDs as follow:

A.1. *"The existence of regulations continues to grow, while the socialisation has not yet had the chance to suddenly be implemented. It is difficult to coordinate with related parties, especially BPJS participants, as well as health facilities" (FG.03.STK.D.H.O.Y)*

On the one hand, Yogyakarta District Hospital representative informants from respond to regulatory complaints that socialisation is too fast and some regulations still apply backwards to affect administrative and technical services.

A.1. *"… in terms of BPJS Kesehatan regulation, if it's further studied, it does not then apply backwards. Certainly, it is very troublesome in terms of administrative and technical service"* (FG.12.STF.D.H. Y)

The explanation from the District Health Hospital representatives is similar to that the Dr Sardjito Public hospital representative that reveals if the regulation is not too clear from BPJS and the regulation from Ministry of Health was late as well.

A.1. *"…Sometimes in terms of regulations, they are already good, but not too clear, we feel…* **(**FG.09.STK.G.H.Y)

Furthermore, Board of Trustees of General Welfare/Pembina Kesejahteraan Umum (PKU) Muhammadiyah Yogyakarta Private Hospital, and informant from the district Health Office also confirmed bellow.

A.1.6. *"The existence of new regulations is often not socialised, and even if it is socialised, for example at that time there was a Performance Based Capitation (KBK) regulation at the end of March the regulation had to be implemented in that same month. In fact, there are several regulations that have been carried out since the beginning of the year, even though the regulations related to the preparation we have done for First Level Healthcare Service (Puskesmas/GP) is different the Ministry of Health..."* (FG.06.STK.D.H.O.Y)

Related to regulations from BPJS Kesehatan, Health Financing Division representatives also conveyed; there is still overlap in terms of regulations, and efforts that need to be made are evaluating UHC implementation and proposing efforts to improve policies with relevant ministries/institutions.

"There are overlapping and out of sync regulations…"(S.3.Indepth.HSP.C)

"Efforts made: Evaluating UHC implementation, and proposing efforts to improve policies with relevant ministries/institutions." (S.3. Indepth.HSP.C)

The Social Security Council advises "*Coordination with related parties to synchronize regulations and their implementation so that overlapping does not occur."* (S.1.Indepth.DJS)

Referring to the findings, the regulations need to socialisation in advance in order to better prepare health providers in implementing regulations, whether it is from the Indonesia Government, BPJS Kesehatan or Ministry of Health. There are many rules at the beginning of the UHC transformation.

On the other hand, BPJS Kesehatan Health Financing Assurance Division representative, highlighted several obstacles that occurred related to the transition in the UHC era.

A.1.4. *"Obstacles encountered; (1) There are overlapping and out of sync regulations (3) Minimal understanding of UHC (3) Reforms related to UHC were not only carried out by PT Askes to become BPJS Kesehatan, but all aspects related to healthcare such as the pharmaceutical industry and hospital management. The speed and direction of change for each role is not done simultaneously and on the same track, so there are still many things that must be addressed so that implementation can run optimally."*(S.3. IN depth .HSP.C)

5.3.3.2. Demand on Health Services

The demands included in this study are the public's demand for UHC, in this case related to the service package covered by UHC, as well as the enthusiasm of the community in participating in this UHC programme. Based on the results of FGDs and in-depth interviews with the key actors on UHC programme, it can be described as follows:

A.2.2. "*The UHC programme, as well as the BPJS Kesehatan, benefit the community, but the package and premiums may need to be studied further, especially the increase in premiums that will impose*." (FG.15.STK.PR.H.Y)

BPJS Kesehatan Health representative, and from Provincial health office explained the guaranteed benefit package is too broad.

A.2.2.*"The guaranteed benefit package is currently too broad with medical indication restrictions. This makes it difficult in the guarantee process because in some cases, the definition of medical indications is also subjective." (S.3.Indepth.HSP B)*

A.2.2. *"Already, the benefits package is broad; all guaranteed with medical indications, but there are still benefit packages that are not insured by UHC..."* (S.6.Indepth.DHY)

In the UHC benefits package, further evaluation still needs to be done so that the benefits are in accordance with public demand, but have effective service

coverage. Determining the benefits needs to consider several aspects; promotive, preventive, curative and rehabilitative service packages.

On the demand side, the utilisation of health services in primary health care before and after UHC continues to increase as stated by the following informant:

a.1**.** "*…before and after UHC the number of patients has increase in demand, but we still have to give priority to the quality and provide excellent service to all patients. They are of course in accordance with government regulations that our main task is promotive and preventive*." (FG.18.STF.U2.PR.H.Y)

Respondents from the puskesmas said that there was an increase in the number of patients after UHC, but puskesmas still have to prioritise quality and provide excellent service to all patients, in line with the main task of primary health care providers is to be concerned on promotive and preventive.

5.3.3.3. Supply of Health Services

This section describes the results of FGDs related to Supply in h especially those related to funding sources, human resources, health facilities including the availability of drugs and medical equipment, and information systems. UHC funds come from several sources, as explained by informants:

A.3.1. *"Prior to UHC, the income was mainly coming from non-health insurance receiver and relation. Nowadays the income is coming from UHC patients (including from other health insurances) and also non-receiver patients. There are some BPJS patients but they choose not to use their benefit and are willing to pay more."* (FG.14.STF.P.H.Y)

Prior to the UHC era, government agencies such as health centers, regional hospitals, public hospitals, for UHC funding came from the Regional Government Expenditure Budget (APBD) such as the District Health Insurance program. Also is come from the central government budget (APBN) for health insurance participants whose premiums are subsidised by the government, such as the UHC for low-income group programme. The APBN also applied to private

hospitals such as PKU Muhammadiyah Yogyakarta, which the government has designated as a hospital that serves UHC or the low-income group patients.

Informant from private hospital also conveyed prior to UHC, the income was mainly coming from non-health insurance receivers and relations. Nowadays, the income comes from UHC patients (including from other health insurances) and non-receiver patients. There are some BPJS patients but they chose not to use their benefit and willing to pay more. The reason is because some patients want to get health services quickly, without going through referral. In addition patient loyalty is another factor as patients tend to be loyal to the service provided by the hospital of their choice.

In addition, at the beginning of UHC implementation, the funding came from UHC APBN 52.15% sourced, 32.79% from insurance premiums through deductible salaries of government employees, such as civil servants, Indonesian National Army and Police, meanwhile, 13.01% from formal business entities, 1.73% from Regional Health Insurance, 0.27 % of UHC Independent participants and 0.04%% of Foreign Citizens (BPJS Kesehatan, 2014).

The percentage of Independent participants in the UHC programme is still low in this data. Therefore, the researcher would find out more about stakeholder responses related to funding from independent participants in this study. Including the premium paid, whether it is following the acturia calculation and ATP/WTP. In addition, who has the authority to analysed premiums and determine the premiums the UHC premium the following are excerpts from relevant stakeholder's independence funding on UHC programme

A.2.1 "…*The premium paid is not in accordance with the access to services obtained, because it utilises the service more often even though the premium is not sufficient."(*FG.05.STK.D.H.O.Y)

A.2.1. "*Premiums and packages still need to be further evaluated, especially with the planned increase in premiums that will apply*."(FG.12.STF.D.H Y)

A.2.1. "Still needs to be reviewed again for the suitability of premiums and BPJS Kesehatan service packages." (FG.15.STK.PR.H.Y)

The actual premium calculation is under the authority of the National Social Security Council, but the president makes the final decision. From the DJSN calculation, the premium and package are in accordance with the initial calculation, but the implementation is not in accordance with the results we calculated. This has led to conflict so that there is a discourse about rising premiums at this time.

A.2.6. "*… results are submitted to the finance ministry and the president because the DJSN has no authority to decide..."* (S.1.Indepth.DJS)

A.2.2. "*Regarding the adequacy of premiums, currently the amount of premium determined is not in accordance with actual actuarial calculations*." (S.3.Indepth.HSP.C)

Some funding findings explained that the premiums and insurance packages, and health service packages currently being implemented are not in line with the actual health services and actuarial situations. In addition, based on the informants' opinion, the premiums and UHC health service packages do not represent the needs of the Indonesian community yet. These are not yet following the rules of actuarial calculation. Even though National Social Security Council has been calculated according to the standard and has done ATP / WTP, it turns out that the premium applied by the government does not match the National Social Security Council calculation. Eventually, it caused conflict when the issue of rising premiums became an alternative from the government.

Other problems highlighted related to the lack of human resources in certain competencies, drug stocks, health facilities and health information systems.

A.3.6. *"... We still lack in human resource. The facilities are still not yet adequate but we are still trying to improve*" (FG.17.STK.U1.PR.H.Y).

Another problem in implementing the UHC programme is the fulfilment of human resources according to the competencies needed by health service providers:

b.3. *"As long as the UHC implementation is still fulfilling, it only needs to add the Sanitation Nutrition and Hygiene section."* (FG.18.STF.U2.PR.H.Y)

b.3. *"Currently Primary Hospital does have specialist doctors, but not all are state civil servants. So, there are specialist doctors that we contract per year. That is in order to meet the service needs of the Primary Hospital…"* (FG.15.STK.PR.H.Y)

The adequate supply on medicines, some informants from government and District hospitals complained that their stocks were often unavailable.

A.3.5. *"For drug supplies because stocks are often empty, this needs to be examined so that we do not harm the needs of patients who need the drug immediately."* (FG.10.STF.G.H)

A.3.5. "*Stock of medicine is fulfilled, although sometimes it is empty but it is immediately resolved."* (FG.15.STK.PR.H.Y)

b.5. *"In our hospital a lot of drugs unavailable from the factory, this is the problem. The medicine is actually cheap, but there isn't any in the factory. "Sadly, there is no solution. That means that the continuity of treatment will be disrupted and the patient's risk will recur and can be severe. There are no other alternative medicines, we have tried similar drugs at a price of 3 times or 10 times, but the amount is also limited and there are also a few."* (FG.09.STK.G.H.Y.)

b.1. "*…BPJS does not greatly cover proprietary drugs, so, for patients who should receive proprietary drugs in their medication will be based on national formulary. In terms of service, however, there is no significant impact*". (FG.14.STF.P.H.Y.)

Constraints in the procurement of medicines include stock that is often empty, and some informants argued that this could affect patient treatment. In addition, the cost of replacing drugs has not been assessed as feasible from BPJS Kesehatan.

Meanwhile, some of informants explained some barriers in management information system, including P-care system in the primary health care and hospitals.

A.1.4. ”… *in the hospital there is also a Vi-claim application, which is an online application with P care. So on the line there will be information that in the hospital there are internal medicine doctors who can serve coronary heart disease, can serve orthopedic surgery, or if the hospital is updated, you can find out the number of rooms or beds available*, *The key is the hospital must update the number of rooms available. We have prepared a management system, but it really depends on the hospital with updating the data…”* (S3.Indepth.HSP.B.)

Some obstacles in the P-Care explained from the respondents that the P-Care not yet been integrating with the MoH *Regional Health Information System (SIKDA).*

A.3.3. "*Information System Management has been integrated even though some are still trial*" (FG.15.STK.PR.H.Y.)

A.3.5. *"…Among them are evaluations for receiving P-Care information systems (online referral) by BPJS."* (FG.06.STK.D.H.O.Y)

b.6. *"System P-Care, for online referral, but it still needs to be evaluated because there are still many problems in maintenance…"* (FG.05.STK.D.H.O.Y)

b.6. "*For hospital SIM we employ a third-party company, but we plan to have an E-Medical Records next year. For information system with third parties, it is not good because if there is a problem, we have to pay again..*." (FG.11.STK.D.H.Y)

B.3. *" P-Care has not yet been integrated with the Ministry of Health's system because the Ministry of Health has created a Regional Health Information System, which we make is generic and the regions change the fox according to their needs. Because the autonomy system so that the regions may adopt but may develop themselves, once they develop themselves it is difficult to standardise and retrieve data..."* (S.4.Indepth. MoH)

Summary of supply readiness: Some needs to be addressed, including funding from community participation through UHC premium and lack of permanent health workers in several health providers such as government and regional

hospitals. Meanwhile, the government facilitates contract health workers or cooperates with other hospitals in supplying specialist doctors.

Supply problems related to drug procurement have been arguing become complaints from health workers, especially third-level referral hospitals. Sometimes to overcome this problem, pharmacists provide similar alternative drugs. Still, because they are not following the national drug formulary, the claim for these drugs cannot be approved by BPJS Kesehatan. If it charged to the patient it will in breach of the procedure.

There are some barriers in the information system originating from the government regarding infrastructure procurement, such as Simpus and P-Care. Such as, P-Care online referral system, this system has not been integrated with several systems organised by MoH. The Department of Health also argues that they do not have access to P-Care. So, MoH or District Health Office only gets reports from health providers and BPJS Kesehatan. In terms of officer discipline in updating data on P-care, it is still not optimal; this results in information on the availability of the number of beds in hospitals not being updated correctly.

5.3.3.4. Process before and after Universal Health Coverage Implementation

The findings on Inputs such as regulations, funding, the era of transformation towards UHC, demand and supply affect the process of implementing UHC in Indonesia. The most prominent obstacle is the implementation of tiered referrals. Even though tiered referrals existed before UHC, after UHC, felt this referral to be complex by key UHC actors, such as BPJS Kesehatan, MoH, Health Office, and health service providers.

In health services, as well as the implementation of referrals, there are many obstacles faced by the District Health Office, as well as health service agencies, as explained below:

B.3. *"Such costs and coverage are still worth it, but the tiered regulation is not. Some patient should go for treatment very far from their house (about 15 km). It will be easier and cheaper for them if they can just go to the nearest facility and pharmacy. "*(FG.14.STF.P.H.Y)

B.3. *"… It's much better if UHC doesn't tier the type of person seeking to receive the treatment. This way, the public can obtain all benefits. Nowadays, it's very time consuming and arduous*." (FG.14.STF.P.H.)

B.3. *"I am from the Type D referral hospital with PPK 1, the link to DI Yogyakarta, there is a reference manual with the Maternal Mortality Rate and Infant Mortality Rate. I should be able to go directly to Type a Hospital, but because referrals are tiered, the risk of delay has actually been discussed with the city health office. Maybe related to Obgyn who was expelled from the BPJS. "*(FG.15.STK.PR.H.Y)

B.3. *"We hope that the tiered referral procedure cannot be done locally, because it will be troublesome for patients."* (FG.14.STF.P.H.Y.)

B.7. *"A tiered referral system still needs to be evaluated again because it is still less effective for the utilisation of access."* (FG.11.STK.D.H.Y)

The informants said that the referral system still needs to be evaluated because this will affect to the responsiveness health care service to the patients whose need the health services at the hospital. It could be due to distance, procedure or regulation.

Relating to referrals, because the location of the GP or hospital determined by the BPJS is far, according to one informant, patients prefer the nearest health facilities; this can solve the problem by moving the GP mechanism according to the health facility nearest to UHC participants.

For BPJS Kesehatan With regard to the principle of portability (BPJS Kesehatan service which can be accessed from anywhere) - patients who visit other areas wishing to access health services through this tiered referral system needs to be analysed further.

A.2.1. "*Our hospital…because it's in the city centre – many international and domestic tourists come to seek medication to our hospitals but they can't enjoy BPJS service except mild illness such as flu, cough, and fever. If the referral is not tiered, they can easily get the BPJS benefit*..." (FG.13.STF.P.H.Y.)

Other challenges in the implementation of referral services are also related to reverse referral programme or PRB.

A.1.6. "…*Yes, the problem is also about tiered referral then with the change in PROLANIS, which is also said to cover a patient of diabetes mellitus (DM) and hypertension (HT)…"* (FG.19.STK.U2.PR.H.Y.)

Reverse referral programme (PRB), began to be implementing in the UHC era. This programme proided to patients with chronic deseases with stable conditions and still requiring long-term treatment or nursing care carried out at the First Level Health Facilities on the recommendation/referral of the trating specialist or sub specialists. PRB is a new programme, making health service providers still need to adjustment. In this case, BPJS Kesehatan has provided operational guidelines, which may still need to be disseminated to health care workers.

5.3.3.5 Output of Universal Health Coverage

In this section, there some key points are explored to find out more about the outcome of the programme, includes; This component includes equity in accessing health services, quality of health services and financial risks protection. Furthermore, the achievement of the UHC programme targets that have been implemented so far, the obstacles that will affect if the programme achieves the target. Also, to find out the benefits of the health insurance programme, as well as the expectations of policyholders for the sustainability of the programme.

In the results of this qualitative study, the target for UHC participation in 2019 should be 95% of all community groups have been covered by UHC. However, as stated by respondents, the target is only 80% due to the following obstacles:

C.2. *"Whether or not the target was achieved, it must be in accordance with the National Medium Term Development Plan (RPJMN) in the old RPJM UHC in 2019, it mentioned 95% of the population." (S.3.Indepth.HSP C)*

C.1 "...*At present, only 80% of the 95% membership target at the end of this year has not been achieved*." (S.4.Indepth.MoH.)

The reasons for not achieving the target were, among others, due to funding problems, participant drop rates, especially from Independent participants who usually pay monthly premiums, as well as overlapping data for UHC participants who received premium subsidies from the central government.

C.1 "*The target has not been achieved, due to the availability of funds for the integration of UHC district/city for* Government Contribution Beneficiaries Recipients *funds...*"(S.6.Indepth.DHY).

A.1.4. "*Problems with membership (drop out), benefit packages, fees and communication for independent participants*."(S.6.Indepth.DHY)

A.2.3 "*Central membership, because all this time participants at the centre were surveyed by BPS, even though BPS surveys every 5 years, meanwhile we in the regions get survey every 5/6 months which makes the real problem because they are actually not poor anymore. Because of 5-year survey the data is not valid. We can verify but the process takes a long time*. .." (FG.07.STK.D.H.O.Y)

A.2.2. *"… but there are still poor people who have not received UHC card*." (S.6.Indepth.DHY)

C.6. "*Community participation in providing accurate data during the data collection process. Also participation from all relevant parties, such as BPJS, Ministry of Health for reconciliation updating data for PBI participants, so that the data do not overlap*."(S.5.Indepth. MoS.)

Overall, the people covered by UHC have reached 80% of the 2019 target of 95%. However, due to funding problems during the integration process before and after UHC, this has an effect, especially in relation to the collection of Government Contribution Beneficiaries Recipients data, which is currently still overlapping for accuracy. The participation of all parties, including the community, is needed to overcome the overlapping low-income group data

Furthermore, as mentioned above, public awareness to participate in UHC can still be said to be low. More UHC participants still consist of formal workers or permanent workers whose premium payments are deductible from their monthly salary.The Ministry of Health explained, in the process of implementing social health insurance, the community must also have awareness that the programme is important. As well as addressing the efforts of the ministry of health so that people can become UHC participants through programs conducted by the Ministry of Health.

B.3. *"Community processes in understanding the need for health insurance have not yet become a culture..."* (S.5.Indepth.MoH)

C.6. "*We hope that the public will become more aware of becoming JKN participants. Because UHC is made for the community, so the community must understand their rights and obligations. Being a participant is important, paying contributions is important...*" (S.4.Indepth. MoH.)

At the stage of the process of implementing social health insurance, the role of the community is also important in health insurance membership. However, relevant stakeholders also remain important in continuing to work to increase their awareness with cross-program activities, socialisation and improvement of health services starting from the primary health care facilities.

Turning to equitability in accessing health services, there were some barriers relates to mall distribution in rural or remote areas, as explained by the respondent as follows.

B.7. “*the problem of UHC maldistribution can only be enjoyed by people in big cities. Justice is not yet, the equity is yes but the equitability is not yet. We pay the same premium but the benefits are different. Regarding access, when we want to take advantage of services for heart hospitals in big cities, the taxis are affordable, but for those in Papua, the costs are very expensive because they have to rent a plane, etc*.” (S.4.Indepth. MoH)

The problem of the distribution of health services is a challenge for the ministry of health today. According to a representative from MoH, the difficulty in overcoming the equity of access to health services is Indonesia's varied geographical location, especially in remote areas.

On the output side of UHC, the most serious problems are related to risk financial protection including; the impact of the deficit of funds from BPJS health causes delays in payment of BPJS health claims to health service facilities,

b.2. “*Delayed claim payment. If the payment can be proposed timely (H + 5), then we expect to receive the payment in 15 days. We try to tackle this problem by opening Deposit Box to cover the operating costs* “. (FG.13.STF.P.H.Y.)

b.2. “*If only UHC applies accordingly, but reality doesn’t speak the same. Treatment claims payment can be delayed for 15 days, but worse is medicine/drugs claims. It can be delayed for months. As of today (30 August 2019), drugs claim for February 2019 hasn’t been paid at all*.” (FG.13.STK.P.H.)

b.2. "*Administering expansion for other services which are not provided in other hospitals, creating a Deposit Box to cover the operational costs*” (FG.14.STF.P.H.Y.)

b.4. *“Basically, the same, we will move more freely if the claim is paid on time, especially since we are small hospital with abundant patients, our rationale is actually difficult if we bear it ourselves…***"** (FG.15.STK.PR.H.Y**.)**

B.7. *"The accuracy of payment of claims, we are trying to communicate with BPJS Health so that claims can be paid on time. Also related to the common perception of UHC services to all health care providers and staff."* (FG.09.STK.G.H. Y.)

B.7. *"We hope that the claim made is suitable and on time. More importantly is the issuance of new regulation (from minister of health/government) should be informed before the action takes effect.* " (FG.13.STF.P.H.Y.)

With regard to funding, late claims also disrupt the implementation of the UHC programme. Although, such as the PKU Muhammadiyah Hospital, it tries to take advantage of the Hospital's savings fund. Meanwhile, regional hospital use *Remaining Budget* Calculation, namely the excess of realized budget revenues and expenditures during one budget period (Silpa) funds to solve the problem of delayed BPJS claims:

Relating to the benefits of UHC, respondents stated that UHC is beneficial in improving the standard of Indonesia public health, such as quality of life and adjustment life years. Also improving another programme that integrated to the Please refer to the following quote:

C.3. "...*We hope this (insurance programme) can continue because of many positive impacts (garnered).”* (FG.18.STK.U2.PR.H.Y.)

C.3. “*This is related to the PROLANIS programme at BPJS which is actually useful, to improve the quality of life of BPJS participants who have a diagnosis of DM and hypertension. The existence of this program is preventive for the disease to be controlled. Because there are gymnastics activities, checking fasting blood sugar, blood pressure and drug administration*." (FG.06.STK.D.H.O.Y.)

C.5. “*The benefit is impacted in the implementation of Cordination of benefits (COB) programme*." (FG.14.STF.P.H.Y)

C.6. *“We hope this (insurance programme) can continue because of many positive impacts (garnered).”* (FG.18.STK.U2.PR.H.)

C.3. *"Keluarga Harapan Programme (PKH) is integrated with the goals of UHC Programme. Increasing the purchasing power of disadvantaged people PKH has proven to be a social assistance program that encourages family creativity in increasing productivity. Improving the quality of human resources in the family."* (S.5.Indepth. MoS.)

C.3. "*We do the participation stages as we explained earlier, also efforts to improve quality include the credibility of the health facilities that will work with BPJS Kesehatan.*" (S.3.Indepth.HSP A.)

In essence, Yogyakarta District Health Office and the health service providers such as Yogyakarta District Hospital, Dr Sardjito Public Hospital, Primary Hospital, and both Puskesmas Tegalrejo also Umbulharjo are aware of the UHC sustainability. Because the UHC programme brings benefits related to access to health services, improving management systems and services, improving the quality of health care, and improving the quality of life for the community.

The benefits of the UHC program in reducing communicable and non-communicable diseases (DALYs) were explained by respondents as follows:

C.4. "UHC participants can access UHC benefit packages for infectious and non-communicable diseases in health care facilities in collaboration with BPJS. So that participants can be controlled by the disease and if illness is treated, BPJS participants can improve their quality of life. However, for diseases that have been covered by this program are not guaranteed by the BPJS Kesehatan such as Tuberculosis, HIV AIDS, and Extraordinary Events (KLB)." (S.6.Indepth.DHY.)

Based on the explanation of the respondents above, the UHC program is useful to contribute to cover funding for communicable diseases such as TB, HIV. UHC also organizes the PROLANIS Program, in which PROLANIS participants are sufferers of type 2 diabetes mellitus and hypertension managed in primary health facilities. Every month the PROLANIS participants must come for working out, drug administration, checking blood sugar level. Every 6 months, there is an HBA1C examination. This program is an effort to manage chronic diseases to improve the quality of life. The UHC program is related to national programs *"Keluarga Harapan Programme (PKH),* SDGs, so that the UHC program is felt by the people to benefit from it, as their response below:

C.5. "Social Health Insurance is integrated with the Family of Hope Program Keluarga Harapan Programme (PKH organized by the Ministry of Social

Affairs, in this case many benefits. This programme has a significant impact on reducing poverty and inequality. In addition to obtaining tuition assistance (PBI-KIS), the Family of Hope program can work together to improve the quality of public health and the economy." (S.5.Indepth. MoS)

The informants agreed that the UHC programme could be sustainable, as well as benefit the people of Indonesia, although there are still points that need to be improved or evaluated further. Respondents expressed their hopes for the improvement of the UHC Programme as follows:

C.6. *"We are optimistic about the UHC programme as long as each stakeholder has the same goals so that the UHC programe will continue to work. For instance; those who want to sustain are not only the government or BPJS, but health facilities also have the same understanding, that this UHC program will be sustainable, so health service facilities will get a substantial income because currently private hospitals that have collaborated with BPJS There are already 80% of patients served are BPJS participants. Only 20% are general patients, meaning that health facilities have the same goals. This useful program can continue to be sustainable; it will eliminate fraud and abuse. "* (S.3.Indepth.HSP.B.).

C.6. "Future expectation in UHC is first restructuring so not only to reorganise the procedure but also that the DJSN is voicing the restructuration so this is the total starting from the DJSN, BPJS and by the Minister of Health to re-check the role where the role must be reorganised. Second is the fees and benefits must be one package. The current benefit arrangement must be clearly defined as characteristic of social insurance. Participants here are also mandatory participation. Standard medical service rates must be recalculated in accordance with applicable medical standards and the readiness supply must be prepared not to allow participants to have financial access via cards but no service. We want the government's active processing strategy using regulatory players to urge accreditation to use power through licensing to monitor normal standards of procedures that is the work of government." (S.1.Indepth.DJS.)

There are many suggestions for UHC sustainability; all parties are expected to support each other. The Indonesia community needs to improve their awareness to participate in UHC programme. In addition, institutions must be aware of their duties and functions in sustaining the UHC programme, like the Ministry of Health which must focus on equitable access to services, public awareness, and the quality of health services.

5.4. Quantitative Data Analysis

Population in this research is based on Indonesia Socio Economic National Survey. The total sample was 7.778.946; the sample was taken in 2012, 2013, 2015, 2017 and 2018 (refer to Chapter 4 page 107). The research started in 2012 and 2013 because this year marks the start of UHC transformation. The National Health Insurance/UHC announced by the Indonesian Government. The single payer system began in 2014; therefore this research evaluates the UHC implemented before and during UHC programme, until 2018 at the time when the UHC achieved 95% coverage of the Indonesian population.

Table-29 Univariate Analysis

Respondents Characteristics	Year														Total		*P value*
	2012		2013		2014		2015		2016		2017		2018				
	n	%	n	%	n	%	n	%	n	%	N	%	n	%	n	%	
Type of insurance																	
out of pocket	593.447	53,3	496.802	45,4	485.949	44,3	495.759	45,2	461.408	41,6	436.882	38,6	386.661	34,2	3.356.908	43,2	***0.00***
public insurance	432.599	38,8	549.273	50,2	551.481	50,2	583.559	53,2	634.865	57,2	649.020	57,3	709.563	62,7	4.110.360	52,8	
private insurance	64.029	5,8	33.266	3,0	45.167	4,1	15.431	1,4	9.616	0,9	39.031	3,5	26.315	2,3	232.855	3,0	
both insurance	24.370	2,2	14.838	1,4	15.683	1,4	2.970	0,3	3.860	0,4	7.816	0,7	9.286	0,8	78.823	1,0	
Insurance membership																	
out of pocket	593.447	53,3	496.802	45,4	485.949	44,3	495.759	45,2	461.408	41,6	436.882	38,6	386.661	34,2	3.356.908	43,2	***0.00***
have insurance	520.998	46,8	597.377	54,6	612.331	55,8	601.960	54,8	648.341	58,4	695.867	61,4	745.164	65,8	4.422.038	56,9	
Territorial status																	
rural	636.514	57,1	627.300	57,3	630.575	57,4	626.624	57,1	637.503	57,5	650.452	57,4	651.356	57,6	4.460.324	57,3	***0.00***
urban	477.931	42,9	466.879	42,7	467.705	42,6	471.095	42,9	472.246	42,6	482.297	42,6	480.469	42,5	3.318.622	42,7	
Age category																	
young age	340.297	30,5	327.409	29,9	327.159	29,8	320.713	29,2	316.359	28,5	321.758	28,4	327.122	28,9	2.280.817	29,3	***0.00***
productive age	721.440	64,7	713.360	65,2	717.725	65,4	725.383	66,1	739.671	66,7	754.203	66,6	747.734	66,1	5.119.516	65,8	
elderly	52.708	4,7	53.410	4,9	53.396	4,9	51.623	4,7	53.719	4,8	56.788	5,0	56.969	5,0	378.613	4,9	

Education category																	
not education	643.500	57,7	628.396	57,4	617.734	56,3	606.744	55,3	665.155	59,9	601.631	53,1	613.223	54,2	4.376.383	56,3	***0.00***
lower level education	392.464	35,2	384.926	35,2	393.425	35,8	408.948	37,3	345.276	31,1	441.287	39,0	425.836	37,6	2.792.162	35,9	
higher level education	78.481	7,0	80.857	7,4	87.121	7,9	82.027	7,5	99.318	9,0	89.831	7,9	92.766	8,2	610.401	7,9	
Access to health services experience																	
never access	966.077	86,7	938.822	85,8	935.916	85,2	906.749	82,6	922.530	83,1	958.323	84,6	938.594	82,9	6.567.011	84,4	***0.00***
ever access	148.368	13,3	155.357	14,2	162.364	14,8	190.970	17,4	187.219	16,9	174.426	15,4	193.231	17,1	1.211.935	15,6	
Employment status																	
unemployment	382.931	42,9	364.806	41,2	379.453	42,6	385.600	43,2	391.188	43,1	403.769	43,6	398.971	43,5	2.706.718	42,9	***0.00***
employment	510.008	57,1	520.100	58,8	510.733	57,4	507.684	56,8	517.160	56,9	522.449	56,4	518.857	56,5	3.606.991	57,1	
Percentile Expenditure																	
Percentile - 1	394.332	35,4	313.390	28,6	267.721	24,4	200.588	18,3	154.157	13,9	126.037	11,1	99.566	8,8	1.555.791	20,0	***0.00***
Percentile - 2	240.842	21,6	248.067	22,7	248.197	22,6	237.449	21,6	220.731	19,9	189.743	16,8	170.761	15,1	1.555.790	20,0	
Percentile - 3	194.882	17,5	210.693	19,3	217.118	19,8	241.594	22,0	222.655	20,1	234.172	20,7	234.674	20,7	1.555.788	20,0	
Percentile - 4	158.880	14,3	176.836	16,2	195.126	17,8	222.380	20,3	253.322	22,8	272.230	24,0	277.014	24,5	1.555.788	20,0	
Percentile - 5	125.509	11,3	145.193	13,3	170.118	15,5	195.708	17,8	258.884	23,3	310.567	27,4	349.810	30,9	1.555.789	20,0	
Total	1.114.445	100,0	1.094.179	100,0	1.098.280	100,0	1.097.719	100,0	1.109.749	100,0	1.132.749	100,0	1.131.825	100,0	7.778.946	100,0	

The Indonesia National Socioeconomic Survey sample from year on year showed that there are significant changes in characteristics, besides that access to health services also seems to be increasing which is thought to be because of opening access to health services (universal health coverage) in the era of UHC implementation. This condition can have implications on the analysis of the relationship between the UHC programme and insurance membership. To understand the effects of each variable on the relationship between the application of the UHC programme and to understand the

effect of each variable on the relationship of UHC program implementation, this study uses a different in differences analysis to calculate the difference in changes in insurance use due to other variables.

5.4.1. Bivariate Analysis

Bivariate analysis was conducted to determine the correlation between UHCera with UHCmembership. The UHC era referred to in this analysis is the era before UHC (2012-2013) and the period during UHC implementing (2014-2018).

Table-30 Bivariate Analysis

Variable	out of pocket		have insurance		*Odds Ratio*	*Std. Err.*	*T*	*P Value*
	n	%	n	%				
Year								
2012	593.447	53,3	520.998	46,75	1.00 (1.00 - 1.00)			
2013	496.802	45,4	597.377	54,6	1.35 (1.34 - 1.36)	0,01	80,30	0
2014	485.949	44,3	612.331	55,75	1.43 (1.42 - 1.44)	0,01	95,71	0
2015	495.759	45,2	601.960	54,84	1.33 (1.32 - 1.34)	0,00	75,98	0
2016	461.408	41,6	648.341	58,42	1.59 (1.58 - 1.60)	0,01	122,97	0
2017	436.882	38,6	695.867	61,43	1.90 (1.89 - 1.91)	0,01	168,75	0
2018	386.661	34,2	745.164	65,84	2.32 (2.30 - 2.34)	0,01	219,08	0
_cons					0.77 (0.77 - 0.77)	0,00	-100,36	0
Status UHC era								
Prior to UHC era	1.090.249	49,4	1.118.375	50,64	1.00 (1.00 - 1.00)			
During UHC	2.266.659	40,7	3.303.663	59,31	1.44 (1.43 - 1.45)	0,00	162,98	0
_cons					0.90 (0.89 - 0.90)	0,00	-57,70	0
Territorial status								
rural	2.015.129	45,2	2.445.195	54,82	1.00 (1.00 - 1.00)			
urban	1.341.779	40,4	1.976.843	59,57	1.28 (1.28 - 1.29)	0,00	123,18	0
_cons					1.03 (1.02 - 1.03)	0,00	20,23	0

Gender								
Female	1.667.827	43,0	2.212.103	57,01	1.00 (1.00 - 1.00)			
Male	1.689.081	43,3	2.209.935	56,68	0.99 (0.98 - 0.99)	0,00	-7,03	0
_cons					1.18 (1.17 - 1.18)	0,00	112,48	0
Age category								
young age	1.041.654	45,7	1.239.163	54,33	1.00 (1.00 - 1.00)			
productive age	2.162.205	42,2	2.957.311	57,77	1.18 (1.17 - 1.18)	0,00	72,25	0
elderly	153.049	40,4	225.564	59,58	1.30 (1.29 - 1.31)	0,01	53,09	0
_cons					1.03 (1.03 - 1.04)	0,00	16,70	0
Education level								
Never/not yet school	612.871	49,7	620.096	50,29	1.00 (1.00 - 1.00)			
Elementary school	1.388.686	44,2	1.754.730	55,82	1.24 (1.24 - 1.25)	0,00	72,39	0
Junior school	556.949	44,8	685.520	55,17	1.21 (1.20 - 1.22)	0,00	53,01	0
High school	631.039	40,7	918.654	59,28	1.49 (1.48 - 1.50)	0,01	115,06	1
University	167.363	27,4	443.038	72,58	2.59 (2.57 - 2.62)	0,01	200,85	2
_cons					0.89 (0.89 - 0.89)	0,00	-45,17	3
Education category								
not education	2.001.557	45,7	2.374.826	54,26	1.00 (1.00 - 1.00)	0,00	0,00	
lower level education	1.187.988	42,6	1.604.174	57,45	1.16 (1.15 - 1.16)	0,00	67,94	0
higher level education	167.363	27,4	443.038	72,58	2.22 (2.20 - 2.23)	0,01	189,17	0
_cons					1.04 (1.04 - 1.04)	0,00	29,94	0
Access to health services experience for outpatient								
never access	2.952.909	44,0	3.759.466	56,01	1.00 (1.00 - 1.00)			
ever access	403.999	37,9	662.572	62,12	1.22 (1.21 - 1.22)	0,00	65,77	0
_cons					1.14 (1.13 - 1.14)	0,00	115,92	0
Access to health services experience for inpatient								
never access	3.287.319	43,6	4.249.200	56,38	0.00 (0.00 - 0.00)			
ever access	69.589	28,7	172.838	71,29	1.86 (1.84 - 1.89)	0,01	100,27	0
_cons		43,2	4.422.038	56,85	1.14 (1.14 - 1.15)	0,00	130,95	0

Access to health services experience								
never access	2.909.300	44,3	3.657.711	55,7	1.00 (1.00 - 1.00)			
ever access	447.608	36,9	764.327	63,07	1.29 (1.28 - 1.30)	0,00	90,12	0
_cons					1.12 (1.12 - 1.12)	0,00	102,65	0
Employment status								
unemployment	1.126.241	41,6	1.580.477	58,39	1.00 (1.00 - 1.00)			
employment	1.524.930	42,3	2.082.061	57,72	0.99 (0.98 - 0.99)	0,00	-6,20	0
_cons					1.24 (1.23 - 1.24)	0,00	122,67	0
Percentile Expenditure								
Percentile - 1	693.533	44,6	862.258	55,42	1.00 (1.00 - 1.00)			
Percentile - 2	724.833	46,6	830.957	53,41	0.93 (0.92 - 0.93)	0,00	-24,47	0
Percentile - 3	729.335	46,9	826.453	53,12	0.93 (0.92 - 0.94)	0,00	-22,69	0
Percentile - 4	677.856	43,6	877.932	56,43	1.09 (1.08 - 1.10)	0,00	26,34	0
Percentile - 5	531.351	34,2	1.024.438	65,85	1.69 (1.68 - 1.70)	0,01	159,87	0
_cons					1.06 (1.06 - 1.07)	0,00	26,28	0

Based on the data, a correlation between UHC era with UHC membership can be seen on odd ratio of social insurance membership from year to year always increases (every year compared to membership in 2012), this shows the increasing odds of insurance users, this increase is statistically considered significant. Using UHCin 2018 showed an Odd Ratio of 2.3, this can be interpreted that respondents or communities in 2018 had 2.3 times the chance to have insurance compared to respondents or communities in 2012 similar to the year, in the UHC era also showed an increase in insurance membership, respondents or community in the UHC era had the opportunity to have insurance by 1.4 times compared to before the BPJS era.

The correlation between UHC era with territorial status, gender and age category based on respondents / residents who live in cities have a 1.3 times tendency to have insurance compared to those who live in rural areas

(need to be strengthened with theories and realistic explanations why urban people tend to have insurance). Male tends to use less insurance (there is a difference even though it is only 0.01 times lower than women) compared to the productive population children group (15-65 years) have the opportunity to have insurance as much as 1.2 times compared to the child population (<15 years). In addition those who have been classified as elderly the opportunity to have insurance is 1.3 times greater than the child population.The correlation between UHC with education level, can be seen that the higher education a person has the greater the possibility that the person uses insurance. Those who have attended college classified as having high education have a 2.2 times chance of having insurance than those who do not attend school or those who are not educated, while those with low education have only 2 times the opportunity to have insurance while those who have accessed outpatient services tend to have 1.2 times insurance compared to those who have never accessed outpatient services.

The correlation between UHC era with health care access can be seen from those who have accessed outpatient services who tend to have 1.2 times insurance compared to those who have never accessed outpatient services. Those who have accessed outpatient services tend to have 1.2 times insurance compared to those who have never accessed outpatient services. Respondents/communities who have accessed health services in the past year tend to have insurance as much as 1.3 times compared to those who have never accessed it.

Furthermore, the correlation between UHC era with employment status, and percentiles based on the results shows that there is no difference in insurance ownership which can be seen from the value of the odds ratio which is close to 1. When compared with respondents/communities who are in the lowest 20% of expenditure (percentile-1), those with groups of percentiles 2 and 3 do not have

any difference in insurance membership, unlike those in percentiles 4 and 5 where there is a significant difference of 1.1 and 1.7 times the opportunity to use insurance.

5.4.2. Interacting Analysis

Based on the results of a bivariate analysis it can be seen that the social health variable of the social era has a significant relationship with the increasing status of UHC membership. Likewise with territorial status, gender, age category, education level, and access to health care services. However, employment status and percentiles variables have significant differences. Referring to these results, interacting analysis needs to be done.

Table-31 Interacting Analysis

Variable	*Odds Ratio*	*Std. Err.*	*t*	*P Value*
Social Health Insurance	1.44 (1.43 - 1.44)	0.0	162.1	0
Age category				
productive age	1.18 (1.17 - 1.18)	0.0	70.8	0
elderly	1.29 (1.28 - 1.30)	0.0	51.8	0
_cons	0.80 (0.79 - 0.80)	0.0	-92.2	0
Social Health Insurance	1.43 (1.43 - 1.44)	0.0	159.8	0
Education category				
lower level education	1.15 (1.15 - 1.16)	0.0	65.5	0
higher level education	2.20 (2.18 - 2.22)	0.0	187.2	0
_cons	0.81 (0.80 - 0.81)	0.0	-104.0	0
Social Health Insurance	1.43 (1.42 - 1.44)	0.0	160.0	0
Access to health services experience	1.27 (1.27 - 1.28)	0.0	85.0	0
_cons	0.87 (0.86 - 0.87)	0.0	-74.3	0
Social Health Insurance	1.55 (1.54 - 1.55)	0.0	175.2	0
Employment status	0.99 (0.99 - 0.99)	0.0	-4.4	0
_cons	0.90 (0.90 - 0.91)	0.0	-42.0	0

Social Health Insurance	1.37 (1.37 - 1.38)	0.0	137.8	0
Percentile Expenditure				
Percentile - 2	0.88 (0.88 - 0.89)	0.0	-38.7	0
Percentile - 3	0.87 (0.87 - 0.88)	0.0	-42.4	0
Percentile - 4	1.01 (1.00 - 1.01)	0.0	2.0	0.05
Percentile - 5	1.54 (1.53 - 1.55)	0.0	129.8	0
_cons	0.89 (0.89 - 0.90)	0.0	-44.6	0
UHC	1.44 (1.43 - 1.44)	0.0	161.1	0
Territorial status	1.28 (1.27 - 1.28)	0.0	120.8	0
_cons	0.79 (0.79 - 0.80)	0.0	-111.8	0

From the odd value, there is no significant change (UHC range odd ratio value still coincides with the odd ratio value before entering the gender variable). Age category does not affect the relationship. As to the odd value, there is no significant change (UHC range odd ratio value still coincides with the odd ratio value before entering the territorial variable). Gender variable does not affect the relationship of UHC era with UHC membership. As to the odd value, there is no significant change (UHC range odd ratio value still coincides with the odd ratio value before entering the education level). Education level does not affect the relationship of UHC era with UHC membership.

As to the odd value, there is no significant change (UHC range odd ratio value still coincides with the odd ratio value before entering the access to healthcare service variable). Access to healthcare service does not affect the social insurance membership. Territorial Status does not affect the relationship of UHC era with UHC membership.

The odd value ratio of the UHC era has increased from 1.44 to 1.55; this may be subject to an interaction between the UHC status variable and the job status variable. The value of the UHC era odd ratio has decreased from 1.44 to 1.37; this may be subject to an interaction between the UHC era and the percentile expenditure variable.

5.4.3. Different in Differences Analysis on Percentile Expenditure

Considering the interaction between UHC era and percentile variables, it is necessary to calculate the magnitude of the influence of the percentile on the odd ratio of the UHC era, by looking at the conditions per category. The following changes are as follows:

Table-32 Different in Differences Analysis on Percentile Expenditure

Variable	*Odds Ratio*	*Std. Err.*	*t*	*P Value*
Status BPJS era	1.38 (1.37 - 1.40)	0,0	72,3	0
Percentile Expenditure				
Percentile - 2	0.88 (0.87 - 0.89)	0,0	-25,4	0
Percentile - 3	0.88 (0.87 - 0.89)	0,0	-23,7	0
Percentile - 4	1.07 (1.06 - 1.08)	0,0	11,5	0,00
Percentile - 5	1.49 (1.47 - 1.51)	0,0	62,1	0
Status BPJS era ## Percentile Expenditure				
UHC era ## Percentile - 1	1 (1-1)			
UHC era ## Percentile - 2	1.01 (1.00 - 1.02)	0,0	1,4	0,18
UHC era ## Percentile - 3	0.99 (0.98 - 1.00)	0,0	-1,6	0,12
UHC era ## Percentile - 4	0.92 (0.91 - 0.94)	0,0	-11,2	0
UHC era ## Percentile - 5	1.04 (1.03 - 1.06)	0,0	5,6	0
_cons	0.89 (0.88 - 0.89)	0,0	-36,1	0

In the UHC era the odd scores of respondents / community in the UHC era with percentile two and three status did not show any significant difference (odd close to 1) to insurance membership, but in the UHC era in percentile four and five the odd values were stated to be significant at 0.92 and 1.04. This means, the UHC era has an influence on UHC participation in groups of people who have high income standards (percentage 4-5).

5.4.4. Different in Differences Analysis on Employment Status

Odd values in the UHC era when analyzed together with working status show significant changes.

Table-33 Different in Differences Analysis on Employment Status

Variable	*Odds Ratio*	*Std. Err.*	*t*	*P Value*
UHC era	1.52 (1.50 - 1.53)	0.0	108.6	0
Employment status	0.97 (0.96 - 0.97)	0.0	-8.3	0
Status UHC era ## Employment status				
UHC era employment	1.04 (1.03 - 1.05)	0.0	6.9	0
_cons	0.91 (0.91 - 0.92)	0.0	-27.8	0

The odd value of the UHC era to insurance membership increased to 1.52. Odd ratio of working status value is fixed. UHC era odd values that work the value is 1.04 (significantly different from the UHC membership ratio odds 1.44). In these results, people who have employment status are more interested in being UHC participants compared to people who do not work.

Statistically, it can be concluded. Univariate results show the percentage of public insurance continues to increase from 2012-2018. However, what is very striking is when UHC began to be implemented in 2014. Health insurance membership continues to increase compared to people who pay health care costs out of pocket. The respondent's age is more dominated by men, for the age of the more productive age. There are more educated people, especially on the number of junior high school students. The percentage of people living in villages is more dominant. Employment status, more people are working. From the level of economic status, people at the first and second percentiles (the category of people with low economic status) are more numerous than people with upper middle income or wealthy people (percentile 4-5). Access to health services, both outpatient and inpatient, has experienced an increase every year.

The results of the bivariate test showed a correlation between the UHC era and the increase in health insurance participation. This result is interesting to see whether the intermediate variable has an effect on the increase in participation. Then an interaction analysis was performed on all intermediate variables

consisting of age, gender, education level, employment status, economic status, territorial status, and access to health services. The positive findings from this quantitative data are that, year on year, there are increasing numbers of people who have taken up and/or are covered by public insurance, especially after the implementation of the new scheme, and that the people are accessing the utilisation of access to health services, both outpatient and inpatient health services.

After the DID analysis was carried out, the most dominant intermediate variable influencing UHC participants were people who had jobs compared to those who did not work, while economic status showed that people in the fourth and fifth percentiles who were wealthy people were more UHC participants compared to people with middle and lower economic status.

CHAPTER SIX

MIXED METHODS; A CONCURRENT EMBEDDED DESIGN

ANALYSIS AND RESULTS

6.1. Overview

The previous chapter presented the results of qualitative and quantitative data analysis. This chapter will integrate this set of data to the Mixed Methods Concurrent Embedded Design analysis approach. As explained in the methodology chapter, the qualitative data in this study would be analysed using the CIPP model. Meanwhile, quantitative data were analysed using correlation and Different in Differences analysis test using Stata software.

The embedded design model's emphasis in this study is qualitative data, which is the primary data in the study. Preliminary data were collected first through FGDs and in-depth interviews using the stratified purposive sampling method. After the qualitative data collection was completed, the researcher switched to quantitative data. The challenge in doing this approach is that the quantitative data is also re-coded based on national data from 2012 to 2018. Therefore, data analysis took a long time. In the Mixed Methods Embedded analysis in this study, the data qualitative analysis was conducted first, then the quantitative. The results of the analysis can be summarised as follows:

6.1.1. Qualitative Results: Context, Input, Proses, Product Evaluation

In the CIPP model, there are four components which are critical points for evaluation. First, the Context component which consists of regulatory aspects, objectives, targets, and benefits of the social health insurance programme before and after UHC has been implemented in Indonesia. The second component is the input, which consists of the UHC programme managers` divisions and functions, the availability of funds, human resources, infrastructure, and health service facilities, including medicines. Demand and supply-side readiness are also included in the input component. The third

component is the process. At this point, it is essential to evaluate the implementation of the social health insurance programme before, during or after the new UHC scheme has been implemented. The process was explored in more depth regarding the suitability of demand and supply in programme implementation, including its relation to the rules that are applied during program implementation. The Output aspect includes equity coverage, including equity in accessing health service and the financial risk protection.

Meanwhile, the outcome of this study is the sustainability of UHC in Indonesia.The core value in the CIPP model is the sustainability programme of UHC in Indonesia. This core value is essential because it is the core part that needs to be achieved from a programme. The sustainability or failure of the UHC programme in Indonesia depends on its objectives, goals and benefits, a solid legal foundation, and its management. Apart from that, the availability of human resources, a match between demand and supply is also crucial for program implementation. Analysis of the CIPP model was conducted by a formative analysis of how a programme is designed and implemented as well as a summative analysis that looks at the output or product that has been achieved by a programme. The results of the CIPP model analysis can be seen as follows:

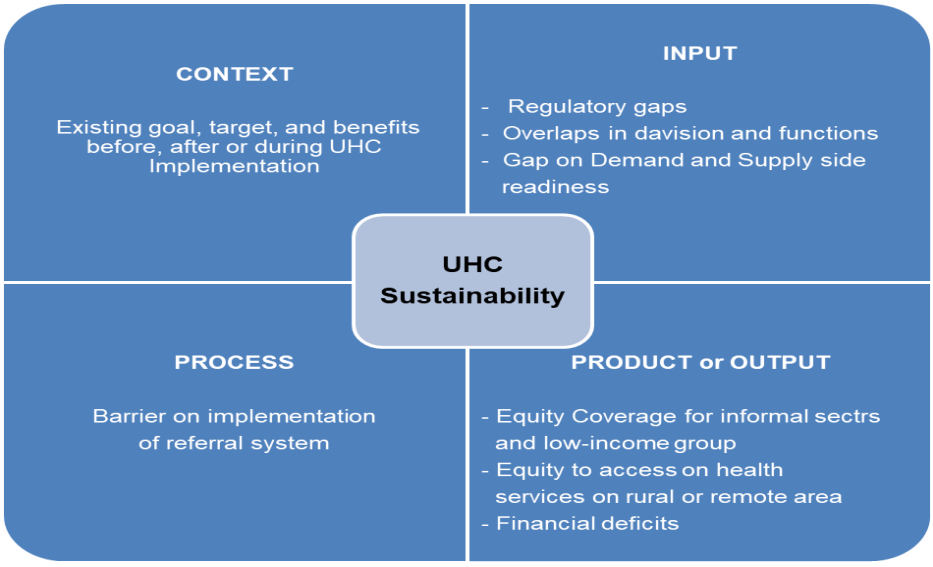

Figure-25 CIPP Model Analysis Results

Document analysis on all regulations before and during the new UHC scheme was complete. Therefore, in the Context of the UHC programme, its legal basis was decisive, and the philosophical aspects of the transformation plan created in 2012. Before UHC was declared on 1st January 2014, its programme objectives, targets, and benefits existed.

As to the Input component, there were findings relating to the overlapping regulations, especially between the National Social Security Council, whose duties are more as the regulator in the UHC programme, and BPJS Kesehatan as the UHC programme funder and the ministries. In this case, the Ministry of Health implements health services. The Ministry of Social Welfare is concerned with data collection and data validity of low-income groups whose insurance premiums are borne by the government. The Ministry of Finance determines the UHC premium. In the input component, there were also findings related to the readiness of human resources, infrastructure, suitability of premiums and health service packages. Most of the findings highlighted on Input component, such as in implementing regulations, respondents commented on the new rules and the lack of socialisation from BPJS Kesehatan. The Ministry of Health also needed to ensure socialisation so that there was no conflict at the implementation stage among BPJS Kesehatan, health service providers and UHC participants. Despite the increase in participation of more than 50% after the UHC era, there are still many dropouts of UHC participants. Public awareness is also still lacking on the benefits of participating in the UHC programme.

On the demand side, health service packages are proposed to be reviewed because they were not following community expectations. The health service package guaranteed in UHC is too broad, while the funding from premiums is not appropriate. In addition, public awareness is low to participate in UHC, such as efforts to find out the benefits of being a UHC participant and awareness to register to become a UHC participant.

On the supply side, funding from UHC independent participants, there are still challenges because UHC premiums are not in accordance with actual actuarial calculations and ATP/WTP analysis. Thus, the increase in premiums is one of the solutions taken by the government to match the premiums and UHC packages.

Furthermore, there is still a shortage of certain permanent human resources, such as in government referral hospitals. Aspects of the infrastructures in the primary health care facilities are still under development. Drug stocks are often empty although this could be overcome by health service providers. All health service providers already have an integrated information system. However, they still experience problems with the Online Referral System (P-Care), so they still require further inquiries from BPJS Kesehatan. However, with P-Care providers' existence, it is hoped that the commitment in updating the data on the availability of inpatient rooms is also expected so that the benefits of P-Care can be more optimal to simplify the online referral system.

The implementation of the programme, related to tiered referrals, is still a matter of debate, especially for people who live far from health facilities included in the BPJS network. The referral returns programme mechanism, especially for PROLANIS patients, still needs further evaluation from BPJS Kesehatan. Disparities in health services for patients in urban and rural or remote area are also highlighted in the findings.

Delay in payment of claims from BPJS Kesehatan to health providers is an obstacle in social health insurance during UHC implementation, which significantly affects the operational performance of the programme. The delay in payment of BPJS health claims to health service providers is an average of 15 days. For private hospitals, overcoming claims delays by using deposit funds or deposit boxes are usually used by hospitals for social activities such as helping low-income patients who are not covered by health insurance. In contrast, regional or government hospitals use funds from the National Revenue Budget

(APBD) or the National Revenue Budget (APBN) to resolve the delay claims. The discourse of increasing premiums to cover the financial deficit is also a matter of debate among stakeholders currently.

As to the Output aspect, the participation target for independent and low-income group participants has not been 100% achieved as expected by the government. This target has not been achieved because the accuracy data for low-income people was not updated properly. This programme also requires the government's commitment to re-evaluate the low-income group's updated data, especially the social ministry. The target of developing health facilities in collaboration with BPJS has increased by 87%, even though it has not reached 100%. The financial deficit findings also affect programme outputs, so related parties need to address them.

Based on qualitative data analysis, UHC programme can be sustainable even though it needs improvements in many areas, such as evaluation as to the division and function of all UHC key stakeholders, recalculation of premium alongside its benefits, availability of supply, i.e., the number of health human resources, sufficient funding for health care, availability of drugs, adequate prerequisite infrastructure (IT management system). Additionally, the process needs to be further reevaluated through a referral and online referral system as well as reverse referral programme.

In terms of output, even though there is an increase of UHC participants, yet there is a substantial number of low-income group of people who are still uncovered by UHC, i.e., the informal sector with no fixed income as well as the unemployed.

6.1.2. Quantitative Results

Based on the Indonesia National Socioeconomic Survey data sample from year on year there was seen to be significant changes in characteristics. Access to health services also seems to increase which is purportedly because of opening

access to health services (universal health coverage) in the era of UHC implementation. These conditions can have implications for the analysis of the relationship between the UHC programme and insurance membership to understand the effect of each variable on the relationship of UHC programme implementation. This study uses a `different in differences` analysis to calculate the difference in changes in insurance use due to other variables.

After analysing the interaction between all intermediate variables; age, education, employment, economic status, access of health care service and territorial status, employment and economic status have a dominant influence compared to other intermediate variables. Before the UHC era, the variable economic status percentile 2 was 1.01 which means that community belonging to the -2-percentile category is classified as lower middle-class group – some are already members of a social security scheme even though this may be because of government subsidy.

The results of the DID analysis after the UHC era show that there is a significant employment status and economic status variables. In the employment status, the odds ratio value is 1.04 for the odds ratio on economic status; the 4th percentile is 1.01, and the 5th percentile with the odds ratio of 1.54. From these results, it can be explained that, after the UHC era, the participation of the working people is more dominant than those who are unemployed. This condition is possible in Indonesia. The majority of those who already have permanent employment, such as civil servants, are automatically registered as UHC participants. The premium payment is directly deducted from their fixed monthly salary. This result follows the DID calculation in the 4th and 5th percentiles. The percentiles include people who have income in the middle to upper criteria. Usually, those in this group already have permanent jobs, so they can pay the UHC premium.

6.2. Integration of Mixed Methods Results with Research Questions

This section will describe the integration of the results of the Mixed Methods Embedded Model with the Research Question. As mentioned in Chapter one, this thesis has two research questions with key points in each question. To respond to the research questions, data that is not only qualitative but also quantitative is needed, to avoid bias. After conducting a study of several literature reviews, as well as examining the research methodology, the researcher conducted data collection and analysis using the Mixed Methods Embedded Model. The results after the analysis related to the research question were as follows:

Table-34 the Integration of Mixed Method Results with Research Questions

	Research Questions	Data Collection and Analysis	Results
R1	What has been the various impacts of the implementation of the chosen methods via UHC in Indonesia? **Key Points 1:** Population: Who is covered?	Quantitative Data Collection based on Indonesia National Socio-Economic Survey data 2012-2018. Data Analysis using Stata	• Univariate: Increasing numbers of UHC memberships from 2012 to 2018. In total membership of UHC is 4.422.038 (56,9%) based on Susenas 2012-2018 data • Bivariate analysis showed that variable of the social health insurance era has a significant relationship with the increasing status of UHC membership. • Also has a significant correlation with the territorial status, gender, age category, education level, and access to health care services. • However, employment status and percentiles variables have significant differences (more dominant in influencing the increase in participation after the UHC era)
	Key points 2 Which Services are Covered?	Quantitative data Collection based on Indonesia National Socio-Economic Survey 2012-2018 (regarding outpatient and inpatient Data) Analysis using Stata	Bivariate analysis showed that the correlation between social health insurance era with health care access can be seen from those who have accessed outpatient services who tend to have 1.22 times insurance compared to those who have never accessed outpatient services.

			Those who have in-patient services tend to have 1.86 times insurance compared to those who have never accessed outpatient services. Respondents or communities who have accessed health services in the past year tend to have insurance as much as 1.3 times compared to those who have never accessed it. Based on the results of this correlation, the number of people who can access health services both in outpatient and inpatient settings has increased compared to before the UHC era.
	Key Point 3 People: Who pay out of Pocket?	Quantitative Data Collection based on Indonesia National Socio-Economic Survey data 2012-2018. Data Analysis using Stata	There is a meaningful relationship between the implementation of UHC and a decrease in out of pocket, especially in 2016 of 41.6%, 2017 of 38.6% and 2018 of 34.2%. This decrease is in line with the increase in UHC participation membership) in the same year, in 2016 it was 58.4%, 2017 was 61.4% and 2018 was 65.8%.
R2	How successful has the introduction and implementation of UHC been in Indonesia? **Key point 1** what has worked well and supported the implementation of UHC	Qualitative data Context on UHC CIPP Model Analysis Qualitative data Output on UHC CIPP Model Analysis	• The existed of regulations or policies on the implementation of UHC in Indonesia • There are clear objectives on social health insurance programme implementation • Roadmap of social • health insurance programme before and after UHC • Available targets of social health insurance programme to be achieved

	Qualitative data Output on UHC CIPP Model Analysis	• Increasing access in health care services including the low-income people
	Quantitative Data Collection based on Indonesia National Socio-Economic Survey data 2012-2018. Data Analysis using Stata	• Increasing access in health care services including the low-income people
Key point 2 What has not worked well and what the barriers have been	Qualitative data Input on UHC Programme Demand	• Synchronisation of premium and healthcare package needs to be re-examined, particularly for those people working in the informal sector without a permanent income. • Communities do not have sufficient understanding of the referral system hence would rather access health services in a hospital directly even though the care can be undertaken at the primary level
	Qualitative data Input on UHC Programme Supply CIPP Model Analysis	• Luck of human resources • Accuracy on low-income membership data • Barriers on P-Care referral online system • Sometimes stock of medicine and drugs are unavailable • Delayed claim payment from BPJS Kesehatan to health care facilities at hospital level
	Process on UHC Programme CIPP Model Analysis	referral mechanism and online referral system in primary health care and hospitals needs to be evaluated

Qualitative data Output UHC Programme CIPP Model Analysis UHC	UHC in Indonesia will sustain if all stakeholders and society are aware of their respective duties and responsibilities to participate in the UHC programme.

Quantitative and qualitative data analysis is in line with the UHC significant increase memberships between 2013 and 2018. Types of occupation have certain impact on the UHC participation because quantitative data reveals that a considerable number of formal workers are UHC members as opposed to informal or contract workers. Level of income also influences participation, the more so with unsubsidised members. This correlates with qualitative research findings which emphasise the re-evaluation of premium adjustment alongside health service packages for the public.

Meanwhile, the Ministry of Social Welfare needs to monitor data updates for low-income groups entitled to subsidies in premium payments. To improve community awareness on participation on UHC programme, socialisation still needs to be conducted by all parties so that people can better understand the goals, benefits, and procedures of UHC. In addition, BPJS Kesehatan also needs to expand the benefits of health services, especially for promotion and prevention benefits.

The online referral system (P-Care) needs to be monitored immediately, including evaluation of commitments in updating data for online referrals. The accuracy of payment of claims to health providers needs to be resolved immediately, because this has an enormous impact on health services. Regarding access to health services, there has been an increase in the utilisation of out-patients and inpatients since the UHC era. However, the Ministry of Health needs to address inequality in access to health services in rural and remote areas.

The CIPP Model analysis shows that UHC could be effective, proven by increasing longevity rate and quality of life. The rising numbers of populations covered by the UHC, including low-income people, have more accessible access to outpatient and inpatient health services. However, all stakeholders related to UHC implementation still need to ensure that the programme is sustainable, especially in terms of improving equity on coverage for all community groups. Access should address to health facilities in rural or remote areas. BPJS Kesehatan needs to immediately resolve the problems regarding the financial deficit because the latter can affect the quality of health services.

CHAPTER SEVEN

DISCUSSIONS ON CRITICAL FINDINGS

7.1. Overview

This chapter discussed related critical findings and their relevance to the research questions in this thesis. The first research question relates to the impact of the implementation of UHC in Indonesia. The critical points in the first research question include: Population covered, Services are covered on UHC programme and out of pocket payment.

The second research question about How successful has the introduction and implementation of UHC been in Indonesia. In this second research question include; what has worked well and supported the implementation of UHC, and what has not worked well and what the barriers have been.

The results of this study will also be reviewed in accordance with relevant theories, standards, regulations on UHC implementation as well as the government commitment, especially stakeholders related to the implementation of UHC in Indonesia. In addition, the results in this study will also be discussed and compared with other research that has been conducted by previous researchers.

7.2. What has been the various impacts of the implementation of the chosen methods via UHC in Indonesia?

The implementation of social health insurance in Indonesia before and since UHC implementation and the Indonesia's population, including by examining the service packages covered and the number of people who still pay out of pocket. The sustainability of UHC in Indonesia going forward will also be explored while the impact of the UHC implementation in Indonesia will be discussed further in the sections.

The implementation of UHC affects the development of social insurance in Indonesia, including the increased population covered in this programme; access to health services; the decline in the number of Indonesian people who pay for health services via Out-of-Pocket payments. In more detail, to find out the impact of UHC implementation on the development of social insurance in Indonesia, it is explored in the following sections:

7.2.1. Population Coverage

The Mixed Methods results show that the implementation of UHC in Indonesia significantly increased community participation in the UHC Programme compared to before the UHC system that the goal ratified on the 1st of January 2014. The univariate results showed that public insurance coverage continued to increase every year and during the UHC era. The level of public insurance coverage before UHC was 38.8% in 2012 to 62.7% of the total sample of 386,661 respondents in 2018 during the UHC era. The bivariate analysis results also showed that the number of respondents that used insurance in 2018 was 2.3 times more likely than respondents in 2012. This increase in participants of UHC is in line with the results of interviews and FGDs that the UHC membership percentage has increased by 80% from the 2019 target of 95%. There is a difference in the percentage results between quantitative and qualitative data. This difference is because the quantitative analysis data was undertaken between 2012-2018 while the qualitative was conducted in September 2019. Nonetheless, in essence, both quantitative and qualitative data reveal an increase percentage in UHC community membership.

Updating data on BPJS Kesehatan data on 27th December 2019, the number of UHC participants was 224.1 million or 83% of the total population of Indonesia of 269 million people. The population covered included 96.5 million participants from Government Contribution Beneficiaries, paid for by central Government; another 38.8 million participants were Government Contribution Beneficiaries paid for by sub-national Government, 14.7 million participants are Wage

Recipient Worker State Organize. A total of 1.57 million were Wage Recipient Workers from the Armed Forces of the Republic of Indonesia, 1.28 million were Wage Recipient Workers from the National Police of the Republic of Indonesia, and 1.57 million from Business Entity Wage Recipient Workers- a total of 210 thousand participants, were Wage Recipient Workers from Regional Owned Enterprises, 34.1 million Recipient Workers from private sectors, and 30.2 million Non-Wage Recipient for Independent Workers while 5.01 million participants came from non-workers.

The increase in participation has a positive impact, for the development of UHC in the future, including as stated by Duta *et al*. (2019), that During the UHC launch the big risks relating to health services have gradually decreased because of the rise of membership and the fact that the more healthy people begin to join this scheme. This trend will have a significant implication to the long term financial sustainability and the social income received from this scheme.

7.2.2. Which Services are covered?

Referring to bivariate data analysis from 2012 until 2018, the respondents who had accessed outpatient services tended to have insurance 1.2 times higher than those who had never accessed outpatient services. The respondents who had accessed inpatient services were twice as likely to have insurance as those who had never accessed outpatient services.

The results align with the updated data on the utilisation of health services in outpatient and in-patient care mentioned by the Deputy of Planning and Evaluation (BPJS, 2019). The numbers of outpatient and in-patient from 2014 to 2019 significantly increased, there was an increase in the number of outpatient utilisations in the primary healthcare facilities in Public Health Centre (Puskesmas), in general practitioner and clinics, as well as type D primary hospitals and dentist. Meanwhile, an increased number of in-patient utilizations ere seem in both private and public hospitals, due to the expanded access to health services in outpatient and in-patient. It showed that during the UHC era,

access to health services has improved. The results are supported by the findings from the FGDs and in-depth interviews in this study. The informants stated the ease of access and increased utilisation of health services at primary health care and referral hospitals. This access is better than before the UHC era.

The existence of UHC increased access to health services at the Puskesmas or Primary Health Centre as well as the Referral Hospitals. In addition, in the UHC era, the participation coverage of people who have health insurance increased, including participation from low-income groups.

Data from BPJS Kesehatan also showed that the costs for utilising health services both in outpatient and inpatient care rose to IDR.640,821 million (£ 32,957 million) in 2018 (BPJS Kesehatan 2018). In contrast, the contribution of health promotion and prevention still need to be emphasised greater by BPJS Kesehatan, as the provisions in Law No. 40/2004 concerning the National Social Security System which state that BPJS Kesehatan is also given the responsibility to conduct promotion and prevention activities. The budget allocation for promotion and prevention programs by BPJS Kesehatan in 2017 was only IDR 417.96 billion (£ 21,215 trillion) or about 0.47% of the budget for health care benefits in 2017, which was IDR 87.22 trillion (£ 4,425 trillion).

In terms of funding, the promotion prevention programme has been allocated, but its utilisation is still low as well as data submitted by the Advocacy Coordinator of the Social Security Administering Agency (BPJS) Watch who assesses that the promotion and prevention programme at BPJS Kesehatan have not emphasised sufficiently. The budget allocation and its realisation, it seems that this programme has not been maximally implemented. In terms of the use of this programme's budget, BPJS Kesehatan is also less than optimal in using its funds. Until the end of November 2017, BPJS Kesehatan was only able to use promotion and prevention programme funds amounting to IDR 163.99 billion or around 39.23%. Meanwhile, as of May 2018, BPJS Kesehatan

was only able to use promotion and prevention program funds of IDR 72.91 billion (£ 3,699,453.40) or around 15.33%. Given the strategic importance of promotion and prevention programme to support the Indonesian people to live healthy lives and reduce the cost of JKN by BPJS Kesehatan, the Government needs to emphasise more that these promotive and preventive programmes are implemented by all hospitals and BPJS Kesehatan.

The law utilisation of promotion and prevention budget is unfortunate because these benefits include many programme that can be used to increase public awareness for preventing chronic diseases and living a healthier life. The promotion prevention programme covered by BPJS Kesehatan includes:

- Individual health education, including at least counseling on the management of disease risk factors and clean and healthy living behavior.
- Basic immunization, including Bacille Calmett Guerin (BCG), Diphtheria Pertussis Tetanus and Hepatitis B (DPT HB), Polio, and Measles.
- Family planning programme, including counseling, basic contraception, vasectomy, and Tubectomy in collaboration with institutions in charge of family planning. Vaccines for basic immunization and basic contraception are provided by the Government and/or Local Governments.
- Health screening, given selectively aimed at detecting disease risks and preventing further impacts of certain disease risks

While related to health screening such as Pap smears, there are still many people who still do not understand how to take advantage of these services. Even those who do not know are still paying for health services in private clinics. There are also some people who are still afraid of the Pap-smear because of the lack of knowledge and benefits for cervical cancer prevention. Seeing this condition, BPJS Kesehatan and all related parties still need to work hard and improvise in increasing the utilisation of promotive and preventive benefits.

Moreover, as estimated made by BPJS Kesehatan (2013) in 2030 the number of Indonesian citizens will reach 270 million people. Seventy million of them are thought to be over 60 years old. It can be concluded that in 2030 25% of

Indonesia's population will be elderly and susceptible to various degenerative diseases which can reduce productivity and various other impacts. The estimation is very rational, and the prevention program that has been developed by BPJS Kesehatan for the Chronic Disease Management Programme (PROLANIS) also still needs to be socialized more intensively in the community. PROLANIS programme is a system of governance of health services and health education for social health insurance participants who suffer from hypertension and type 2 diabetes mellitus to achieve the optimal quality of life independently (Idris, 2014).

The activities of PROLANIS itself consist of a medical consultation for PROLANIS participants: consultation schedules agreed between participants with health facility managers, high-risk educational clubs (PROLANIS Club) which are an activity to improve health knowledge in an effort to restore the disease and prevent a resurgence of the disease and improve the health status of PROLANIS remind, reminders or activities to motivate participants to make regular visits to health facilities through a consultation scheduling them to go to the health facilities manager, and home visits such as service activities of home visits of PROLANIS participants for the provision of information /self-health education and the environment for PROLANIS participants and their families (BPJS Kesehatan 2015).

The PROLANIS programme was very precisely developed, in accordance with the 2009-2019 Global Burden Diseases data, Diabetes is ranked number three (49.9%) from the ten top causes of death in 2009-2019 in Indonesia (Institute for Health Metrics and Evaluation, 2017). Previous research conducted by Ahmad *et.al.* (2017) show the optimal implementation of PROLANIS is amazingly effective for controlling the levels of fasting blood sugar (HbA1c) and total cholesterol in patients with type-2 diabetes. Another study has been conducted by Meilany *et al*. (2021) find that there is a relationship between the PROLANIS and hypertension controlling in the working area of Puskesmas Betoambari. Puskesmas officers need to maximise PROLANIS activities to

motivate the community to follow every activity conducted to lower blood pressure.

Besides PROLANIS, BPJS Kesehatan also needs to re-analyse the benefit package for healthy UHC participants, such as an annual medical check-up for participants who have never used UHC because they are healthy. This needs to be done so that healthy people also feel the benefits of UHC. In addition, with a more complete medical check-up package, it will detect chronic diseases early. The data of healthy patients or those who have never used UHC benefits needs to be conducted, like NHS England for cervical cancer prevention- female NHS participants aged 25 to 64 is invited for cervical screening (a smear test). This programme should be conducted by BPJS Kesehatan so that regardless of economic status or premiums paid by participants, there are rewards to foster public trust in UHC and BPJS Kesehatan whilst there are also many other benefits that are more towards increasing promotive and preventive efforts. For the utilisation of outpatient and inpatient health services, BPJS Kesehatan still has the responsibility to realise the target in expanding cooperation between health providers. As stated by one of the informants from BPJS Kesehatan of Referral Health Service Insurance Division, the target of health facilities is determined in the Primary Health Referral Assurance`s Budget Work Plan (RKA), for example until 2019 it must be a percentage of the number of hospitals registered at the Ministry of Health. Now there are 2500-2600 hospitals which have collaborated with BPJS, or around 87%, but not 100%. The most are private hospitals.

Universal Health Coverage is concerned with providing comprehensive healthcare services, including promotion and prevention. However, in Indonesia, BPJS Kesehatan is still more focused on developing curative benefits. As mentioned in Chapter Seven, Section 7.22, funds for developing promotive preventive programmes have been allocated. However, the absorption of the realisation of the use of funds is still low. As updated on the allocation of funds in May 2018, BPJS Kesehatan only absorbed promotion and prevention programme funds of IDR 72.91 billion (£ 3,699,453.40) or around

15.33% on the assumption that these promotive preventive programmes are successfully implemented. In that case, the benefits will be significant for investment in better public health in the future and reduce the increasing health costs of degenerative diseases, which continue to increase every year, as discussed in Chapter Three related to catastrophic disease costs. The data in Table 10 shows that heart disease has the greatest number of non-communicable diseases in Indonesia, which is increasing between 2014 and 2016. In 2016, the most expensive expenditure was IDR 6,491,761,274,870. In addition, kidney failure cases increased in 2014, 2015, and 2016, resulting in a total cost of more than IDR 12 trillion. Prevention programmes such as PROLANIS will help minimise the number of catastrophic diseases, while community promotion programmes such as personal consultation will help promote health behaviour awareness.

Apart from establishing the PROLANIS programme by BPJS Kesehatan to reduce the risk of hypertension and diabetes, BPJS Kesehatan still needs to continue developing health service packages that are more promotive preventive, like the development of routine medical check-ups for BPJS Kesehatan members. Apart from being an early detection effort of catastrophic illnesses, these benefits are also significant for BPJS Kesehatan participants who are never sick or who rarely take advantage of BPJS Kesehatan benefits.

Implementing promotive preventive benefits can be integrated or collaborated with various parties. Likewise, primary healthcare and first health service facilities have promotive preventive programmes for the community. To help socialise awareness of the community regarding these promotive preventive programmes, BPJS Kesehatan can collaborate with universities that have a role in health education, community service and research.

Furthermore, the critical role of stakeholders in implementing UHC, strengthening the health system, are also essential to be improved, as it is known that Indonesia adheres to a tiered health service system. This system includes service level, the first or primary level, the second or secondary level, and the third or tertiary level. Each level is divided into Community Health

Efforts (UKM) and Individual Health Efforts (UKP), which can be organised by the government, local governments, communities, and private. The government continues to encourage the strengthening of health services, both in terms of facilities, health services (infrastructure) and in terms of health human resources (HR). However, there are still problems of inadequacy and reasonable distribution of health facilities and human resources, thus affecting the quality and service (Ministry of National Development Planning/Bappenas, 2019).

The National Health System (SKN) states that the spearhead for services of the first strata of Community Health Efforts (UKM) is puskesmas which is cross-sectoral supported. In contrast, in the second strata of Community Health Efforts, the body in charge is the district/city health office, which has two functions, namely managerial and technical. The Provincial Health Office and the Ministry of Health oversee the third tier of Community Health Efforts. The first is realized through various efforts, from one family to community-sourced joint health efforts (UKBM). Currently, multiple forms of UKBM are being developed, such as Posyandu, Polindes, Village Medicine Post, Post Occupational Health Efforts, and Health Efforts (UKS). To strengthen Community Health Efforts, the Central Government seeks various programmes such as the Movement to Healthy Living Community (Germas), SPM (Minimum Service Standards), and the Indonesian Programme Healthy with Family Approach (PIS-PK) (Ministry of National Development Planning/Bappenas, 2019).

The efforts as described above and prioritising primary health care in the implementation of UHC will be beneficial because primary health care is the gatekeeper in health services at the next level. If the role of the primary health care service is optimal, it can reduce the number of unnecessary referrals. Therefore, monitoring and evaluation of this referral system need to be routinely conducted, both by the primary health care, the health service, and the Ministry of Health as the body in charge at the central level in terms of this referral service system.

It is important to increase promotive and preventive programs in this era of UHC. The optimising promotive and preventive programmes would increase public health status and public awareness. It can prevent chronic diseases, which will impact the quality of life and expensive health costs. The efforts made as described in the description above, as well as through strengthening primary health care and strengthening the referral system are efforts that can be conducted by crucial UHC stakeholders and GoI with good synchronisation and integration by all parties.

Additionally, the relationship between various programmes that are integrated with promotive and preventive programme will also greatly influence the success of UHC, such as the SDGs programme, the Movement to Healthy Living Community Programme (Ministry of Health), PROLANIS Programme (BPJS Kesehatan).

With a balance between promotive, preventive, curative, and rehabilitative health care as well as the expansion of collaboration with health providers, both government and private as well as private insurance for programme coordination of benefits or (COB), BPJS Kesehatan will be more successful in providing UHC benefits needed by all Indonesians in the future.

7.2.3. Why Do People Pay Out of Pocket?

Several Asian nations, including Indonesia, have introduced social health insurance in the last two decades to re-organise their healthcare funding systems and enhance access to healthcare services by lowering the cost of medical treatments at the point of use. Health insurance has a beneficial impact on increasing health care consumption in most studies conducted in these developing countries. In this thesis, Out of Pocket before UHC was 53.3% in 2012 and declined until 2018 with 34.2% Out of Pocket.

The lower number of Out of Pocket is better because the number of Indonesians covered by social health insurance increases. The number of private insurance participants has decreased from year to year since the start of the UHC era. The fewer people who pay for health financing out of pocket will

affect the management of finances, which should be more controlled by the social health insurance system. The result of this study is in contrast with the OECD (2016) reports, which stated that Out Pocket payments as a percentage of overall health spending are often more significant in many low and middle-income nations. Out of Pocket payments range from; 30% to 60% of total health spending in Brazil, China, Indonesia, and the Russian Federation (OECD, 2016). However, this thesis's results can be said to be more up to date because it was conducted using data from 2012-2018. Indonesia has tried to cover the Indonesian people to be protected by social health insurance and improving management so that the distribution of health services can be accessed by all people, including low-income groups and vulnerable groups. This research is in line with a study conducted by Tarigan and Suryati (2017). One of the main goals of the UHC programme is to provide financial protection for all UHC participants from medical costs, particularly catastrophic costs. UHC beneficiaries are entitled to numerous services as part of their essential benefits, offered free of charge. Compared to those who do not have health insurance, UHC participants who obtain health services are predicted to have lower Out of Pocket health costs.

In Tarigan and Suryati's research, there was a modest difference in Out of Pocket among the lowest-income population compared to the wealthy population at the start of the UHC era. This demonstrates that the low-income population's financial security for medical expenses is still inadequate. When opposed to people who do not have health insurance, having health insurance provides financial protection against medical bills, particularly catastrophic expenses. According to the findings of this study, by 2019, when the government's goal is to achieve Universal Health Coverage (UHC), financial support for low-income people will be higher, and so Out of Pocket should be closer to zero.

Although the Out of Pocket number has begun to decline, there are still problems related to public awareness, which before UHC tended to use Out of

Pocket to take advantage of health services. They are impatient with the referral health service system. Indeed, patients cannot cross paths in utilising health services through a tiered referral system from primary health centres to advanced health facilities such as Regional General Hospitals and Central, or private health providers collaborating with BPJS Kesehatan. However, a social health insurance system is encouraged to change people's behaviour in utilising health services more orderly. For example, if the patient has received sufficient first-level health care, the patient needs to be referred to a health service at a hospital. This action can also save money in terms of health costs. In this case, health service providers must maintain and improve quality by implementing excellent service and patient safety according to accreditation standards in primary health services and hospitals. In addition, health service providers also need to pay attention to patient satisfaction with the health services. Health workers and related parties to UHC actors must also encourage the public to realise that participating in social health insurance is better than using health services with the Out of Pocket system.

7.3. How successful has the introduction and implementation of UHC been in Indonesia?

How successful has Indonesia been in introducing UHC? This section will describe the efforts of the goal and the key UHC players in implementing UHC in Indonesia. As discussed in Chapter Two, state has responsivity to implement social protection, one of which is implementing social health insurance for the entire population. As mentioned in Chapter Three, goal has a long history of trying to implement UHC. Based on the results of this study, goal efforts were not in vain, including reform social health insurance in Indonesia into a single-payer health insurance scheme. The transformation is not easy because it unites various social insurance models into one administrator body under BPJS. BPJS is in two major divisions, namely BPJS Kesehatan and BPJS Ketenagakerjaan. BPJS is structurally under the President. Besides BPJS, critical players in the success of UHC include are the National Social Security Council, the Ministry of Health, the Ministry of Social Affairs, and the Ministry of

Finance. According to the results of in-depth interviews with key actors and mixed methods analysis, the efforts of goal and key UHC actors can be seen in achieving successful UHC implementation in Indonesia. What has been achieved well, things that still need to be improved in the future, and how they go through all processes, including resolving obstacles in UHC implementation in Indonesia, will used to be explored.

7.3.1. What has worked well and supported the implementation of Universal Health Coverage

The equity referred to in this study is seen from the utilisation of health services in outpatient and in-patient care by UHC participants. Beneficiaries of health services are not differentiated between Government Contribution Beneficiaries Recipients and Non-Government Contribution Beneficiaries Recipients. Based on the results of bivariate data analysis in 2012 until 2018, the respondents who had accessed outpatient services tended to have insurance 1.2 times compared to those who had never accessed outpatient services. The respondents who had accessed in-patient services were twice as likely to have insurance as those who had never accessed outpatient services. Meanwhile, updating data from BPJS Kesehatan (2019) on the utilisation of health services in outpatient and in-patient care from 2014 to 2019. The out-patients healthcare service in 2014 was 1.681, in 2018, 2.455 and in 2019 were 2.489. The in-patient healthcare service utilisation in 2014 was 18.437; in 2018 was 23 298 and in 2019 was 23.019.

The increasing number of outpatient utilisation in the primary healthcare facilities in Public Health Centres, general practitioners, clinics, type D Primary hospitals, and dentists. Meanwhile, the increasing number of in-patient health care services includes private and public hospitals. The increasing access to health services outpatient and in-patient shows that access to health services has improved during the UHC era. From the FGDs and in-depth interviews in this study, informants stated the ease of access and increased utilisation of

health services at primary health care and referral hospitals and that access has improved than before the UHC era.

7.3.1.1. Transformation Social Health Insurance System into Universal Health Coverage

Despite the many challenges in implementing UHC in Indonesia, the Indonesian government's determination to continue to improve the social health insurance system is very persistent. In the results presented in Chapter Five, it has been mentioned that on the UHC road map Indonesia has begun to develop a road map to reform and transform Social Health Insurance into UHC since 2012 and declared on 1st January 2014.

This process was complicated at the beginning of the transition period, as stated by all respondents in the FGDs and In-depth Interviews. The process included transforming several implementing agencies such as PT Askes, PT Jamsostek, PT Taspen and PT ASABRI into one implementing agency under BPJS. BPJS was then given the authority as an administrator body that directly coordinated with the President.

The stages of transformation include: The change from PT Askes to BPJS Kesehatan is the first transformation phase. The Second stage, the institutional positions. PT. Askes is under the Minister of State-Owned Enterprises is under the Minister of Health, while BPJS Kesehatan is under the President. Third, a change in mindset, from orientation to mere institutions to being more focused on participant satisfaction while still strengthening the institutions. Fourth, there was a significant increase in participants. At the time Health Insurance for Civil Servants (Askes) managed about sixteen million people, now it is around two hundred million and must be the entire population of Indonesia--including foreign nationals who have lived in Indonesia for more than six months. In terms of utilisation, 2017 data shows that there are 223.4 million people who use JKN-KIS services or an average of 612,055 people per day. In total, in the four years since 2014, there were 640.2 million people using JKN-KIS health services.

Fifth, changes in systems and procedures, which are now more complex but friendlier because of the presence of information technology. Sixth, expansion of partners and health facilities (Masha, 2018).

Regardless of the complexity of the transformation and accusations from many parties that goal is ambitious in conducting the transformation. The government's efforts need to be appreciated. The UHC transformation brings many benefits for the progress of UHC in the future. Many improvements were felt by various parties, especially UHC implementers in various sectors. Looking at the history and implementation of social security in Indonesia before UHC was overly complex, with many agencies or funders involved. For example, the central government had PT ASKES, PT JAMSOSTEK, PT TASPEN, and PT ASABRI, social security managed by the Ministry of Health, district, and regional social health insurance. The existence of many agencies made coordination more difficult, especially for participation, funding including premium payments. The latter also affects data, financial information systems, health care benefits and others.

Furthermore, there were also various models as described in Chapter Three on the Indonesian Social Health Insurance Schemes. There is Social Health Insurance for Civil Servants, Social Security for Private Sector Employees, Managed Care, Social Health Insurance for the low in-come group, District Health Insurance, and Universal Delivery Care. Because of these many models, the government had difficulty in coordinating and evaluating, health providers were also confused because of the many models of participation; people from the informal section were also confused about choosing the right health insurance model.

From launch, UHC became one of the largest health insurance schemes in the world, with over 117 million members. Pooling members from the various schemes meant UHC covered 46 percent of the total population in its first month. There are four primary segments of membership within the UHC

scheme, defined in various legislative regulations; Government contribution beneficiaries, Paid workers Nonpaid workers, Unemployed (see Chapter One Page 5-6)

The transformation of the health insurance system before and after UHC still has many challenges. Still, the transformation is the right decision to provide more optimal health insurance protection to the community. The transformation opened more comprehensive access to health services for all Indonesians regardless of economic status. Improve the health service system from Health Service Facilities to Referral Health Service Facilities. Including; expanding cooperation with health service providers and pharmacies so that health facilities are more feasible.

Some of the challenges in the post-transformation UHC implementation will be discussed in the next sections as well as how the efforts and solutions to overcome any barriers faced by policy holders and UHC implementers will be discussed.

The implementation of UHC in Indonesia was designed by GoI to provide comprehensive protection for the people of Indonesia. However, in reality this programme still needs to be evaluated further in terms of equity in health financing and health services especially during the transformation of social health insurance in Indonesia, which before 1st January, 2014 was managed by multi-payers and beyond that date the social health insurance system has been transformed into a single payer. This transformation effort shows the seriousness of GoI in providing health insurance protection for all community groups without exception, as the concept of UHC refers to financing and organisational arrangements that are sufficient to cover the entire population, by removing barriers to the ability to pay for access to health services and providing protection to people from financial risks (Ravindran, 2012).

The financing aspect of the implementation of UHC in Indonesia needs to be continuously monitored as it cannot be separated from the aspect of equity in financing and access to health services. The results of this study show that there are still approximately 50% of people who do not pay premiums in an orderly manner. One needs to better understand why is this happening. One of the factors is that many people's ability to pay is still low, not least because people from the informal sector do not have a fixed monthly salary to pay for BPJS Kesehatan premiums. The low-income group is subsidised by the employees with more secure employment such as those within the community sector and civil servants whose contributions are deducted from salaries, but for the informal sector, this remains a dilemma. To overcome this problem, an analysis of the ability to pay for UHC needs to be carried out in order to try to reduce the gap in health financing.

In the era of transformation, apart from the gaps in health financing, the issue of equity in health services is urgently needed to be resolved by the Ministry of Health and related parties. Health equity, as described by Murti (2017), consists of two major categories - horizontal and vertical:

- Horizontal equity refers to equal treatment of individuals or groups in the same circumstances (equal treatment for equal need). Horizontal equity exists when people with the same needs have access to the same resources. It is often the case that what might be considered equity (such as equal use between population subgroups) is, in fact, iniquitous. For example, similar use of services across population groups which have different levels of good health and/or different levels of health need signifies underlying inequalities and, as such, different population subgroups often have different needs or levels of need. This comes up to the second category of equity-vertical equity.

- Vertical equity refers to the principle that unequal individuals should be treated differently according to their level of need. Vertical equity exists

when people with greater needs are provided with greater resources (Starfield, 2011).

Based on the results of this study, during the transformation period of UHC, the horizontal equity in terms of providing comprehensive health services, has improved as evident by the increased population coverage but it there still needs to be further improvement, especially in improving insurance coverage and health care access in remote areas such as Papua and East Nusa Tenggara. The improvements that are necessary mean the potential redistribution of human resources for health services, facilities and infrastructure from the relatively better provided to the less well provided, that is an attention to vertical equity.

7.3.2. What has not worked well and what barriers have there been

The goal achievements in the implementation of UHC in Indonesia have been working well. However, the challenges faced today and in the future are also diverse, as discussed in the following sections. These challenges include employment, and economic status Affects the Membership in Universal Health Coverage, gaps and Implementation Regulation Overlap Between Stakeholders at National and Regional Levels, synchronization of premium and benefits; delayed claims effected to the financial protection; health care referral barriers; supply-side readiness; challenges in implementing health services in remote areas; low-income group accuracy data; lack of community awareness to participate in the UHC programme.

7.3.2.1. Employment and Economic Status Affects the Membership in Universal Health Coverage

The results of the difference in difference analysis, intermediate variable employment and economic status affect the participation variable in UHC. In the UHC membership data, it is true that most of the working population contribute more of UHC membership funds. In fact, for formal workers, things are more easily measured. Such as regular salary, allowances, taxes. So that it is easier

to calculate the number of contributions that can be deducted directly from the salary of formal employees, The health insurance contribution for wage-recipient workers is 5% of the monthly salary or wage (BPJS Kesehatan, 2018).

Based on the qualitative data analysis results, it is better if the premium payment can be re-evaluated and calculated carefully based on the concept of Ability to Pay and Willingness to pay. Naturally, if the population has a high income, they should pay a premium that is more in line with their income. This premium review is essential because insurance for the informal sector with no fixed monthly salary is still a problem in Indonesia. Furthermore, Indonesia does not have an unemployment insurance arrangement at present. This not only leaves employees vulnerable to a drastic reduction in welfare if they lose their employment, combined with the unequal functioning of severance pay but also suggests that Indonesia lacks an adequate counter-cyclical social security system (OECD, 2019).

Referring to OECD, it is recommended that health insurance participation from the informal sector be reviewed again. Likewise, the involvement of the community sector does not function. Indeed, the government does not yet have a scheme for unemployment. However, the unemployed also needs to have access to health services. It can be coordinated with the Ministry of Social Welfare and the local government to find a suitable solution. For instance, Yogyakarta Province still maintains its District Health Insurance to protect people who are not covered by other any health insurance. Indeed, since the official implementation of UHC, in 2014. In Indonesia, all social health insurance has been transformed into a single scheme under UHC and BPJS as the administrator body nationally.

7.3.2.2. Gaps on Implementation Regulation between Stakeholders at National and Regional Levels

According to CIPP Model evaluation results the most respondents explained that many regulations had to be adjusted during the transformation period

before and during the UHC era. Referred to the results, rules, especially those in technical form, should be socialisation in advance so that health providers are better prepared to implement regulations, whether it is from the Indonesian Government, BPJS Kesehatan or the Ministry of Health. There are many rules at the beginning of the UHC transformation. This transformation makes policyholders such as the Health Office and health service providers; Puskesmas, Hospitals find it difficult in terms of administration, management, and technical services.

The results of triangulation with various parties in this study, related to post-transformation regulation, have many changes. On the one hand, it is considered normal because of the new schema, such as online referrals with P-Care. However, stakeholders, especially the Health Office, health service providers, expect that the socialisation of the new regulations will not be rushed. They need time to prepare and disseminate information to their internal organisation, including external parties such as patients, partners, and others.

The results of triangulation with one of the informants from the National Social Security Council, the main problems in UHC about institutional and one about regulation. Rules also cause this institutionalisation, too many sub-delegations. Many rules are regulated under Government Regulations, and disharmonies, conflicts, or regulations are increasingly complex.

There were interesting findings during the FGDs regarding the management of UHC. Many informants suggested that UHC be managed by the Ministry of Health. In my view, if UHC is managed by the Ministry of Health, this is not appropriate considering several reasons; UHC needs to be managed by a special agency that focuses on managing health insurance coverage such as BPJS Kesehatan, starting from membership, premium management and health insurance packages. Meanwhile the Ministry of Health is more appropriate to focus more on optimisation to improve the quality of health services, while the

National Social Security Council is a trustee who has the authority, including reminding BPJS Kesehatan, UHC actors to do not deviate from regulations.

Therefore, some regulations have not been synchronised, while many sub-delegates are still in implementation. There are already rules for their respective duties and functions between the National Social Security Council, the Ministry of Health, and BPJS Kesehatan. However, there is still much confusion because it is still early in implementation. To resolve this issue, all parties need to sit down together to review the overlapping regulations, including cross-checking their respective duties and functions.

7.3.2.3. Synchronisation of Premium and Benefits

The demand in this study is to find out more clearly about community needs related to premiums and social health insurance packages, explored this question from the opinions of relevant stakeholders in determining the premium and social health insurance package.

Some findings related to the Ability to pay or contribution levels in social health insurance are the premiums, insurance packages, and health service packages currently being implemented are not in line with the actual health services and actuarial situations. The Provincial Health Office, District health office, hospitals, and primary health care have no authority. They have never been involved concerning Ability to pay and Willingness to Pay (ATP/WTP. The premium calculation is from the central, as one of the respondents explained. The determination of premiums is coordinated with the National Social Security Council, the Ministry of Finance and the President.

When conducting this research, the issue of increasing fees began to be discussed by all stakeholders. Many people blame BPJS Kesehatan because the public does not know the regulations that have the right to apply and determine the UHC premium. When observing documents related to the duties and functions of the National Social Security Board, the proposed premium is indeed the authority of the National Social Security Board, not BPJS. I did the

triangulation by confirming directly with the National Social Security Council; in fact, the National Social Security Board has conducted Ability to Pay and Willingness to Pay (ATP/WTP) to determine premiums and benefits following actuarial calculations. Unfortunately, the proposed premium was not approved by the President and decided the amount to the premium was different from what had been calculated by National Social Security Council. Therefore, the premium and benefits do not represent the community's needs. Eventually, it caused conflict when the issue of rising premiums became an alternative from the government.

The latest update regarding the increase in contributions is that at the end of 2019, the government has issued an increased policy BPJS Kesehatan contributions set through Presidential Regulation Number 75 of 2019. The policy has generated a response from the community because the percentage increase in contributions is high. In early March 2020, the Supreme Court of Indonesia overturned the increase in fees based on a judicial review submitted by the public.

In my view, the government needs to consider the premium proposal from the National Social Security Council, which has conducted a survey of ATP/WTP and calculates the suitability of premiums with actuarial calculations. The National Social Security Council has also coordinated with all relevant parties, such as BPJS, Ministry of Health, Ministry of Social Affairs. Although these stakeholders are not authorised to decide the amount of the UHC premium, they are entitled to provide opinions and considerations through the National Social Security Council for the appropriate amount of premium proposed to the Minister of Finance and the President.

The calculation of the UHC premium needs to be considered carefully. It is hoped that it will be able to predict future health service needs. If unexpected things happen, such as increasing health costs for non-communicable diseases,

Outbreaks, and disasters, everything needs to be calculated carefully, both from an economic perspective, as well as community needs and demands.

The number of contributions is not following actuarial calculations and is insufficient to finance service expenditures, let alone expensive health services for catastrophic diseases, is extremely high and continues to increase. Contributions that are currently running are not able to sustain the existing load.

Review of the currently generous UHC benefits package is occurring incrementally through a process related to health technology assessments; a more comprehensive review will help to ensure that what UHC provides matches the evolving health financing landscape. The Ministry of Health has started to use health technology assessments to rationalize the type and use of pharmaceuticals and certain diagnostic technologies covered under UHC, to ensure the most cost-effective interventions are used (Duta et.al. 2019).

The evaluation conducted by Duta *et al* is in line with the results of interviews in this study, as stated by one of the representatives from the Ministry of Health that the Ministry of Health is developing and reviewing HTA to improve efficiency in the health care provided as well as drugs, and cost efficiency.

Based on the findings from my study, an analysis of the suitability of premiums and UHC packages needs to be conducted to achieve conformity of premiums with benefits with community demand, effective in terms of supply side and efficient in terms of costs. To achieve this, the National Social Security Council has the authority to coordinate all key UHC actors to jointly review the suitability of UHC premiums and benefits and oversee the results of joint calculations and decisions up to the President level. So that the decisions passed are in accordance with the actual calculation results, and the benefits are also in accordance with the needs of the community and health services in accordance with the mandate of the National Social Security System.

7.3.2.4. Delayed Claim and Financial Sustainability of BPJS Kesehatan

Financial protection is one of the essential components in the implementation and sustainability of UHC. Financial Protection includes that countries should make comprehensive financial coverage for cost-effective services a top priority for the entire population. Financial protection necessitates a careful evaluation of which health services are valuable and which are not. Second, countries must embed economic sustainability into their plans from the outset, with the necessary tools to assess the scope of the problem and revenue diversification and cost containment. Third, countries should be creative in their service delivery, looking for methods to make health spending more efficient (OECD, 2016)

As mentioned above, Social Health Insurance in Indonesia is still experiencing challenge in how to manage its finances, as can be found related to delays in UHC claims in health services, especially in hospitals. This problem certainly requires a solution because it affects many other issues in implementing health services.

At the time of the study, the average delay in claims was 5 to 15 days, sometime more. Various efforts have been made by health service providers, such as those conducted by private hospitals, namely by using an allocation of savings funds called "Deposit Boxes". This fund is usually intended for low-income patients who do not have health insurance and look for opportunities to open health service packages that do not yet exist in other hospitals. Meanwhile, public hospital uses funds from the Annual State Budget. Regional hospitals use the Annual Regional Budget or from Excess Remaining Budget Financing of the Year funds. Coordination and communication with BPJS Kesehatan are also conducted continuously.

Another study that examined delayed claims and the financial deficit of UHC was conducted by Putri et al. (2019). The results the duration since the invoice is prepared by the hospital until paid by BPJS increased steadily from 62 days

in 2014 to 129 days in 2017 or more than four months. The delayed claim is unfortunate for the hospital, especially the private hospital sector; if allowed to drag on, there is a domino effect that ends down service to attendees even the possibility of bankruptcy of the hospital.

Research on the sustainability of the BPJS Kesehatan financing was conducted by Chazali H. Situmorang (2016) and showed evidence of the existence of a funding gap for the UHC programme. It was concluded that UHC's financial condition was unsustainable, at least under current conditions. Nevertheless, there are several ways that can be done to make the UHC financial system more sustainable, including by revising the value of contributions, rationalising health service rates, and launching a series of cost control programmes, and promoting efficiency. The tiered referrals between Health Service Facility Referral Level have resulted in more claims paid by BPJS Kesehatan to hospitals. Based on field findings, type B hospitals will accept patients who cannot be managed by the type of hospital in Indonesia with conditions that are serious enough so that the burden of costs incurred by the hospital becomes inefficient. The BPJS Kesehatan performance reports and financial reports do not include in detail the expenditures as stipulated in the BPJS Law Number 24 of 2011. Lack of transparency and accountability can create conditions that allow financial mismanagement, either intentionally or unintentionally. At the service delivery in the First Level and Referral Health Service at local governments, fraud also occurs or misuse of UHC funds. Many houses' hospitals and clinics suspected of "mark-up" claims for BPJS Kesehatan funds.

If there is no increase in contributions and alternative funding for 11 years (2019 - 2030), then the cumulative deficit of the JKN-BPJS Kesehatan will reach IDR 609 trillion in 2030. So, related to alternative funding JKN-BPJS Kesehatan to be optimal and sustainable and free from deficits. This study shows that the combined scenario increase in contributions and tax on goods or service can resolve the UHC deficit. The projection is that if the contribution increase scheme and extensification of excisable goods are conducted simultaneously,

then by 2030, UHC funds will have a surplus of IDR 13.5 trillion. If it only increases the dues periodically two annually with the amount of 15-18%, the UHC fund surplus amounted to IDR 4.9 trillion in 2030. The increase in periodical fees will be more accepted by the community because it is not burdensome society spontaneously. The choice of a combination of extensification of excisable goods and an increase in dues according to the analysis of this research is the most feasible, both politically and economically technocratic.

Another alternative to overcome the UHC deficit is described by Duta *et al*. (2019), the revised financial projections for UHC demonstrate that deficits could stabilise once the scheme approaches universal coverage. Currently the aim continues to affirm its commitment to UHC and to continuing to fund its deficits from the national budget. The Ministry of Finance has requested more certainty around the expected amount of the deficit, suggesting there are upper limits to what can and will be paid.

In addition, for delayed claims, an internal evaluation of health service providers can be conducted, by checking whether so far, the health services provided have been in accordance with BPJS Kesehatan operational standards. For example, medicines that already have the National Formulary standard, if they are not in accordance with the BPJS Kesehatan, the claim will not be refunded, as well as other health services. On the other hand, BPJS Kesehatan also has the responsibility to check whether the results of the verifier have verified correctly. As well as efforts to speed up the claim review process so that it does not take long for the reimbursement process to health service providers.

Problems related to the BPJS Kesehatan financial deficit, several alternatives can be implemented, including conducting internal and external audits, to map the deficit problems that have occurred so far. Another alternative is to review the suitability of UHC premiums and benefits, mainly considering the increasing number of Non Communicable Diseases (NCDs) can affect the cost of health services. Furthermore, increasing promotion and prevention programme. As

well as increasing public understanding to follow UHC with full awareness, so that there will be no drop-out of participants who are not disciplined in paying UHC premiums. Another alternative could be from paying taxes, excise duty on cigarettes or tobacco. Conduct cooperation between the public and private sectors to seek alternative funding. Local government support is also especially important, even though UHC is under the central government.

7.3.2.5. Health Care Referral Barriers

Regarding the implementation of this regulation, it was explained by representatives of the BPJS Kesehatan division of referral health service insurance explained that the number of providers who have collaborated with BPJS continues to increase even though they are not 100%. Meanwhile, the issue of Ina-CBGs rates is still a concern for BPJS and providers in its implementation. However, the calculation is tighter, some providers still consider INA-CBGs rates not to benefit the hospital. In this study, the referral service problem was also one of the findings. Specifically, the tiered referral, referral returns programme (PRB), an online referral (P-Care).

Responding to online referrals or P-Care, the Primary Health Financing Assurance and Primary Health Referral Assurance BPJS Kesehatan representatives argue. In implementing P-Care, which aims to facilitate access to online referrals, maintenance is needed, to ensure that the network, facilities, and infrastructure in health care facilities are adequate. In addition, understanding procedures and commitment from providers to update room availability data also needs to be done.

To overcome access to referrals, the Ministry of Health is trying to make health facilities the same standard through accreditation. The Ministry of Health builds regional referrals spread across thirty-four provinces, including one province, district, and city. This effort is expected to facilitate access. The desire to build health care centers, cancer services outside Jakarta has begun to be planned. Expectantly, this plan can be realised soon, so that it can facilitate access to

health services, especially in suburban or remote areas that are geographically difficult to reach.

The referral return Programme also needs to be evaluated because the increase in the number of uncontrolled referrals and not following standards will cause an increase in the cost of health services. Similar research conducted by Permatasari and Ernasari (2019) stated that policies on referral networks have long existed in Indonesia. Non specialist references continue to occur and result in health care Inefficiency. BPJS Kesehatan estimated that the primary health care facilities referred in 2015 had 2,236,379 visits, 214,706 of which were non-nonspecific referrals. In 2016, there was an increase of 4.9 million secondary and tertiary outpatient re-control cases compared to 2015, resulting in a cost increase of 789 billion compared to 2015.

The Referral Return Programme or PRB is not optimal because several things need to be evaluated further by BPJS Kesehatan and health providers. Permatasari and Ernasari (2019) further stated that PRB is still rarely conducted because some health workers still lack understanding of the Referral Return Programme and treatment limitations in primary health care facilities. Thus, problems causing patients who must seek treatment at primary health facilities to be referred to secondary and tertiary health facilities. The lack of information from BPJS Kesehatan to health workers about PRB has resulted in different perceptions that have affected the ineffective implementation of PRB in secondary and tertiary health facilities.

7.3.2.6. Supply Side Readiness

As the results chapter has described, although there has been a good deal of progress compared to before UHC in terms of infrastructure, such as availability of human health resources in primary health care and referral hospitals, efforts to complete the infrastructure of health facilities, adequate health management information system, and drug procurement planning. Unfortunately, as

evidenced with the FGDs and through triangulation with related stakeholders, these were still some barriers on the supply side.

This study's findings for supply-side readings include the lack of maintenance of the online referral system, namely P-Care, which should be conducted routinely by BPJS Kesehatan. Such as in the First Level Health Service Facility, this is geographically constrained by an adequate internet network, often the procurement of drugs is not possible due to lack of supply, especially in regional or government referral hospitals. A dilemma for the hospital, if using medications with the same benefits but assorted brands, this can cause problems with BPJS claims because they are not following the agreed National Formulary. The limited number of drugs in the hospital pharmacy installation also occurs at the Yogyakarta Regional Hospital. The respondent admits that the stock of medicines from pharmaceutical companies is often empty. At the same time, Private Hospitals overcome the scarcity of the number of drugs patients need by making annual plans.

In general, for infrastructure since UHC, there have been many improvements. However, the Health Information System still needs further evaluation, especially the Online Referral System (P-Care), which in this study is still a lot of complaints by the Health Service and Health providers.

Primary Care or P-Care is a BPJS Kesehatan application that provides access for participants to first-level health facilities (FKTP). FKTP has a role as a gatekeeper which can enable health workers to manage 144 diagnoses of diseases suffered by UHC/BPJS Kesehatan patients. If the FKTP can no longer treat the patient further, it will refer the patient to an Advanced Level Referral Health Facility (FKRTL). The patient will receive further treatment according to his medical needs. In terms of patients, the presence of P-Care makes BPJS Kesehatan participants feel more satisfied in matters of referral during treatment.

In terms of Health Providers, P-care makes it easier to coordination related to online referral services between First Level Health Facility and Advanced Level Referral Health Facility, including checking the availability of rooms or hospital beds that are still available. P-Care also makes it easier for the process of referring inpatients to a referral hospital. However, this system must be maintained by BPJS Kesehatan, and Health Providers, it is necessary to be more accurate in inputting data into the P-Care System. Another challenge in supply is financial problems due to delays in claims from BPJS Kesehatan to health service providers. And the disparity of health services in remote areas. These two topics are discussed in the next section.

7.3.2.7. The Challenges on Implementing Health Services in Remote Areas

There are thirty-four provinces, 514 districts and around 72,000 villages in the country. Public supply at the district/city level is decentralized. Geographical conditions are an essential barrier to operation as a country with over 6,000 inhabitable islands (Indonesia Island, 2020). Public and private providers deliver health services in Indonesia. In rural areas and secondary care levels, the public sector typically plays a dominant position. However, this does not apply to all health services. In recent years, private coverage, including primary care, has expanded rapidly.

In this study, although it appears that the utilisation of health services is increasing, BPJS still faces several challenges in this regard, as admitted by the informant that there were still gaps in rural and urban communities regarding the utilisation of health services. The results of this research are in line with Britnell (2015). A large population is one of the significant challenges in implementing UHC, especially in remote areas, which still require socialisation of the importance of participating in the UHC programme. Health service infrastructure facilities, provision of professional health human resources, medicines and implementation of optimal management information systems also need to be improved.

In line with the research conducted by Aida (2016), who shows the distribution and availability of health facilities personnel are essential to prepare for UHC in 2019. Based on the Ministry of Health data, health facilities and personnel are not evenly distributed. For example, West Papua has the highest ratio of Primary Health Care per thirty thousand populations among other provinces in Indonesia. Meanwhile, the lowest percentage of Primary Health Care is occupied by the area of North Kalimantan. Although West Papua has the highest ratio of public health centres, unfortunately, the proportion of general practitioners to the number of available health centres is the smallest among other provinces (Aida, 2016).

Even though Indonesia has so many islands with various geographical locations, it is important to implement health equity so that there is no disparity in the utilisation of health care facilities, even in remote areas. As emphasised by Murti (2017), the importance of health equity is a critical policy goal. The policy goals to minimise and finally abolish health disparity have two fundamental motivations. First, health imbalances are unjust. Inequity in health runs against the basic human rights tenet: everyone has the right to the best physical and mental health possible.

One of the findings in this thesis is that outpatient and in-patient service continued to increase from 2014-2019. However, the gap in access for people living in remote areas is still a finding that related stakeholders need to find the right solution. The results of this study are in line with those presented by the Director of Referral Health Services at the Ministry of Health, admitting, "The infrastructure of the existing health facilities is quite adequate. But, if you look at the geographical disparity of our country, which is very varied, there are many islands with an uneven distribution of population, the graves still need additional health facilities" (UNAIR, 2018).

The problem of distance and mal distribution is being addressed by the government. The Ministry of Health representatives state the efforts to provide

facilities and infrastructure to remote areas. There are also efforts to distribute Health Human Resources in remote regions, as JLN (2018) stated. The GoI has launched the Nusantara Sehat programme to improve the connectivity of essential health services in remote areas by sending a medical team.

The Nusantara Sehat Programme is one form of activity launched by the Ministry of Health to realise the policy focus. This programme is designed to support implementing the UHC and Healthy Indonesia Card (KIS) programme. The Government prioritises creating a healthy, independent, and just society—conducted the Nusantara Sehat programme through the team-based placement of health workers was based on a study on the distribution of health workers conducted by the Ministry of Health in 2012. One of the study's recommendations showed that the placement of health workers in certain areas is better if done on a team basis. This study was followed up with a pilot deployment of team-based health workers in 2014 in four Puskesmas in four districts in four provinces (North Sumatra, West Kalimantan, Maluku, and Papua) and succeeded in increasing Puskesmas visits and Community Health efforts. In terms of health, workers feel more comfortable because they are placed and work in a team (Ministry of Health, 2016).

To address health disparities, one of Murti's (2017) recommendations is making the broad changes needed to decrease health disparities which require collaboration and cross-sectoral partnerships. The latter requires the involvement of unconventional players such as public health professionals, businesses, policy makers, financial planners, economists, academics, and faith-based leaders, in addition to public health professionals and traditional social service-related fields people.

In addition, coordination, and communication of various parties such as the Central, Regional Government, Health Office, and Health Workers are needed to ensure that health services and health care facilities are not problematic. It is also crucial for the Department of Health and Health Personnel to plan the

procurement of facilities and infrastructure, to plan for all the needs of health services regularly every year.

7.3.2.8. Low-Income Group Accuracy Data

The accuracy of data for low-income groups is essential to be monitored and updated on an ongoing basis. One of the findings in this study is that the validity of low-income group data, especially for Government Contribution Beneficiaries Recipients, has not been appropriately updated. A representative from the District Health Office explained that it is related to the constraints of updating data and the process.

Updating data is crucial for policymakers and targeting the low-income groups entitled to receive assistance from the government, such as in UHC Programme. The lack of data updates also causes low-income groups who have not been covered by UHC and cannot access health care services, as explained by one of the representatives from private hospitals:

Implementing health insurance aims to increase access to health services for all populations, including the low-income group. Inaccuracy of low-income group data requires cooperation and coordination with all parties, as mentioned at the beginning. Villages, sub-districts, regions, and districts have the authority to ensure that they report data updates and assist with verification according to their area. It is not expected that the subsidy recipients will be misdirected to cause the low-income group to be unable to access proper health services.

The Ministry of Social Welfare already has official regulations regarding verification regulations, updating data for Government Contribution Beneficiaries Recipients, and an information system already in place. However, monitoring and evaluation are crucial to continuing at all levels so that the accuracy and validation of data is no longer a problem.

7.3.2.9. Lack of Community Awareness to Participate in the UHC Programme

Referring to the findings of in-depth interviews and FGDs with key UHC actors, the public awareness of UHC is still low. While crosscheck with quantitative research, although the participation rate of the Indonesian population continues to increase, most participants work as civil servants or informal employees who already have a fixed salary. The participants are automatically registered by the agency or company with a salary deduction system. In this case, the participation of the middle class, who also does not have a basic salary, still needs to increase their awareness. They are more likely to participate in social health insurance because they have illnesses that require regular treatment such as heart disease, diabetes, or other NCDs. The mindset that taking insurance is only because of illness is still common in Indonesian society. The public's lack of awareness to become UHC participants is the substantial number of participant's dropouts. As explained by one respondent:

This problem occurs in addition to not being aware that being a UHC participant is important, maybe because they must pay premiums regularly every month. In contrast, many still do not have a fixed income. They usually work part-time as drivers, traders, farmers, fishermen and own businesses whose salary or income is uncertain every month.

Seeing these problems, the government, especially the National Social Security Board, has the authority to conduct ATP/WTP surveys and is more assertive in submitting the survey results to the central government, in this case, the President as the final decider.

Regarding the public's lack of awareness on UHC participation, it is indeed necessary for all parties to participate in socialising UHC. Because the community component is also important for the implementation and sustainability of UHC in Indonesia, the results of the study conducted by Wulandari *et al*. (2020) show that the UHC Programme has numerous

opportunities for its sustainability. The role of the community undoubtedly influences the implementation of the UHC. Another study conducted by Rosyidah *et al.* (2019) explores that the participation of Indonesian society plays a crucial role in supporting the success of UHC, the willingness to participate in the UHC programme and the awareness of their rights and responsibilities.

Referring to Rosyidah's study, socialisation to increase public awareness related to rights and obligations and the importance of participating in UHC still needs to be conducted. Even though from the results of interviews and FGDs in this research, the National Social Security Board, BPJS, Ministry of Health and all related parties claimed to have conducted socialisation in many ways. There are still many people who do not know about BPJS Kesehatan or UHC, include the rights and obligations. Such as paying premiums, utilising tiered referral health services and others. The public is also less responsive to BPJS Kesehatan services, as it is socialised in various media. Such as through radio broadcasts, newspapers, virtual media, or the official BPJS Kesehatan website.

In my view, from the results of this study, the socialisation conducted so far is still insufficient. This socialisation model is still complex for people who have varying levels of education and knowledge. Also, religion and culture affect people's acceptance to participate in BPJS Kesehatan. It is necessary to develop a mass socialisation strategy that is more in line with community groups in Indonesia. Such as seminars are suitable for the academia who is concerned with scientific forums. In addition to seminars, it can also include it in the curriculum in courses. However, this model is not suitable for lower-middle groups whose forum meetings are held during Village Community Discussions or integrated with community programmes such as the Healthy Community Movement, as announced by the Government under the coordination of the Ministry of Health. Community outreach activities or other programmes close to community activities in the village are happy with social and community activities. Socialisation like what was done at Primary Health Care or Puskesmas could be done more often.

The BPJS Kesehatan, which is currently making progress with its socialisation programmes, still needs to continue to build trust in the community. Before trust and pride, it is necessary to increase public understanding and awareness of UHC and BPJS Kesehatan. They need is continue to conduct public campaigns, accompanying activities that are close to the community at all levels. BPJS Kesehatan needs to improve the quality service for the societies. Furthermore, raising public awareness requires a persistent process, appropriate socialisation strategies, interesting information media. Socialisation is conducted by all parties, but to be more effective, BPJS Kesehatan should cooperate with relevant agencies to help conduct socialisation, also needs to monitor the information submitted to the public, so as not to deviate from the goals and benefits that will be targeted.

Chapter Seven can conclude that the positive impact of the implementation of UHC in Indonesia includes; the increasing population covered in this program, including the poor. Access to inpatient and outpatient health services has also increased, reducing people who pay out of pocket.

The implementation of UHC can be said to be successful in terms of efforts to increase participation, increase access to health services, courage to carry out transformation. Meanwhile, the challenges of future UHC implementation for the government and key UHC players include; employment, and economic status Affects the Membership in Universal Health Coverage, gaps and Implementation regulation overlap between Stakeholders at National and Regional Levels, synchronization of premium and benefits; delayed claims effected to the financial protection; health care referral barriers; supply-side readiness; challenges in implementing health services in remote areas; low-income group accuracy data; lack of community awareness to participate in the UHC programme.

UHC in Indonesia will sustain if all stakeholders and society are aware of their respective duties and responsibilities to participate in the UHC programme and continue expanding membership coverage, recalculating premiums and packages following community needs and health services. Continue to monitor and evaluate the referral system. Increase supply-side readings regarding funding, human health resources, infrastructure, drug supply, and health information systems. Also, improve access to health services in remote areas.

7.4. The Sustainability of Universal Health Coverage

Based on the Mixed Methods analysis results, UHC in Indonesia brings benefits and is expected to sustain. Such is the belief of the Key UHC stakeholders. They optimistically affirm that UHC will be successful even though there are several suggestions for improvement for better UHC implementation in the future. Other respondents also agree that UHC has many positive elements to improve the health status of the Indonesian population. Also, it helps to enhance the quality of life and life expectancy. UHC's sustainability will be achieved through mutual commitment. However, many things still need to be addressed for the success of UHC in the future.

As mentioned in the reference above, all parties from various professions influence the achievement of UHC. Also, effective communication, coordination, and socialisation to related parties, include the community. UHC can be sustainable even though there are still many challenges. The essential things that need to be improved include the commitment with all parties, such as the Ministry of Health, to focus on equitable access to services, public awareness, and quality of health services. The government's commitment is highlighted, especially in determining premiums and service packages according to medical and community needs. This includes Government Contribution Beneficiaries Recipients participants who receive subsidies from the government. The form of government commitment as exemplified by the Referral Services Division as follow:

The commitment and role of all parties to socialise about the implementation of UHC are essential; the relationship between various programmes that are integrated with UHC will also greatly influence the success of UHC. Such as the SDGs programme, Family Hope Program (Ministry of Social Welfare), GERMAS Programme (Ministry of Health), PROLANIS Programme (BPJS Kesehatan) and other programmes that need to be integrated with the implementation of UHC. All parties are expected to support each other.

Submitting proposals to the National Social Security Council, for premium adjustments in accordance with actuarial calculations and ATP/WTP surveys are important to conduct. Relating to membership, BPJS Kesehatan needs to review premium and contribution for informal workers who do not have a fixed income. BPJS Kesehatan also needs to coordinate the Government Contribution Beneficiaries Recipients data with the Ministry of Social Welfare to ensure accuracy and validity of the latter and to coordinate with the Ministry of Health related to equitable distribution of health services, especially in addressing access in remote areas.

As discussed in Chapter Seven, section 7.2.2. Which Services is Covered, UHC Benefits can be added to a more complete medical check-up package. BPJS Kesehatan also continues to improve monitoring and evaluation for promotive preventive programs at Health Service Facilities and Health Providers. It is also necessary to expand cooperation networks with health government or public and private health providers.

Universal Health Coverage sustainability also depends on transparent and accountable monetary management. It is necessary to immediately conduct a more in-depth evaluation related to the financial protection. Such as delayed claims which are a problem, especially at the referral hospital level. If this delayed claim is not resolved, this will result in a decrease in the quality of health services, patient satisfaction or UHC participants and public trust.

Even though socialisation has been conducted, it will continue to be improved, so that people are more interested in becoming BPJS Kesehatan participants. The community is also more aware of the benefits of being a participant, their rights, and responsibilities.

CHAPTER EIGHT

CONCLUSIONS, RECOMMENDATIONS, LIMITATIONS AND PERSONAL REFLECTIONS

8.1. Overview

Chapter Eight provides conclusions to the research conducted, and thus endeavours to provide answers to the overall research objective of this study, that is an examination of the effectiveness of the implementation of the Indonesian social insurance model of health and, specifically, what has been the impact of the implementation of UHC in Indonesia and how successful has the introduction and implementation been.

Therefore, first, what has been the impact of the implementation of UHC in Indonesia, the population covered by UHC and the health services provided by the government in Indonesia? As to BPJS Kesehatan, are there still people who pay out of pocket and what about the sustainability of UHC in the future? The responses to this first question include, among other things, an increase in UHC participation from 2012 to 2018. People who are participants in the UHC programme belong to a low-income group. This increase of the involvement was after the legalisation of UHC on 1st January 2014.

Furthermore, there was an increase in the utilisation of outpatient and inpatient access after or during UHC. The decrease in the number of people who pay for health care costs out of pocket is because most people have become UHC participants. Based on the Mix Methods analysis, we can conclude that UHC can endure even though things still need to be improved.

The second research question is related to how the Indonesian government introduced and implemented UHC. Key responses to this question include what has worked well and assisted the implementation of UHC. Also, what has not worked and what have been the barriers during the UHC implementation. The

government's effort to transform social health insurance from a multi-payer to single payer is one of the achievements that need to be appreciated and supported to improve the UHC system in the future. Regulatory, availability, goals, targets, and benefits which exist before and after UHC need to be monitored and evaluated. If necessary, a synchronisation of regulations may still be needed. An increase in UHC participation, improved and increased access to health services, and a reduction of people who pay out of pocket all began to increase after UHC implementation by GoI.

Despite the achievements in implementing UHC in Indonesia, the challenges of implementation also require attention from all parties, especially the key UHC actors and the community. Challenges during UHC implementation include the informal sector's low participation, especially those who do not have a fixed monthly income. There are still problems in terms of drug supply, a delay in claims from BPJS Kesehatan to health providers and the existence of a financial deficit that has had an impact on health services. Furthermore, referral issues including in relation to P-care online referrals, as well as the challenges of implementing health services in remote areas, low-Income group accuracy data and lack of community awareness to participate in the UHC programme all still need to be addressed further. These points are explained further in the conclusions.

Chapter Eight also includes research recommendations for UHC key actors such as the National Social Security Council, BPJS Kesehatan, Ministry of Health, Ministry of Social Welfare, and health service providers along with recommendations for policymakers, academics and researchers who participate in or examine UHC implementation. Further research on limitations and personal reflections regarding the accomplishment of this dissertation is also included in this chapter.

8.2. Conclusions

The conclusions in this study refer to the research questions and the results of data analysis as follows:

R1: What has been the various impacts of the implementation of the chosen methods via UHC in Indonesia?

There is a correlation between social health insurance era (before UHC and during the UHC) with the membership of UHC in Indonesia. Based on BPJS Kesehatan data on 27th December 2019, the number of UHC participants was 224.1 million or 83% of the total population of Indonesia of 269 million people. The population covered includes 96.5 million participants from Government Contribution Beneficiaries, paid by the central government; another 38.8 million participants were Government Contribution Beneficiaries paid by regional government, 14.7 million participants were civil servants paid by the state, 1.57 million were paid workers from the Armed Forces of the Republic of Indonesia, 1.28 million were paid workers from the National Police of the Republic of Indonesia, and 1.57 million from business paid workers a total of 210 thousand participants were paid workers from the Regional State Owned Enterprises, 34.1 million paid workers from private sectors, 30.2 million independent workers while 5.01 million participants came from unpaid workers. This increase in participants is in accordance with the results of interviews and FGDs which state that only 83% out of 100% of Indonesia's target population were covered by UHC in 2019. The results of the DID analysis show that employment status and income have a relationship that influences UHC participation.

In the UHC era, the population with a high income (quantile 4 and 5) dominate as independent members in this programme. We can assume this group of people has a monthly permanent fixed income; thus, they can regularly pay the premium. The second assumption is that most members are civil servants; hence the UHC premium is automatically deducted from their monthly salary.

Respondents from the informal sector have not participated in UHC optimally, possibly because they do not have a fixed salary every month. So, they cannot afford to pay the UHC premium regularly. Associated with respondents whose

income is in the second percentile with lower middle income, it could be that people with lower middle incomes have not been able to pay UHC premiums, while participants within the fifth percentile with the highest income and have not become UHC participants because they are more interested in private health insurance.

The increasing number of UHC participant's year on year influences the decreasing number of people who pay out of pocket. The results of quantitative data analysis shows that there is a significant relationship between the implementation of UHC and a decrease in out-of-pocket payers, especially in 2016 of 41.6%, in 2017 of 38.6% and in 2018 of 34.2%. This decrease is in line with the increase in UHC participation membership in the same year. In 2016 it was 58.4%, 61.4% in 2017 and 65.8% in 2018.

In this study, one of the impacts in implementation of UHC in Indonesia is the increased participation compared to the era before UHC. However, based on in-depth interviews with informants, public awareness in participating in the UHC programme is still not optimal. People are interested in registering as UHC participants when they are already sick. After becoming BPJS Kesehatan participants, they can take advantage of many health services. This behaviour can be categorised as an Ex-post Moral Hazard, namely the use of health services (after an illness occurs) more because it is insured, so there is no need to bear health costs (Murti, 2021; Arrow, 1963). It is also necessary to pay attention to the occurrence of Ex-ante Moral Hazard, unhealthy behaviour, like ignoring a healthy life because people feel they have health insurance hence is not worried about costs Murti, 2021). If this behaviour occurs, the cost of health services will increase because the orientation of the community is no longer on aspects related to public health but is more curative. This bad behaviour must be prevented by socialising the benefits of participating in the UHC programme. This approach needs to be carried out by BPJS Kesehatan as the organiser of UHC, the Puskesmas or primary health care, which has the closest relationship with the community and which has the responsibility to increase promotive and

preventive efforts, as well as the Health Office as the policyholder for the implementation of promotive preventive programmes, and all related parties

The health services covered by the PHC are comprehensive services at First Level Health Service Facilities (Primary Health Centres, Clinics, General Practitioners, etc.) as well as health services at referral hospitals, such as Regional General Hospitals, Central General Hospitals (Government) and private hospitals in collaboration with BPJS Kesehatan. Bivariate analysis results show that the correlation between social health insurance era with health care access can be seen from those who have accessed outpatient services who tend to have 1.22 times insurance compared to those who have never accessed outpatient services. Those who have in-patient services tend to have 1.86 times insurance compared to those who have never accessed outpatient services. Respondents or communities who have accessed health services in the past year tend to have insurance as much as 1.3 times compared to those who have never accessed it. This data suggests that after UHC has been implementing in Indonesia, the utilisation of access to health services both in-patient and out-patient has increased, when compared to the utilisation of health services before the UHC era.

The qualitative data analysis indicates that UHC in Indonesia has the potential to be sustainable, but still needs various improvements including in terms of context, namely observing regulations so that there is no overlap, especially at the level of key UHC actors. The input aspect still needs to be re-calculated and adjusted to the UHC package in accordance with the demand as well as the community's Ability to Pay and Willingness to Pay. The level of funding factor also influences the implementation of UHC because of the delay in BPJS Kesehatan claims that should be paid to health care facilities, especially hospitals. The necessary improvements include the supply of sufficient human resources (health and other professions) as well as sufficient procurement and supply of medical equipment and drugs. Other necessary improvements include the timely payment by BPJS Kesehatan of claims from hospitals and other

healthcare providers, improvements to the referral system; adequate provision and distribution of health care providers to ensure that all UHC members (including those living in remote areas) are covered, and improvements to the online referral system (including ensuring that healthcare providers provide accurate data on usage and provision, including hospital occupancy and room availability rates).

The results from this research, via a mixed methods analysis, show that the transformation to social health insurance has delivered both positive and negative impacts in the implementation of UHC in Indonesia. The positive effects of the implementation of this programme include completeness in the regulatory context of UHC implementation in Indonesia, including short-, medium and long-term planning. Management is more organised compared to before the transformation. Prior to the implementation of UHC, the management of social health insurance was diverse, with various models. During the implementation of UHC, the influence of key actors in programme implementation were evident, not least in the establishment of the new regulations, such as BPJS Kesehatan as the administrator body for implementing social health insurance in Indonesia.

On the other hand, the DJSN functions as a trustee responsible for evaluating the performance of BPJS Kesehatan including its regulations and operations. The Ministry of Social Affairs has a role in verifying data accuracy of BPJS Kesehatan participants from the low-income groups entitled to government subsidies. Ministry of Health (MoH) is responsible for improving the quality of health services, both in terms of human resources, facilities, and infrastructure. After the transformation era, the number of people covered by health insurance has increased including access to health services at the primary level and referral health service facilities at public or private hospitals in collaboration with BPJS Kesehatan.

However, the transformation of social health insurance impacts in several ways that can be regarded as not wholly positive or even negative and which may need further improvement. As to regulation, it is incomplete. Regulations are overlapping such as regulations that BPJS Kesehatan and the MoH should implement as the aspects of improving healthcare services. The lack of synchronisation between relevant stakeholders in implementing UHC also needs to be addressed. Prior to UHC, the region's role was very dominant in overseeing the success of social health insurance programmes, such as the implementation of District Health Insurance, which was under the management of the local government. However, at the same time that the District Health Insurance was being intensively implemented, the transformation to UHC was declared by the central government, exemplifying this lack of implementation synchronisation.

In contrast, after UHC was implemented, local stakeholders felt that their rights had been fully transferred to BPJS Kesehatan or the central government. Even so, local stakeholders should still be key participants in supporting the success of UHC by participating and encouraging the implementation of the UHC programme in their areas, especially related to UHC participation for vulnerable communities and low-income groups. So, the transformation does not or should not mean that the centre should take overall the regional functions. Resolving the lack of clarity between the local and national levels is essential; clear demarcation of responsibilities and effective coordination is needed between the central and provincial governments to support the sustainability of UHC in overcoming the obstacles that affect each region.

Based on the results of the qualitative data analysis, the premium payment should be re-evaluated and calculated carefully based on the concept of Ability to Pay rather than Willingness to Pay. The premium review is important because insurance for the informal sector that does not have a fixed monthly salary is still a problem in Indonesia. Furthermore, Indonesia does not have an unemployment insurance arrangement at present. This not only leaves

employees vulnerable to a drastic reduction in welfare if they lose their employment, combined with the unequal functioning of severance pay, but also suggests that Indonesia lacks an adequate counter-cyclical social security system (OECD, 2019).

Referring to OECD, it is recommended that health insurance participation from the informal sector and community sector be reviewed again. In addition, the government does not yet have a scheme for the unemployed. This can be coordinated with the Ministry of Social Welfare and the local government to find a suitable solution to overcome this problem. For instance, Yogyakarta Province still maintains its District Health Insurance to protect people not covered by any other health insurance following the official implementation of UHC in 2014.

During the transformation period, supply-side readiness became a challenge, especially the distribution of health workers, readiness of the online referral system, procurement of drugs and adequate infrastructure. These challenges still need to be resolved, especially in geographically remote areas which have transportation and other challenges. The results of this research indicates that the role of MoH is indispensable in overcoming various problems of supply and disparity in health services, including the distribution of health workers and the availability of necessary infrastructure and health service facilities.

In the transformation era, the validation system and data accuracy for low-income groups need to be evaluated effectively. The Ministry of Social Welfare role needs to monitor and assess the reliability of the data. At this stage, the regionals also need to be involved because regional leaders should be better placed to judge the accuracy of their community data. Thus, better coordination between the Ministry of Social Affairs and regional leaders will help to improve the quality of the data relating to the low-income groups who are entitled to BPJS Kesehatan premium subsidies by the central government.

The selection of a Mixed Methods approach to conduct this study can be seen as a sensible one as it has allowed for the collection and analysis of various (quantative and qualitative) data related to implementing social health insurance before and since the implementation of UHC. The findings from this research are relevant and applicable in contributing to the improvement and development of UHC in Indonesia in the future. Policyholders, related stakeholders, and researchers can also draw on the study's findings to conduct other research relating to issues raised in or related to this research, such as BPJS Kesehatan's delayed claims to health service providers, equity in financing and health services, referral systems, supply-side readiness, and managing demand during the implementation of UHC in Indonesia.

R2. How successful has the introduction and implementation of choosing the UHC been before and during the implementation of the new scheme in Indonesia?

Conclusions to the examination of research question number two includes an analysis of what has worked well and has supported the implementation of UHC and what has not worked well and what the barriers have been. Achievements in the implementation of UHC according to the qualitative data analysis include the availability of regulations or policies. Prior and during UHC implementation, regulations already existed either enacted by the President or other related ministries, including at regional level. In terms of objectives, the benefits and targets of social health insurance are clear. Participation continues to increase is another achievement although it still needs further improvement. The decline in people paying out of pocket for health services is also another achievement that needs to be continued in the future.

Meanwhile, barriers in the implementation of UHC relate to the context, input, process, and outcome, among others; At the beginning of 2014 when UHC was declared by the government, the change from multi-payer to single payer required adjustments and further socialisation, especially in term of regulation, division, and function, both at the level of key UHC players, policy makers

related to UHC implementation, health service providers and the community at all levels.

Other areas for improvement include: synchronisation of premium and healthcare packages needs to be re-examined particularly for those people working in the informal sector without a permanent income; referral mechanisms need to be reviewed, including the online referral system and maintenance; stocks of medicines are often unavailable; there remain delays in the payment of claims by BPJS Kesehatan to health care facilities at hospital level; integrating referral mechanism and online referral system in primary health care and hospitals also all need to be improved. In addition, communities do not have a sufficient understanding of the referral system and, hence, would rather access health services in a hospital directly even though the care can be undertaken at the primary level.

8.3. Recommendations

In general, key stakeholders need synchronisation in UHC implementation, such as the Ministry of Health, the National Security Council (DJSN), BPJS Kesehatan and the Ministry of Social Welfare. Specifically, the first recommendation is addressed to BPJS Kesehatan, the founder and administration body in implementing UHC in Indonesia. Delayed claim payment from BPJS Kesehatan to the hospitals must be paid as soon as possible. The referral system should be revisited in terms of where the UHC members live and the health care provider's location, especially in remote areas. P-Care's online referral system needs continuous monitoring and maintenance. Ensuring more optimal benefits of P-Care, it is essential to update information on online referral services integrated between First Level Health Services and referral hospitals. In addition, it is timely for BPJS Kesehatan to expand the scope of benefits for promotive prevention. Meanwhile, healthy patients still need to be considered, such as the introduction of health check packages and other benefits related to prevention efforts so that health costs do not swell for degenerative diseases.

The second recommendation is for the National Social Security Council, which plays an essential role in monitoring and evaluating UHC implementation in Indonesia. Social health insurance does bring benefits. Even so, it needs further improvement, such as creating effective premiums and benefits for all levels of society. Indeed, the National Social Security Council is not the final decision maker regarding UHC premiums and benefits. The National Social Security Council has the authority to exercise the ability to pay and willingness to pay related to UHC premiums by the needs and demands of the Indonesian people. The National Social Security Council also needs to remind all UHC actors of the responsibilities and functions; for example, BPJS Kesehatan is concerned as a funder and administrative body and should focus on improving services to BPJS Kesehatan participants. In contrast, the Ministry of Health needs to focus on: improving regulations and workforce resources; improving the procurement of drugs; and ensuring the provision of adequate health facilities and infrastructure, including improving the quality of health services, which also requires addressing the challenge of the inequality of health services in remote areas.

Data updates for Contribution Assistance Recipients need to be continuously monitored by the Ministry of Social Affairs, given the authority of this ministry because the findings of this study show that there are still inaccuracies in the targeting of Participants Recipient of Contribution Assistance subsidised by the government. After all, the data in the Social Service is still not appropriately updated every year.

As exemplified by DKI Jakarta and Yogyakarta Provinces, the local government should continue to provide health funding assistance for the population that has not been covered by any health insurance, for example, the homeless, neglected people, and the unemployed. Local governments are also authorised to oversee UHC implementation in their respective regions and coordinate with related parties for the successful implementation of UHC.

Policymakers have a continuing critical role in implementing UHC, for example, in strengthening UHC implementation in terms of regulation. This includes reviewing regulations that the competent body has ratified in UHC. These regulations follow the mandate of the National Social Security System, which holds the principle of social justice for the people of Indonesia. In terms of policy, policymakers also have the authority to strengthen the implementation of UHC, such as funding for low-income groups vulnerable communities, which are still not covered by UHC and making policies that support the success and sustainability of UHC.

The academic community has a very strategic role in contributing to the successful implementation of UHC through the Tridarma Concepts of Higher Education, which includes Education, Research and Community Service. Education can produce superior human resources, including the health sectors that can support the optimal distribution of human health resources. Research can produce policy briefs, evaluations of UHC implementation, and journals that can evaluate and provide suggestions for improving the quality of UHC implementation in Indonesia. Academics can also develop research with various appropriate methods for assessing the application of UHC in Indonesia. In addition to community service programmes, academics can socialise the goals and benefits of UHC and improve public awareness of the importance of participating in UHC.

Researchers following competencies in their specific fields need to continue to contribute to conducting quality research for the success and sustainability of UHC. Various data and up-to-date research results will be useful to improve the quality of UHC implementation in Indonesia.

Finally, Universal Health Coverage in Indonesia will sustain if all stakeholders and society are aware of their respective responsibilities and will be more likely to participate in the UHC. Community participation plays a vital role in achieving the success and sustainability of UHC in Indonesia. This participation can be in

the form of registering to become a BPJS Kesehatan participant, paying premiums following the health insurance benefits provided by BPJS Kesehatan, paying premiums every month and actively participating in the socialisation UHC and accessing information related to BPJS Kesehatan services.

8.4. Limitations and Further Research

This study examined many aspects. Future researchers might be better to take on one topic of these results and study each in more depth, for example, related to the suitability of health service premiums and benefits or the implementation of health service referrals. The goal of UHC in Indonesia is not only meant for a short-term but long-term period. Therefore, the government's commitment at all levels is essential and needs to ensure continuous evaluation so that UHC in Indonesia can be successfully sustained.

8.5. Personal Reflections

After completing my master's degree in public health in 2004, specifically about social health insurance, my interest grew stronger and stimulated me to study further. Although the journey to reach my dreams to continue studying for a PhD is full of challenges, I kept trying to make it happen. I finally got the opportunity to continue my PhD study at Coventry University in the United Kingdom by taking research topics according to my expectations about implementing social health insurance in Indonesia. By doing so, I got the chance to understand better the Indonesian government's role in implementing UHC. The government has an essential role in motivating and encouraging society to actively participate in the UHC programme, especially in implementing cross-subsidies from the rich to the low-income group. In addition, I compared the efforts that have been done in Indonesia vis-a-vis other countries to achieve the UHC.

It is precise with the implementation of UHC in Indonesia. Still, at this dissertation writing process, I learned more about aspects of philosophy the long and varied history of social health insurance milestones, before and after or during UHC. In addition, I had the opportunity to review the social health

insurance of UHC in Indonesia its implementation of the welfare state concept, whereby the state should provide social protection for the Indonesian community. Furthermore, I learnt how the state implements social policies in social protection programmes that have been created and socialised to its people, especially in this thesis study relating to social health insurance. Writing the chapter on the theory and implementation of welfare regimes integrated with UHC implementation in Indonesia was the most challenging. Especially in exploring the integration of welfare regime concepts social policy with the rational UHC implementation, which can be easily understood by the supervisors and prospective readers of my thesis, whether in academia, policyholders, or the broader community should this thesis get published.Moreover, I learned how to understand and try to apply research philosophy and research paradigm in this study that I will undertake in the future. This includes developing methodologies and research strategies, which match the data to be collected for the feasibility of research results and contributions. Data retrieval must surely be in line with research ethics, for security aspects of respondents involved in this research. Since this research was conducted in Indonesia, I also had to take care of licensing documents from the central government level, namely the Indonesian Ministry of Home Affairs, the provincial level, and the local level in accordance with the agency for data retrieval. All these processes were really draining of my energy and patience. Nonetheless, in going through all these stages, I can now better understand the flow of research and regulations in other countries.

When undertaking qualitative data collection, I learned a great deal from respondents who had been involved in the social health insurance programme for more than ten years regarding the development of social health insurance policies in Indonesia before and after UHC. I also learned about the experience of other stakeholders, such as health care providers, ranging from primary health care and health service providers referral, be it private regional to the government (central) level. When conducting in-depth interviews and FGDs, I also had to be neutral with respondents to maintain my objectivity in collecting

the qualitative data in this study. At the beginning of data collection, the BPJS premium increase was ongoing, as well as the condition of BPJS financial deficit relating to the payment of health care claims in referral hospitals. I tried hard not to be influenced by these and continued to direct respondents to answer questions following the research instruments I had designed and submitted.

The data analysis process, both quantitative and qualitative, was also very draining because of the volume of data. I strived to focus and continued to work continuously for a rigid data analysis process and consulted my supervisors. The chapters on results and discussions are exciting and challenging because, in these chapters, a researcher's ability is honed, especially the ability to present data findings and integrate them with theories or research that previous researchers have done. I enjoyed this stage, although initially, I had some difficulty managing the vast amount of data and had to summarise and sort them out according to the research questions and systems.

Finally, in the process, I also learned to be an independent researcher concerned about planning, conducting a literature review, research philosophy and methodology. The process of ethics clearance, proper data retrieval, rigid data analysis, writing up process, and how to write the results are all demanding, including discussing the results, drawing the right conclusions, contributing to the research results that have been undertaken, including recommendations for future research. The most critical aspect of this dissertation is not writing a descriptive narrative but applying essential thinking and undertaking practical analysis. I am incredibly grateful for the guidance of my Director of Studies and supervisors, who always provided useful feedback throughout the completion of this dissertation.

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Appendix 1a: Participant Information (PIS) Sheet In-depth Interview (English)

PARTICIPANT INFORMATION SHEET

INDEPTH INTERVIEW

Research Study: Evaluation of the Implementation of the Indonesia Social Insurance Model of Health Care. Before you decide to take part, it is important you understand why the research is being conducted and what it will involve. Please take time to read the following information carefully.

What is the purpose of the study?
The purpose of the study is to evaluate the implementation of the Indonesia Social Insurance Model of Health Care.

Why have I been chosen to take part?
You are invited to participate in this study because you are one of the key stakeholders of the social health insurance programme. The stakeholders included: The Ministry of Health (MOH/Kemenkes), The Ministry of Social, The Board of Social Security (DJSN), and The Social Security Management Agency for Health Sector (BPJS Kesehatan), Representatives from Health Providers (Primary Health care/Puskesmas, District Health Hospital (RSUD), and Government Hospital (RSUP).

What are the benefits of taking part?
By sharing your experiences with us, you will be helping to improve social health insurance implementation in Indonesia.

Are there any risks associated with taking part?
This study has been reviewed and approved through Coventry University's formal research ethics procedure. There are no significant risks associated with participation.

Do I have to take part?
No – it is entirely up to you. If you do decide to take part, please keep this Information Sheet and complete the Informed Consent Form to show that you understand your rights in relation to the research, and that you are happy to participate. Please note down your participant number (which is on the Consent Form) and provide this to the lead researcher if you seek to withdraw from the study later. You are free to withdraw your information from the project data set at any time until the date of the PhD thesis submissions that is likely in May 2021. You should note that your data may be used in the production of formal research outputs (e.g. journal articles, conference papers, theses and reports) prior to this date and so you are advised to contact the university at the earliest opportunity should you wish to withdraw from the study. To withdraw, please contact the lead researcher (Rosyidah), you can also email the researcher (rosyidar@uni.coventry.ac.uk) who will get in touch with you.

What will happen if I decide to take part?
You will be asked several questions regarding social health insurance in Indonesia such as the regulation, funding, human resources, role and function of the various stakeholders in the implementation of social health insurance in Indonesia. The interviews take place in a safe environment at a time that is convenient to you. We would like to audio record your responses (and will require your consent for this), so the location should be in a quiet area. The Individual interview and focus group will time take around 20-30 minutes to complete.

Data Protection and Confidentiality
Your data will be processed in accordance with the UK General Data Protection Regulation 2016 (GDPR) and the UK Data Protection Act 2018. All information collected about you will be kept strictly confidential. Unless they are fully anonymised in our records, your data will be referred to by a unique participant number rather than by name. If you consent to being audio recorded, all recordings will be destroyed once they have been transcribed. Your data will only be viewed by the researcher. All electronic data will be stored on a password-protected computer file (only the researcher will have access to raw data. The data will be stored in password protected files). All paper records will be stored in a locked filing cabinet or the Coventry University only accessed by the researcher. Your consent information will be kept separately from your responses to minimise risk in the event of a data breach. The lead researcher will take responsibility for data destruction and all collected data will be destroyed on or before May 2021.

Data Protection Rights
Coventry University is a Data Controller for the information you provide. You have the right to access information held about you. Your right of access can be exercised in accordance with the General Data Protection Regulation and the Data Protection Act 2018. You also have other rights including rights of correction, erasure, objection, and data portability. For more details, including the right to lodge a complaint with the Information Commissioner's Office, please visit www.ico.org.uk. Questions, comments and requests about your personal data can also be sent to the University Data Protection Officer - enquiry.ipu@coventry.ac.uk

What will happen with the results of this study?
The results of this study will be presented and summarised in the thesis, published articles, reports and presentations. Quotes or key findings will always be made anonymous in any formal outputs.

Making a Complaint

If you are still unhappy with any aspect of this research, please contact the researcher Rosyidah, Faculty of Health and Life Science, Coventry University. Email: rosyidar@uni.coventry.ac.uk. If you still have concerns and wish to make a formal complaint, please write to:

Professor Guy Daly
Director of Studies
Coventry University
Coventry CV1 5FB
Email: hsx885@coventry.ac.uk

Appendix 1b: Participant Information (PIS) Sheet In-depth Interview (Indonesia)

LEMBAR INFORMASI UNTUK SUBJEK PENELITIAN (INFORMAN)

INDEPH INTERVIEW

Topik Penelitian: Evaluasi terhadap model implementasi Jaminan Kesehatan Sosial di Indonesia *(Evaluation of the Implementation of the Indonesia Social Insurance Model of Health Care*). Sebelum Anda memutuskan untuk bersedia menjadi informan, penting bagi Bapak/Ibu/ Saudara (i) memahami mengapa penelitian ini dilakukan dan siapa saja yang akan terlibat sebagi informan dalam penelitian ini. Silakan untuk meluangkan waktu untuk membaca informasi berikut dengan seksama.

Apakah Tujuan Penelitian ini ?

Tujuan dalam penelitian ini adalah untuk mengevaluasi terhadap model implementasi Jaminan Kesehatan Sosisal di Indonesia.

Mengapa saya dipilih sebagai Subjek Penelitian ?

Bapak/Ibu/Sdr (i) diundang untuk berpartisipasi dalam penelitian ini karena Bapak/Ibu/Sdr (i) adalah salah satu pemangku kepentingan utama dari program asuransi kesehatan sosial. Stakeholder dalam penelitian ini termasuk Devisi Pembiayaan Kesehatan dan Asuransi Kesehatan Kementerian Kesehatan, Direktorat Jenderal Perlindungan Sosial dan Asuransi Sosial Kementerian Sosial, Dewan Jaminan Sosial Nasional (DJSN), BPJS Kesehatan. Dinas Kesehatan Propinsi D.I Yogyakarta, Penyedia Pelayanan Kesehatan Puskesmas Jetis Kota Yogyakarta, RSUD Yogyakarta, RSUP Dr. Sardjito, serta RSU PKU Muhammadiyah Kota Yogyakarta.

Apakah Manfaatnya terlibat dalam penelitian ini?

Dengan berbagi pengalaman dengan kami, Bapak/Ibu/Sdr (i) akan membantu meningkatkan penerapan asuransi kesehatan sosial di Indonesia.

Apakah ada resiko jika terlibat dalam penelitian ini?

Studi ini telah ditinjau dan disetujui melalui prosedur etika penelitian formal Universitas Coventry. Tidak ada risiko signifikan yang terkait dengan partisipasi.

Apakah saya harus (Wajib) untuk terlibat dalam penelitian ini?

Pilihan adalah hak Bapak/Ibu/Sdr (i), jika memutuskan untuk bersedia menjadi informan dalam penelitian ini, silahkan simpan Lembar Informasi ini dan mohon untuk melengkapi Formulir Izin yang diinformasikan untuk menunjukkan bahwa Bapak/Ibu/Sdr (i) memahami hak-hak Bapak/Ibu/Sdr (i) sehubungan dengan penelitian ini, dan bahwa Bapak/Ibu/Sdr (i) senang untuk berpartisipasi. Mohon dicatat catat nomor peserta Bapak/Ibu/Sdr (i) (yang ada di Formulir Izin) dan berikan mohon memberikan nomor tersebut kepada peneliti utama jika Bapak/Ibu/Sdr (i) ingin menarik diri dari penelitian di kemudian hari. Bapak/Ibu/Sdr (i) bebas untuk menarik informasi Bapak/Ibu/Sdr (i) dari data pemnelitian yang ditetapkan kapan saja hingga tanggal Submit tesis PhD yang kemungkinan akan dilakukan pada Mei 2021. Bapak/Ibu/Sdr (i) harus mencatat bahwa data Bapak/Ibu/Sdr (i) dapat digunakan untuk hasil penelitian formal (misalnya artikel jurnal, makalah konferensi, tesis, dan laporan) sebelum

tanggal ini dan karenanya Bapak/Ibu/Sdr (i) disarankan untuk menghubungi universitas secepat mungkin seandainya Bapak/Ibu/Sdr (i) ingin menarik diri dari studi ini. Untuk menarik, silakan hubungi peneliti utama (Rosyidah), Anda juga dapat mengirim email kepada peneliti (rosyidar@uni.coventry.ac.uk) yang akan menghubungi Anda.

Apa yang akan terjadi jika saya memutuskan untuk terlibat dalam penelitian ini ?
Bapak/Ibu/Sdr (i) akan ditanya sejumlah pertanyaan mengenai asuransi kesehatan sosial di Indonesia seperti regulasi, pendanaan, sumber daya manusia, peran dan fungsi berbagai pemangku kepentingan dalam penerapan asuransi kesehatan sosial di Indonesia. Wawancara berlangsung di lingkungan yang aman pada waktu yang nyaman bagi Bapak/Ibu/Sdr (i). Kami ingin merekam tanggapan Bapak/Ibu/Sdr (i) (dan akan membutuhkan persetujuan Bapak/Ibu/Sdr (i) untuk hal ini). Wawancara Mendalam akan dilaksanakan dengan durasi waktu sekitar 20-30 menit.

Perlindungan Data dan Kerahasiaan
Data Bapak/Ibu/Sdr (i) akan diproses sesuai dengan Peraturan Perlindungan Data *the UK General Data Protection Regulation 2016 (GDPR) and the UK Data Protection Act 2018*. Semua informasi yang dikumpulkan tentang Bapak/Ibu/Sdr (i) akan dijaga kerahasiaannya. Kecuali jika mereka sepenuhnya dianonimkan dalam catatan kami, data Bapak/Ibu/Sdr (i) akan dirujuk oleh nomor peserta khusus dan bukan dengan nama. Jika Bapak/Ibu/Sdr (i) menyetujui rekaman audio, semua rekaman akan dimusnahkan setelah proses transkrip data selesai. Data Bapak/Ibu/Sdr (i) hanya akan dilihat oleh peneliti. Semua data elektronik akan disimpan pada file komputer yang dilindungi kata sandi (hanya peneliti yang akan memiliki akses ke data mentah. Data akan disimpan dalam file yang dilindungi kata sandi). Semua catatan kertas akan disimpan di lemari arsip yang dikunci atau di Universitas Coventry hanya diakses oleh peneliti. Informasi persetujuan Bapak/Ibu/Sdr (i) akan disimpan secara terpisah dari tanggapan Anda, hal ini untuk meminimalkan risiko jika terjadi pelanggaran data. Peneliti utama akan bertanggung jawab atas pemusnahan data dan semua data yang dikumpulkan akan dimusnahkan pada atau sebelum Mei 2021.

Hak Perlindungan Data
Universitas Coventry adalah Pengontrol Data untuk informasi yang Bapak/Ibu/Sdr (i) berikan. Bapak/Ibu/Sdr (i) memiliki hak untuk mengakses informasi yang dimiliki tentang Anda. Hak akses Anda dapat dilaksanakan sesuai dengan Peraturan Perlindungan Data Umum dan Undang-Undang Perlindungan Data 2018. Bapak/Ibu/Sdr (i) juga memiliki hak-hak lain termasuk hak-hak koreksi, penghapusan, keberatan, dan portabilitas data. Untuk perincian lebih lanjut, termasuk hak untuk mengajukan pengaduan ke Kantor Komisaris Informasi, silakan kunjungi www.ico.org.uk. Pertanyaan, komentar, dan permintaan tentang data pribadi Bapak/Ibu/Sdr (i) juga dapat dikirim ke Petugas Perlindungan Data Universitas - enquiry.ipu@coventry.ac.uk

Apa yang akan terjadi dengan hasil penelitian ini?
Hasil penelitian ini akan disajikan dan dirangkum dalam tesis, artikel yang dipublikasikan, laporan dan presentasi. Kutipan atau temuan kunci akan selalu dibuat anonim dalam output formal apa pun.

Membuat Pengaduan
Jika Bapak/Ibu/Sdr (i) masih tidak senang dengan aspek penelitian ini, silakan hubungi peneliti:

Rosyidah, Faculty of Health and Life Sciences (Fakultas Ilmu Ilmu Kesehatan) Coventry University. Email: rosyidar@uni.coventry.ac.uk.

Jika Anda masih memiliki masalah dan ingin mengajukan keluhan resmi, Kepada:

Professor Guy Daly

Director of Studies

Coventry University

Coventry CV1 5FB

Appendix 2a. Participant Information Sheet (PIS) Focus Group Discussion (FGD) (English)

PARTICIPANT INFORMATION SHEET

FOCUS GROUP DISCUSSION

Research Study: Evaluation of the Implementation of the Indonesia Social Insurance Model of Health Care. Before you decide to take part, it is important you understand why the research is being conducted and what it will involve. Please take time to read the following information carefully.

What is the purpose of the study?
The purpose of the study is to evaluate the implementation of the Indonesia Social Insurance Model of Health Care.

Why have I been chosen to take part?
You are invited to participate in this study because you are one of the key stakeholders of the social health insurance programme. The stakeholders included: The Ministry of Health (MOH/Kemenkes), The Ministry of Social, The Board of Social Security (DJSN), and The Social Security Management Agency for Health Sector (BPJS Kesehatan), Representatives from Health Providers (Primary Health care/Puskesmas, District Health Hospital (RSUD), and Government Hospital (RSUP).

What are the benefits of taking part?
By sharing your experiences with us, you will be helping to improve social health insurance implementation in Indonesia.

Are there any risks associated with taking part?
This study has been reviewed and approved through Coventry University's formal research ethics procedure. There are no significant risks associated with participation.

Do I have to take part?
No – it is entirely up to you. If you do decide to take part, please keep this Information Sheet and complete the Informed Consent Form to show that you understand your rights in relation to the research, and that you are happy to participate. Please note down your participant number (which is on the Consent Form) and provide this to the lead researcher if you seek to withdraw from the study later. You are free to withdraw your information from the project data set at any time until the date of the PhD thesis submissions that is likely in May 2021. You should note that your data may be used in the production of formal research outputs (e.g. journal articles, conference papers, theses and reports) prior to this date and so you are advised to contact the university at the earliest opportunity should you wish to withdraw from the study. To withdraw, please contact the lead researcher (Rosyidah), you can also email the researcher (rosyidar@uni.coventry.ac.uk) who will get in touch with you.

What will happen if I decide to take part?
You will be asked several questions regarding social health insurance in Indonesia such as the regulation, funding, human resources, role and function of the various stakeholders in the implementation of social health insurance in Indonesia. The focus group will take place in a safe environment at a time that is convenient to you. We would like to audio record your responses (and will require your consent for this), so the location should be in a quiet area. The Individual interview and focus group will time take around 30-40 minutes to complete.

Data Protection and Confidentiality
Your data will be processed in accordance with the UK General Data Protection Regulation 2016 (GDPR) and the UK Data Protection Act 2018. All information collected about you will be kept strictly confidential. Unless they are fully anonymised in our records, your data will be referred to by a unique participant number rather than by name. If you consent to being audio recorded, all recordings will be destroyed once they have been transcribed. Your data will only be viewed by the researcher. All electronic data will be stored on a password-protected computer file (only the researcher will have access to raw data. The data will be stored in password protected files). All paper records will be stored in a locked filing cabinet or the Coventry University only accessed by the researcher. Your consent information will be kept separately from your responses to minimise risk in the event of a data breach. The lead researcher will take responsibility for data destruction and all collected data will be destroyed on or before May 2021.

Data Protection Rights
Coventry University is a Data Controller for the information you provide. You have the right to access information held about you. Your right of access can be exercised in accordance with the General Data Protection Regulation and the Data Protection Act 2018. You also have other rights including rights of correction, erasure, objection, and data portability. For more details, including the right to lodge a complaint with the Information Commissioner's Office, please visit www.ico.org.uk. Questions, comments and requests about your personal data can also be sent to the University Data Protection Officer - enquiry.ipu@coventry.ac.uk

What will happen with the results of this study?
The results of this study will be presented and summarised in the thesis, published articles, reports and presentations. Quotes or key findings will always be made anonymous in any formal outputs.

Making a Complaint

If you are still unhappy with any aspect of this research, please contact the researcher Rosyidah, Faculty of Health and Life Science, Coventry University. Email: rosyidar@uni.coventry.ac.uk. If you still have concerns and wish to make a formal complaint, please write to:

Professor Guy Daly
Director of Studies
Coventry University
Coventry CV1 5FB
Email: hsx885@coventry.ac.uk

Appendix 2b. Participant Information Sheet (PIS) Focus Group Discussion (FGD) (Indonesia)

LEMBAR INFORMASI UNTUK SUBJEK PENELITIAN (INFORMAN)

FOCUS GROUP DISCUSSION (FGD)

Topik Penelitian: Evaluasi terhadap model implementasi Jaminan Kesehatan Sosial di Indonesia *(Evaluation of the Implementation of the Indonesia Social Insurance Model of Health Care*). Sebelum Anda memutuskan untuk bersedia menjadi informan, penting bagi Bapak/Ibu/ Saudara (i) memahami mengapa penelitian ini dilakukan dan siapa saja yang akan terlibat sebagi informan dalam penelitian ini. Silakan untuk meluangkan waktu untuk membaca informasi berikut dengan seksama.

Apakah Tujuan Penelitian ini ?

Tujuan dalam penelitian ini adalah untuk mengevaluasi terhadap model implementasi Jaminan Kesehatan Sosisal di Indonesia.

Mengapa saya dipilih sebagai Subjek Penelitian ?

Bapak/Ibu/Sdr (i) diundang untuk berpartisipasi dalam penelitian ini karena Bapak/Ibu/Sdr (i) adalah salah satu pemangku kepentingan utama dari program asuransi kesehatan sosial. Stakeholder dalam penelitian ini termasuk Devisi Pembiayaan Kesehatan dan Asuransi Kesehatan Kementerian Kesehatan, Direktorat Jenderal Perlindungan Sosial dan Asuransi Sosial Kementerian Sosial, Dewan Jaminan Sosial Nasional (DJSN), BPJS Kesehatan. Dinas Kesehatan Propinsi D.I Yogyakarta, Penyedia Pelayanan Kesehatan Puskesmas Jetis Kota Yogyakarta, RSUD Yogyakarta, RSUP Dr. Sardjito, serta RSU PKU Muhammadiyah Kota Yogyakarta.

Apakah Manfaatnya terlibat dalam penelitian ini?

Dengan berbagi pengalaman dengan kami, Bapak/Ibu/Sdr (i) akan membantu meningkatkan penerapan asuransi kesehatan sosial di Indonesia.

Apakah ada resiko jika terlibat dalam penelitian ini?

Studi ini telah ditinjau dan disetujui melalui prosedur etika penelitian formal Universitas Coventry. Tidak ada risiko signifikan yang terkait dengan partisipasi.

Apakah saya harus (Wajib) untuk terlibat dalam penelitian ini?

Pilihan adalah hak Bapak/Ibu/Sdr (i), jika memutuskan untuk bersedia menjadi informan dalam penelitian ini, silahkan simpan Lembar Informasi ini dan mohon untuk melengkapi Formulir Izin yang diinformasikan untuk menunjukkan bahwa Bapak/Ibu/Sdr (i) memahami hak-hak Bapak/Ibu/Sdr (i) sehubungan dengan penelitian ini, dan bahwa Bapak/Ibu/Sdr (i) senang untuk berpartisipasi. Mohon dicatat catat nomor peserta Bapak/Ibu/Sdr (i) (yang ada di Formulir Izin) dan berikan mohon memberikan nomor tersebut kepada peneliti utama jika Bapak/Ibu/Sdr (i) ingin menarik diri dari penelitian di kemudian hari. Bapak/Ibu/Sdr (i) bebas untuk menarik informasi Bapak/Ibu/Sdr (i) dari data pemnelitian yang ditetapkan kapan saja hingga tanggal Submit tesis PhD yang kemungkinan akan dilakukan pada Mei 2021. Bapak/Ibu/Sdr (i) harus mencatat bahwa data Bapak/Ibu/Sdr (i) dapat digunakan untuk hasil

penelitian formal (misalnya artikel jurnal, makalah konferensi, tesis, dan laporan) sebelum tanggal ini dan karenanya Bapak/Ibu/Sdr (i) disarankan untuk menghubungi universitas secepat mungkin seandainya Bapak/Ibu/Sdr (i) ingin menarik diri dari studi ini. Untuk menarik, silakan hubungi peneliti utama (Rosyidah), Anda juga dapat mengirim email kepada peneliti (rosyidar@uni.coventry.ac.uk) yang akan menghubungi Anda.

Apa yang akan terjadi jika saya memutuskan untuk terlibat dalam penelitian ini ?
Bapak/Ibu/Sdr (i) akan ditanya sejumlah pertanyaan mengenai asuransi kesehatan sosial di Indonesia seperti regulasi, pendanaan, sumber daya manusia, peran dan fungsi berbagai pemangku kepentingan dalam penerapan asuransi kesehatan sosial di Indonesia. Wawancara berlangsung di lingkungan yang aman pada waktu yang nyaman bagi Bapak/Ibu/Sdr (i). Kami ingin merekam tanggapan Bapak/Ibu/Sdr (i) (dan akan membutuhkan persetujuan Bapak/Ibu/Sdr (i) untuk hal ini). Focus Group Discussion (FGD) akan dilaksanakan dengan durasi waktu sekitar 20-30 menit.

Perlindungan Data dan Kerahasiaan
Data Bapak/Ibu/Sdr (i) akan diproses sesuai dengan Peraturan Perlindungan Data *the UK General Data Protection Regulation 2016 (GDPR) and the UK Data Protection Act 2018*. Semua informasi yang dikumpulkan tentang Bapak/Ibu/Sdr (i) akan dijaga kerahasiaannya. Kecuali jika mereka sepenuhnya dianonimkan dalam catatan kami, data Bapak/Ibu/Sdr (i) akan dirujuk oleh nomor peserta khusus dan bukan dengan nama. Jika Bapak/Ibu/Sdr (i) menyetujui rekaman audio, semua rekaman akan dimusnahkan setelah proses transkrip data selesai. Data Bapak/Ibu/Sdr (i) hanya akan dilihat oleh peneliti. Semua data elektronik akan disimpan pada file komputer yang dilindungi kata sandi (hanya peneliti yang akan memiliki akses ke data mentah. Data akan disimpan dalam file yang dilindungi kata sandi). Semua catatan kertas akan disimpan di lemari arsip yang dikunci atau di Universitas Coventry hanya diakses oleh peneliti. Informasi persetujuan Bapak/Ibu/Sdr (i) akan disimpan secara terpisah dari tanggapan Bapak/Ibu/Sdr (i), hal ini untuk meminimalkan risiko jika terjadi pelanggaran data. Peneliti utama akan bertanggung jawab atas pemusnahan data dan semua data yang dikumpulkan akan dimusnahkan pada atau sebelum Mei 2021.

Hak Perlindungan Data
Universitas Coventry adalah Pengontrol Data untuk informasi yang Bapak/Ibu/Sdr (i) berikan. Bapak/Ibu/Sdr (i) memiliki hak untuk mengakses informasi yang dimiliki tentang Anda. Hak akses Anda dapat dilaksanakan sesuai dengan Peraturan Perlindungan Data Umum dan Undang-Undang Perlindungan Data 2018. Bapak/Ibu/Sdr (i) juga memiliki hak-hak lain termasuk hak-hak koreksi, penghapusan, keberatan, dan portabilitas data. Untuk perincian lebih lanjut, termasuk hak untuk mengajukan pengaduan ke Kantor Komisaris Informasi, silakan kunjungi www.ico.org.uk. Pertanyaan, komentar, dan permintaan tentang data pribadi Bapak/Ibu/Sdr (i) juga dapat dikirim ke Petugas Perlindungan Data Universitas - enquiry.ipu@coventry.ac.uk

Apa yang akan terjadi dengan hasil penelitian ini?
Hasil penelitian ini akan disajikan dan dirangkum dalam tesis, artikel yang dipublikasikan, laporan dan presentasi. Kutipan atau temuan kunci akan selalu dibuat anonim dalam output formal apa pun.

Membuat Pengaduan

Jika Bapak/Ibu/Sdr (i) masih tidak senang dengan aspek penelitian ini, silakan hubungi peneliti: Rosyidah, Faculty of Health and Life Sciences (Fakultas Ilmu Ilmu Kesehatan) Coventry University. Email: rosyidar@uni.coventry.ac.uk.

Jika Anda masih memiliki masalah dan ingin mengajukan keluhan resmi, Kepada:

Professor Guy Daly

Director of Studies

Coventry University

Coventry CV1 5FB

Appendix 3a : Informed Consent In-depth Interview (English)

Participant No.

INDEPTH INTERVIEW

INFORMED CONSENT FORM:

EVALUATION OF THE IMPLEMENTATION OF THE INDONESIA SOCIAL INSURANCE MODEL OF HEALTH CARE

You are invited to take part in this research because you are one of the key stakeholders of the social health insurance programme in Indonesia.

Before you decide to take part, you must **read the accompanying Participant Information Sheet.**

Please do not hesitate to ask questions if anything is unclear or if you would like more information about any aspect of this research. It is important that you feel able to take the necessary time to decide whether you wish to take part.

If you are happy to participate, please confirm your consent by circling YES against each of the below statements and then signing and dating the form as participant.

1	**I confirm that I have read and understood the Participant Information Sheet for the above study and have had the opportunity to ask questions**	**YES**	**NO**
2	**I understand my participation is voluntary and that I am free to withdraw my data, without giving a reason, by contacting the lead researcher and the Research Support Office at any time until the date specified in the Participant Information Sheet**	**YES**	**NO**
3	**I have noted down my participant number (top left of this Consent Form) which may be required by the lead researcher if I wish to withdraw from the study**	**YES**	**NO**

4	**I understand that all the information I provide will be held securely and treated confidentially**	**YES**	**NO**
5	**I am happy for the information I provide to be used (anonymously) in academic papers and other formal research outputs**	**YES**	**NO**
6	**I am happy for the interview discussion to be <u>audio recorded</u>**	**YES**	**NO**
7	**I agree to take part in the above study**	**YES**	**NO**

Thank you for your participation in this study. Your help is very much appreciatet

Participant's Name	**Date**	**Signature**
Researcher	**Date**	**Signature**
Rosyidah		

Appendix 3b : Informed Consent In-depth Interview (Indonesia)

Participant No

INDEPTH INTERVIEW

INFORMED CONSENT FORM:

EVALUASI TERHADAP MODEL IMPLEMENTASI JAMINAN KESEHATAN SOSIAL DI INDONESIA
***(EVALUATION OF THE IMPLEMENTATION OF THE INDONESIA SOCIAL INSURANCE MODEL OF HEALTH CARE*).**

Bapak/Ibu/Sdr (i) diundang untuk ikut serta dalam penelitian ini karena Bapak/Ibu/Sdr (i) adalah salah satu pemangku kepentingan utama dari program asuransi kesehatan sosial di Indonesia.

Sebelum Bapak/Ibu/Sdr (i) memutuskan untuk mengambil bagian, Bapak/Ibu/Sdr (i) mohon membaca Lembar Inform Consent terlebih dahulu.

Harap jangan ragu untuk bertanya jika ada sesuatu yang tidak jelas atau jika Bapak/Ibu/Sdr (i) ingin informasi lebih lanjut tentang segala aspek penelitian ini.

Adalah penting bahwa Bapak/Ibu/Sdr (i) dapat mengambil waktu yang diperlukan untuk memutuskan apakah Bapak/Ibu/Sdr (i) ingin mengambil bagian atau tidak.

Jika Bapak/Ibu/Sdr (i) senang berpartisipasi, harap konfirmasikan persetujuan Bapak/Ibu/Sdr (i) dengan melingkari **YA** terhadap masing-masing pernyataan di bawah ini dan kemudian menandatangani formulir sebagai peserta.

1	**Saya mengkonfirmasi bahwa saya telah membaca dan memahami Lembar Informasi Peserta untuk studi di atas dan memiliki kesempatan untuk mengajukan pertanyaan**	**YA**	**Tidak**
2	**Saya memahami partisipasi saya bersifat sukarela dan bahwa saya bebas untuk menarik data saya, tanpa memberikan alasan, dengan menghubungi peneliti utama dan Kantor Dukungan Penelitian kapan saja hingga tanggal yang ditentukan dalam Lembar Informasi Partisipan.**	**YA**	**Tidak**
3	**Saya telah mencatat nomor peserta saya (kiri atas Formulir Persetujuan ini) yang mungkin diperlukan oleh peneliti utama jika saya ingin menarik diri dari penelitian ini.**	**YA**	**Tidak**
4	**Saya mengerti bahwa semua informasi yang saya berikan akan disimpan dengan aman dan dijaga kerahasiaanya**	**YA**	**Tidak**

5	**Saya senang atas informasi yang saya berikan untuk digunakan (secara anonim) dalam makalah akademis dan hasil penelitian formal lainnya**	**YA**	**Tidak**
6	**Saya senang diskusi wawancara direkam secara audio**	**YA**	**Tidak**
7	**Saya setuju untuk berpartisipasi dalam studi di atas**	**YA**	**Tidak**

Terima kasih atas partisipasi Bapak/Ibu/Sdr (i) dalam penelitian ini. Bantuan Bapak/Ibu/Sdr (i) sangat kami hargai.

Nama Informan	**Tanggal**	**Tanda Tangan**
Peneliti	**Tanggal**	**Tanda Tangan**
Rosyidah		

Attachment 3c: Informed Consent Focus Group Discussion (FGD) (English)

Participant No.

FOCUS GROUP DISCUSSION

INFORMED CONSENT FORM:

EVALUATION OF THE IMPLEMENTATION OF THE INDONESIA SOCIAL INSURANCE MODEL OF HEALTH CARE

You are invited to take part in this research because you are one of the key stakeholders of the social health insurance programme in Indonesia.

Before you decide to take part, you must **read the accompanying Participant Information Sheet.**

Please do not hesitate to ask questions if anything is unclear or if you would like more information about any aspect of this research. It is important that you feel able to take the necessary time to decide whether you wish to take part.

If you are happy to participate, please confirm your consent by circling YES against each of the below statements and then signing and dating the form as participant.

1	**I confirm that I have read and understood the Participant Information Sheet for the above study and have had the opportunity to ask questions**	**YES**	**NO**
2	**I understand my participation is voluntary and that I am free to withdraw my data, without giving a reason, by contacting the lead researcher and the Research Support Office at any time until the date specified in the Participant Information Sheet**	**YES**	**NO**
3	**I have noted down my participant number (top left of this Consent Form) which may be required by the lead researcher if I wish to withdraw from the study**	**YES**	**NO**
4	**I understand that all the information I provide will be held securely and treated confidentially**	**YES**	**NO**

5	**I am happy for the information I provide to be used (anonymously) in academic papers and other formal research outputs**	**YES**	**NO**
6	**I am happy for the Focus Group Discussion (FGD) to be <u>audio recorded</u>**	**YES**	**NO**
7	**I agree to take part in the above study**	**YES**	**NO**

Thank you for your participation in this study. By sharing your experience with us, you will be helping to improve social health insurance implementation in Indonesia.

Your help is very much appreciated.

Participant's Name	**Date**	**Signature**
Researcher	**Date**	**Signature**
Rosyidah		

Attachment 3d : Informed Consent Focus Group Discussion (FGD) (Indonesia)

Participant No.

FOCUS GROUP DISCUSSION (FGD)

INFORMED CONSENT FORM:

EVALUASI TERHADAP MODEL IMPLEMENTASI JAMINAN KESEHATAN SOSIAL DI INDONESIA

***(EVALUATION OF THE IMPLEMENTATION OF THE INDONESIA SOCIAL INSURANCE MODEL OF HEALTH CARE*).**

Bapak/Ibu/Sdr (i) diundang untuk ikut serta dalam penelitian ini karena Bapak/Ibu/Sdr (i) adalah salah satu pemangku kepentingan utama dari program asuransi kesehatan sosial di Indonesia.

Sebelum Bapak/Ibu/Sdr (i) memutuskan untuk mengambil bagian, Bapak/Ibu/Sdr (i) mohon membaca Lembar Inform consent terlebih dahulu.

Harap jangan ragu untuk bertanya jika ada sesuatu yang tidak jelas atau jika Bapak/Ibu/Sdr (i) ingin informasi lebih lanjut tentang segala aspek penelitian ini.

Adalah penting bahwa Bapak/Ibu/Sdr (i) dapat mengambil waktu yang diperlukan untuk memutuskan
apakah Anda ingin mengambil bagian atau tidak.

Jika Bapak/Ibu/Sdr (i) senang berpartisipasi, harap konfirmasikan persetujuan Bapak/Ibu/Sdr (i) dengan melingkari YA terhadap masing-masing pernyataan di bawah ini dan kemudian menandatangani formulir sebagai peserta.

1	**Saya mengkonfirmasi bahwa saya telah membaca dan memahami Lembar Informasi Peserta untuk studi di atas dan memiliki kesempatan untuk mengajukan pertanyaan**	**YA**	**Tidak**
2	**Saya memahami partisipasi saya bersifat sukarela dan bahwa saya bebas untuk menarik data saya, tanpa memberikan alasan, dengan menghubungi peneliti utama dan Kantor Dukungan Penelitian kapan saja hingga tanggal yang ditentukan dalam Lembar Informasi Partisipan.**	**YA**	**Tidak**
3	**Saya telah mencatat nomor peserta saya (kiri atas Formulir Persetujuan ini) yang mungkin diperlukan oleh peneliti utama jika saya ingin menarik**	**YA**	**Tidak**

	diri dari penelitian ini.		
4	**Saya mengerti bahwa semua informasi yang saya berikan akan disimpan dengan aman dan dijaga kerahasiaanya.**	**YA**	**Tidak**
5	**Saya senang atas informasi yang saya berikan untuk digunakan (secara anonim) dalam makalah akademis dan hasil penelitian formal lainnya**	**YA**	**Tidak**
6	**Saya senang diskusi FGD ini direkam <u>secara audio</u>**	**YA**	**Tidak**
7	**Saya setuju untuk berpartisipasi dalam studi di atas**	**YA**	**Tidak**

Terima kasih atas partisipasi Bapak/Ibu/Sdr (i) dalam penelitian ini. Bantuan Bapak/Ibu/Sdr (i) sangat kami hargai.

Nama Informan	**Tanggal**	**Tanda Tangan**
Peneliti	**Tanggal**	**Tanda Tangan**
Rosyidah		

Appendix 5. Indepth Interview Bilingual (English and Indonesia)

IN-DEPTH INTERVIEW

Interviewees: Health Financing and Health Insurance the Ministry of Health (MOH) Republic Indonesia

A.1. Regulations and Policy on Social Health Insurance Programme

No	Indonesian Version	English Version
	Input on Social Health Insurance (A1-A3)	**Input on Social Health Insurance (A1-A3)**
1.	Mohon dijelaskan tugas dan fungsi Kementerian kesehatan keterkaitanya dengan Jaminan kesehatan sosial Nasional.	Please explain the duties and functions of the ministry of health in relation to the National social health insurance.
2.	Mohon dijelaskan, bagaimanakah kementerian kesehatan menghadapi era reformasi sebelum dan sesudah JKN.	Please explain, how is the ministry of health facing the reformation era prior to and after JKN?
3.	Bagaimana koordinasi yang dilakukan oleh Kementerian Kesehatan dalam perencanaan implementasi JKN? Siapa saja yang terlibat dalam koordinasi tersebut.	How is the coordination conducted by the ministry of health in planning the implementation of JKN? Who involved in such activities?
4.	Mohon dijelaskan kendala yang dihadapi saat proses transformasi sebelum dan sesudah JKN?	Please explain the obstacles faced during the transformation process prior to and after JKN?
5.	Bagaimana upaya dalam menghadapi kendala tersebut?	How do you deal with these obstacles?
6	Bagaimana perencanaan kementerian kesehatan dalam mengimplementasikan JKN, dalam hal ini termasuk peraturan-peraturan yang dibuat oleh kementerian kesehatan untuk implementasi program jaminan kesehatan sosial	How is the ministry of health planning to implement JKN, in this case including the regulations made by the ministry of health for the implementation of social health insurance programs?
7	Bagaimana dalam melakukan sosialisasi perencanaan yang telah dibuat untuk program JKN kepada staf anda, dan pihak terkait?	How about in conducting the socialisation of planning that has been made for the JKN program to your staff and related parties?
8	Bagaimana upaya kementerian kesehatan anda dalam melakukan sosialisasi perencanaan dalam implementasi JKN kepada masyarakat?	How is effort of the ministry of social in conducting socialisation planning for JKN implementation to the public?

A.2. Demand on Social Health Insurance Programme

No	Indonesian Version	English Version
1.	Menurut anda, apakah premi dan paket Jaminan kesehatan sosial di Indonesia sudah sesuai dengan kebutuhan dan harapan masyarakat Indonesia?	In your opinion, are the premium and package of social health insurance in Indonesia in accordance with the needs and expectations of Indonesian people?
2.	Menurut anda, apakah premi serta paket jaminan kesehatan sosial yang selama ini diimplementasikan di Indonesia, sudah mewakili semua kebutuhan masyarakat Indonesia, termasuk bagi kelompok masyarakat miskin?	In your opinion, are the social health insurance premiums and packages implemented so far in Indonesia already representing all the needs of Indonesian people, including the poors?
3.	Apakah kementerian kesehatan dilibatkan dalam pendataan peserta jaminan kesehatan sosial terutama bagi kelompok miskin? Jika dilibatkan bagaimana mekanismenya?	Is the ministry of health involved in the data collection of participations in social health insurance, especially for the poor? If so, what is the mechanism?
4.	Apakah secara khusus instansi anda pernah melakukan analisis kemampuan (ATP) serta kemauan membayar (WTP) jaminan kesehatan sosial? Jika pernah lanjut pada (pertanyaan no.4,5)	Has your agency specifically conducted the analyses of Ability To Pay (ATP) and Willingness To Pay (WTP) for social health insurance? If so, continue to the questions no. 4, 5)
4.	Jika pernah, kapan dilakukan analisis tersebut, bagaimana mekanismenya, serta hasilnya?	If doing ATP/WTP analyses, when were the analyses conducted, what was the mechanism, and the results?
5.	Bagiamanakah kementerian kesehatan menyampaikan hasil analisis ATP/WTP kepada pihak terkait sepertihalnya BPJS kesehatan?	How did the ministry of health inform the results of ATP/WTP analyses to the related parties like BPJS Kesehatan?

A.3. Supply on Social Health Insurance Programme

No	Indonesian Version	English Version
1.	Mohon dijelaskan dari segi keuangan, bagaimana kontribusi kementerian kesehatan dalam implementasi jaminan sosial kesehatan baik sebelum dan sesudah JKN diimplementasikan.	Please explain in terms of finance, how is the contribution of ministry of health in the implementation of social health insurance prior to and after the implementation of JKN?
2.	Mohon dijelaskan bagimanakah upaya kementerian kesehatan dalam memastikan ketersediaan untuk akses pelayanan kesehatan, jumlah Sumber daya manusia, sarana prasarana, pengadaan/penyediaan obat serta system informasi sudah mencukupi untuk pelaksanaan jaminan kesehatan sosial baik sebelum dan sesudah JKN?	Please explain how the ministry of health's efforts in ensuring the availability for access to health services, number of human resources, facilities and infrastructure, and information systems is sufficient for the implementation of social health insurance prior to and after JKN?
3.	Mohon dijelaskan, apakah sudah tersedia system informasi kesehatan yang memadai dalam implementasi pelayanan kesehatan? Baik di puskesmas atau rumah sakit.	Please explain whether there is an adequate information system in the implementation of health services (either in public health centre or hospital).
4.	Mohon dijelaskan kendala dari segi pendanaan, penyediaan pelayanan kesehatan di puskesmas/di rumah sakit, sarana prasarana maupun system informasi pada program jaminan kesehatan sosial sosial sesebul dan sesudah JKN?	Please explain the obstacles in terms of funding, the provision of health services in public health centre/hospital, facilities and infrastructure, as well as information system on the social health insurance program prior to and after JKN?
5.	Bagaimana upaya dalam menyelesaikan kendala kendala yang dihadapi selama ini?	How is the effort to solve the obstacles that have been faced so far?
6.	Apakah ada harapan atau saran khusus untuk pemerintah atau pihak terkait dalam hal supply pada implementasi program jaminan kesehatan sosial?	Are there any specific expectations or suggestions to the government or related parties in terms of supply at the implementation of social health insurance program?

B. Process (Implementation) of Social Health Insurance Programme

No	Indonesian Version	English Version
1	Bagaimanakah upaya kementerian kesehatan dalam mengimplementasikan jaminan kesehatan sosial sebelum dan sesudah JKN pada hal-hal berikut:	How are the efforts of the ministry of social in implementing social health insurance prior to and after JKN on the following matters:
1a	Peraturan-peraturan dalam implementasi program jaminan kesehatan sosial	Regulations in the implementation of social health insurance program.
1b	Pendanaan program jaminan kesehatan sosial	Funding of social health insurance program.
1c	Penyediaan tenaga kesehatan	Provision of health personnels
1.d	Penyediaan fasilitas, sarana dan prasaran pelayanan kesehatan	Provision of facilities and infrastructures for health services.
1.e	Pengadaan obat	Procurement of medicines
1.f	Sistem informasi kesehatan	Health information system
2.	Mohon dijelaskan bagaimana pelaksanaan sosialisasi yang dilakukan oleh kemterian kesehatan kepada masyarakat terkait dengan manfaat serta kepesertaan jaminan kesehatan sosial.	Please explain how the socialisation conducted by ministry of health to the public related to the benefits and membership of social health insurance.
3.	Mohon dijelaskan bagaimanakah implementasi rujukan bagi peserta jaminan kesehatan sosial di tingkat pelayanan primer sampai pada pelayanan lanjutan di rumah sakit.	Please explain how is the implementation of referrals for social health insurance participants at the primary care level to follow-up services at the hospital.
4.	Mohon dijelaskan keterkaitan program jaminan kesehatan sosial dengan program lainnya yang diimplementasikan oleh kementerian kesehatan (**contoh Sustainability Development Goals/SDGs)**	Please explain the relevance of social health insurance program to other programs implemented by the ministry of health (example: Sustainability Development Goals/SDGs)
5.	Mohon dijelaskan bagaimana mekanisme kementerian kesehatan dalam melakukan monitoring dan evaluasi program jaminan kesehatan sosial sosial	Please explain how the mechanism of the ministry of health in monitoring and evaluating social health insurance program.
6.	Mohon dijelaskan parameter kementerian kesehatan untuk mengukur keberhasilan program jaminan kesehatan sosial	Please explain the ministry of health parameters to measure the success of social health insurance program.
7.	Pada program jaminan kesehatan sosial, apakah ada kendala selama pelaksanaan program, serta bagaimana cara mengatasi kendala tersebut?	In the social health insurance program, are there any obstacles during the implementation of the program? How to overcome these obstacles?

C. Outcome on Social Health Insurance Programme

No	Indonesian Version	English Version
1	Mohon jelaskan target kementerian kesehatan dalam pelaksanaan program jaminan kesehatan sosial.	Please explain the ministry of social's target in the implementation of social health insurance program.
2.	Apakah target yang diharapkan telah tercapai? Jika belum mohon disampaikan kendalanya.	Have all program targets been achieved? If not, please explain the obstacles.
3.	Mohon dijelaskan, manfaat jaminan kesehatan sosial sosial dalam meningkatkan derajat kesehatan masyarakat Indonesia seperti kualitas hidup (Quality Adjustment Life Years)	Please explain the benefits of social health insurance in improving the standard of Indonesian public health such as quality of life (Quality Adjustment Life Years)
4.	Mohon dijelaskan manfaat program jaminan kesehatan sosial terhadap penurunan penyakit menular maupun tidak menular (DALY`s)	Please explain the benefits of social health insurance program in reducing communicable and non-communicable diseases (DALY's)
5.	Mohon dijelaskan, bagaimana manfaat program jaminan kesehatan sosial terhadap program lain yang diselenggarakan oleh kementerian kesehatan.	Please explain how are the benefits of social health insurance program to other programs conducted by the ministry of health.
6.	Mohon dijelaskan saran atau harapan untuk keberlangsungan jaminan kesehatan sosial di indonesia	Please explain your suggestions and/or expectations for the sustainability of social health insurance in Indonesia.

IN-DEPTH INTERVIEW

Interviewees: **Members of Directorate General of Social Protection and Social Insurance the Ministry of Social (Walfare) Republic Indonesia**

A.1. Regulations and Policy on Social Health Insurance Programme

No	Indonesian Version	English Version
	Input on Social Health Insurance (A1-A3)	**Input on Social Health Insurance (A1-A3)**
1.	Mohon dijelaskan tugas dan fungsi Kementerian sosial dalam keterkaitanya dengan Jaminan kesehatan sosial Nasional.	Please explain the duties and functions of the ministry of social in relation to the National social health insurance.
2	Mohon dijelaskan, bagaimanakah kementerian kesehatan menghadapi era reformasi sebelum dan sesudah JKN.	Please explain, how is the ministry of health facing the reformation era prior to and after JKN?
3.	Bagaimana koordinasi yang dilakukan oleh kementerian sosial dalam perencanaan implementasi JKN? Siapa saja yang terlibat dalam koordinasi tersebut.	How is the coordination conducted by the ministry of social in planning the implementation of JKN? Who involved in such activities?
4.	Mohon dijelaskan kendala yang dihadapi saat proses transformasi sebelum dan sesudah JKN?	Please explain the obstacles faced during the transformation process prior to and after JKN?
5.	Bagaimana upaya dalam menghadapi kendala tersebut?	How do you deal with these obstacles?
6.	Bagaimana perencanaan kementerian kesehatan dalam mengimplementasikan JKN, dalam hal ini termasuk peraturan-peraturan yang dibuat oleh kementerian kesehatan untuk implementasi program jaminan kesehatan sosial sosial	How is the ministry of health planning to implement JKN, in this case including the regulations made by the ministry of health for the implementation of social health insurance programs?
7.	Bagaimana dalam melakukan sosialisasi perencanaan yang telah dibuat untuk program JKN kepada staf kementerian sosial, dan pihak terkait?	How about in conducting the socialisation of planning that has been made for the JKN program to the ministry of social's staff and related parties?
8.	Bagaimana upaya kementerian sosial anda dalam melakukan sosialisasi perencanaan dalam implementasi JKN kepada masyarakat?	How is the effort of the ministry of social in conducting socialisation planning for JKN implementation to the public?

A.2. Demand on Social Health Insurance Programme

No	Indonesian Version	English Version
1.	Menurut anda, apakah premi dan paket Jaminan kesehatan sosial di Indonesia sudah sesuai dengan kebutuhan serta harapan masyarakat Indonesia?	In your opinion, are the premium and package of social health insurance in Indonesia in accordance with the needs and expectations of Indonesian people?
2.	Menurut anda, apakah premi serta paket jaminan kesehatan sosial yang selama ini diimplementasikan di Indonesia, sudah mewakili semua kebutuhan masyarakat Indonesia, termasuk bagi kelompok masyarakat miskin?	In your opinion, are the social health insurance premiums and packages implemented so far in Indonesia already representing all the needs of Indonesian people, including the poors?
3.	Apakah kementerian kesehatan dilibatkan dalam pendataan peserta jaminan kesehatan sosial terutama bagi kelompok miskin? Jika dilibatkan lanjut bagaimana mekanismenya?	Is the ministry of health involved in the data collection of participants in social health insurance, especially for the poor? If so, what is the mechanism?
4.	Apakah secara khusus instansi anda pernah melakukan analisis kemampuan (ATP) serta kemauan membayar (WTP) jaminan kesehatan sosial? Jika pernah lanjut pada [pertanyaan no.4,5)	Has your agency specifically conducted the analyses of Ability To Pay (ATP) and Willingness To Pay (WTP) for social health insurance? If so, continue to the questions no. 4, 5)
4.	Jika pernah, kapan dilakukan analisis tersebut, bagaimana mekanismenya, serta hasilnya?	If doing ATP/WTP analyses, when were the analyses conducted, what was the mechanism, and the results?
5.	Bagiamanakah kementerian kesehatan menyampaikan hasil analisis ATP/WTP kepada pihak terkait seperti halnya BPJS kesehatan?	How did the ministry of health inform the results of ATP/WTP analyses to the related parties like BPJS Kesehatan?

A.3. Supply on Social Health Insurance Programme

No	Indonesian Version	English Version
1.	Mohon dijelaskan dari segi keuangan, bagaimana kontribusi kementerian sosial dalam implementasi jaminan sosial kesehatan baik sebelum dan sesudah JKN diimplementasikan.	Please explain in terms of finance, how is the contribution of ministry of social in the implementation of social health insurance prior to and after the implementation of JKN?
2.	Mohon dijelaskan bagimanakah upaya kementerian kesehatan dalam memastikan ketersediaan untuk akses pelayanan kesehatan, jumlah Sumber daya manusia, sarana prasarana, serta system informasi sudah mencukupi untuk pelaksanaan jaminan kesehatan sosial baik sebelum dan sesudah JKN?	Please explain how the efforts of ministry of health in ensuring the availability for access to healthcare services, number of human resources, facilities and infrastructure, and information systems are sufficient for the implementation of social health insurance prior to and after JKN?
3.	Mohon dijelaskan, apakah sudah tersedia system informasi yang memadai dalam implementasi jaminan kesehatan (contoh untuk pendataan kepesertaan jaminan kesehatan)	Please explain whether there is an adequate information system in the implementation of health insurance (example for data collection on health insurance membership).
4.	Mohon dijelaskan kendala dari segi pendanaan, penyediaan sarana prasarana maupun system informasi pada program jaminan kesehatan sosial sebelum dan sesudah JKN?	Please explain the obstacles in terms of funding, the provision of facilities and infrastructure, as well as information system on the social health insurance program prior to and after JKN?
5.	Bagaimana upaya dalam menyelesaikan kendala kendala yang dihadapi selama ini?	How is the effort to overcome the obstacles that have been faced so far?
6.	Apakah ada harapan atau saran khusus untuk pemerintah atau pihak terkait dalam hal supply pada implementasi program jaminan kesehatan sosial?	Are there any specific expectations or suggestions to the government or related parties in terms of supply at the implementation of social health insurance program?

B. Process (Implementation) of Social Health Insurance Programme

No	Indonesian Version	English Version
1	Bagaimanakah upaya kementerian sosial dalam mengimplementasikan jaminan kesehatan sosial sebelum dan sesudah JKN pada hal-hal berikut:	How are the efforts of the ministry of social in implementing social health insurance prior to and after JKN on the following matters:
1a	Peraturan-peraturan dalam implementasi program jaminan kesehatan sosial	Regulations in the implementation of social health insurance program.
1b	Pendanaan program jaminan kesehatan sosial	Funding of social health insurance program.
1c	Penyediaan tenaga sumber daya manusia	Provision of human resources
1.d	Penyediaan fasilitas serta sarana dan prasaran pelayanan kesehatan	Provision of facilities and infrastructures for healthcare services.
1.f	Sistem informasi kesehatan	Healthcare information system
2.	Mohon dijelaskan bagaimana pelaksanaan sosialisasi yang dilakukan oleh kementerian sosial kepada masyarakat terkait dengan manfaat serta kepesertaan jaminan kesehatan sosial.	Please explain how the socialisation conducted by ministry of social to the public is related to the benefits and membership of social health insurance.
4.	Mohon dijelaskan keterkaitan program jaminan kesehatan sosial dengan program lainnya yang diimplementasikan oleh kementerian sosial (**contoh Sustainability Development Goals/SDGs)**	Please explain the relevance of social health insurance program to other programs implemented by the ministry of social (example: Sustainability Development Goals/SDGs)
5.	Mohon dijelaskan bagaimana mekanisme kementerian sosial dalam melakukan monitoring dan evaluasi program jaminan kesehatan sosial sosial	Please explain how is the mechanism of the ministry of social in monitoring and evaluating social health insurance program.
6.	Mohon dijelaskan parameter kementerian sosial untuk mengukur keberhasilan program jaminan kesehatan sosial	Please explain the ministry of social parameters to measure the success of social health insurance program.
7.	Pada program jaminan kesehatan sosial, apakah ada kendala selama pelaksanaan program, serta bagaimana cara mengatasi kendala tersebut?	In social health insurance program, are there any obstacles during the implementation of the program? How to overcome these obstacles?

C. Outcome on Social Health Insurance Programme

No	Indonesian Version	English Version
1	Mohon jelaskan target kementerian sosial dalam pelaksanaan program jaminan kesehatan sosial.	Please explain the target of the ministry of social in the implementation of social health insurance program.
2.	Apakah target yang diharapkan telah tercapai? Jika belum mohon disampaikan kendalanya.	Have all program targets been achieved? If not, please explain the obstacles.
3.	Mohon dijelaskan, manfaat jaminan kesehatan sosial dalam meningkatkan kesejahteraan masyarakat Indonesia (contoh pengentasan kemiskinan)	Please explain the benefits of social health insurance in improving the welfare of Indonesian people (for example: poverty alleviation)
4.	Mohon dijelaskan, bagaimana manfaat program jaminan kesehatan sosial terhadap program lain yang diselenggarakan oleh kementerian kesehatan.	Please explain how are the benefits of social health insurance program to other programs conducted by the ministry of health.
5.	Mohon dijelaskan saran atau harapan untuk keberlangsungan jaminan kesehatan sosial di indonesia	Please explain your suggestions and/or expectations for the sustainability of social health insurance in Indonesia.

IN-DEPTH INTERVIEW

Interviewees: National Security Council (DJSN)

A.1. Regulations and Policy on Social Health Insurance Programme

No	Indonesian Version	English Version
	Input on Social Health Insurance (A1-A3)	**Input on Social Health Insurance (A1-A3)**
1.	Mohon dijelaskan tugas dan fungsi DJSN dalam keterkaitanya dengan Jaminan kesehatan sosial Nasional.	Please explain the duties and functions of DJSN in relation to the National social health insurance.
2	Mohon dijelaskan, bagaimanakah DJSN menghadapi era reformasi dari sebelum dan sesudah JKN.	Please explain, how is DJSN facing the reformation era prior to and after JKN?
3.	Bagaimana koordinasi yang dilakukan oleh DJSN dalam perencanaan implementasi JKN? Siapa saja yang terlibat dalam koordinasi tersebut.	How is the coordination conducted by DJSN in planning the implementation of JKN? Who involved in such activities?
4.	Mohon dijelaskan kendala yang dihadapi saat proses transformasi sebelum dan sesudah JKN?	Please explain the obstacles faced during the transformation process prior to and after JKN?
5.	Bagaimana upaya dalam menghadapi kendala tersebut?	How do you deal with these obstacles?
6.	Bagaimana perencanaan DJSN dalam mengimplementasikan JKN, dalam hal ini termasuk peraturan-peraturan yang dibuat oleh DJSN untuk implementasi program jaminan kesehatan sosial	How is the DJSN planning to implement JKN, in this case including the regulations made by DJSN for the implementation of social health insurance programs?
7.	Bagaimana dalam melakukan sosialisasi perencanaan yang telah dibuat untuk program JKN kepada staf dalam organisasi anda, dan pihak terkait?	How about in conducting the socialisation of planning that has been made for the JKN program to your agency staff and related parties?
8.	Bagaimana upaya DJSN dalam melakukan sosialisasi perencanaan dalam implementasi JKN kepada masyarakat?	How is DJSN effort in conducting socialisation planning for JKN implementation to the public?

A.2. Demand on Social Health Insurance Programme

No	Indonesian Version	English Version
1.	Menurut anda, apakah premi dan paket Jaminan kesehatan sosial di Indonesia sudah sesuai dengan kebutuhan serta harapan masyarakat Indonesia?	In your opinion, are the premium and package of social health insurance in Indonesia in accordance with the needs and expectations of Indonesian people?
2.	Meunurut anda, apakah semua kelompok masyarakat telah tercakup dalam target kepesertaan JKN?	In your opinion, are all community groups already included in the JKN membership target?
3.	Menurut anda, apakah premi serta paket jaminan kesehatan sosial yang selama ini diimplementasikan di Indonesia, sudah mewakili semua kebutuhan masyarakat Indonesia, termasuk bagi kelompok masyarakat miskin?	In your opinion, are the social health insurance premiums and packages implemented so far in Indonesia already representing all the needs of Indonesian people, including the poors?
4.	Apakah DJSN dilibatkan dalam pendataan peserta jaminan kesehatan sosial terutama bagi kelompok miskin? Jika jika dilibatkan lanjut bagaimana mekanismenya?	Is DJSN involved in the data collection of participations in social health insurance, especially for the poor? If so, what is the mechanism?
5.	Apakah secara khusus instansi anda pernah melakukan analisis kemampuan (ATP) serta kemauan membayar (WTP) jaminan kesehatan sosial? Jika pernah lanjut pada [pertanyaan no.6,7)	Has your agency specifically conducted the analyses of Ability To Pay (ATP) and Willingness To Pay (WTP) for social health insurance? If so, continue to the questions no. 6, 7)
6.	Jika pernah, kapan dilakukan analisis tersebut, bagaimana mekanismenya, serta hasilnya?	If doing ATP/WTP analyses, when were the analyses conducted, what was the mechanism, and the results?
7.	Bagiamanakah DJSN menyampaikan hasil analisis ATP/WTP kepada pihak terkait sepertihalnya BPJS kesehatan?	How did the DJSN inform the results of ATP/WTP analyses to the related parties like BPJS Kesehatan?

A.3. Supply on Social Health Insurance Programme

No	Indonesian Version	English Version
1.	Mohon dijelaskan dari segi keuangan, bagaimana kontribusi DJSN dalam implementasi jaminan sosial kesehatan baik sebelum dan sesudah JKN diimplementasikan (hal ini dapat berupa peraturan yang dibuat)	Please explain in terms of finance, how is the contribution of DJSN in the implementation of social health insurance prior to and after the implementation of JKN? (this can be a proposed regulation)
2.	**Mohon dijelaskan bagimanakah upaya DJSN dalam berkoordinasi dengan pihak terkait untuk memastikan ketersediaan untuk akses pelayanan kesehatan, jumlah Sumber daya manusia, sarana prasarana, pengadaan/penyediaan obat serta system informasi sudah mencukupi untuk pelaksanaan jaminan kesehatan sosial baik sebelum dan sesudah JKN?**	Please explain how the DJSN's efforts in coordinating with related parties to ensure the availability for access to health services, number of human resources, facilities and infrastructure, medicine procurement/provision and information systems are sufficient for the implementation of social health insurance prior to and after JKN?
3.	**Mohon dijelaskan, apakah sudah tersedia system informasi yang memadai dalam sosialisasi implememtasi jaminan kesehatan sosial?**	Please explain whether there is an adequate information system in the socialisation of implementation of health insurance?
6.	Apakah ada harapan atau saran khusus untuk pemerintah atau pihak terkait dalam hal supply pada implementasi program jaminan kesehatan sosial?	Are there any specific expectations or suggestions to the government or related parties in terms of supply at the implementation of social health insurance program?

B. Process (Implementation) of Social Health Insurance Programme

No	Indonesian Version	English Version
1	Bagaimanakah upaya DJSN dalam mengimplementasikan jaminan kesehatan sosial sebelum dan sesudah JKN pada hal-hal berikut:	How are the efforts of BPJS Kesehatan in implementing social health insurance on the following matters:
1a	Peraturan-peraturan dalam implementasi program jaminan kesehatan sosial	Regulations in the implementation of social health insurance program.
1b	Pendanaan program jaminan kesehatan sosial	Funding for social health insurance program.
1c	Penyediaan tenaga kesehatan	Provision of healthcare personnels
1.d	Penyediaan fasilitas serta sarana dan prasaran pelayanan kesehatan	Provision of facilities and infrastructures for healthcare services.
1.e	Pengadaan obat	Procurement of medicines
1.f	Sistem informasi kesehatan	Healthcare information system
2.	Mohon dijelaskan bagaimana pelaksanaan sosialisasi yang dilakukan oleh DJSN kepada masyarakat terkait dengan manfaat serta kepesertaan jaminan kesehatan sosial.	Please explain how socialisation conducted by DJSN to the public related to the benefits and membership of social health insurance.
3.	Mohon dijelaskan keterkaitan program jaminan kesehatan sosial dengan program lainnya yang diimplementasikan oleh DJSN kesehatan (**contoh Sustainability Development Goals/SDGs)**	Please explain the relevance of social health insurance program to other programs implemented by DJSN Kesehatan (example: Sustainability Development Goals/SDGs)
4.	Mohon dijelaskan bagaimana mekanisme DJSN dalam melakukan monitoring dan evaluasi program jaminan kesehatan sosial sosial	Please explain how the mechanism of DJSN in monitoring and evaluating social health insurance program.
5.	Mohon dijelaskan parameter kementerian kesehatan untuk mengukur keberhasilan program jaminan kesehatan sosial	Please explain the ministry of health parameters to measure the success of social health insurance program.
6.	Pada program jaminan kesehatan sosial, apakah ada kendala selama pelaksanaan program, serta bagaimana cara mengatasi kendala tersebut?	In social health insurance program, are there any obstacles during the implementation of the program? How to overcome these obstacles?

C. Outcome on Social Health Insurance Programme

No	Indonesian Version	English Version
1	Mohon jelaskan target DJSN dalam pelaksanaan program jaminan kesehatan sosial.	Please explain the DJSN target in the implementation of social health insurance program.
2.	Mohon dijelaskan apakah semua target program telah tercapai? termasuk target, manfaat kepesertaan, dan pendanaan.	Please explain, have all program targets been achieved? (including targets, membership benefits, and funding)
3.	Mohon dijelaskan upaya/kontribusi yang dilakukan DJSN dalam mencapai target program JKN?	Please explain the efforts/contributions made by the DJSN in achieving the JKN program target?
4.	Mohon dijelaskan, hasil evaluasi yang dilakukan DJSN terhadap manfaat jaminan kesehatan sosial pada era JKN ini.	Please explain the results of evaluation conducted by DJSN on the benefits of social health insurance in this era of JKN.
5.	Mohon dijelaskan, hasil evaluasi biasanya dilaporkan kepada siapa saja?	Please explain to whom the results of evaluation are usually reported?
6.	Mohon dijelaskan saran atau harapan untuk keberlangsungan jaminan kesehatan sosial di Indonesia	Please explain your suggestions and/or expectations for the sustainability of social health insurance in Indonesia.

IN-DEPTH INTERVIEW

Interviewees: Social Security Management Agency for Health Sector (Badan Penyelenggara Jaminan Sosial Kesehatan/BPJS Kesehatan)

A.1. Regulations and Policy on Social Health Insurance Programme

No	Indonesian Version	English Version
	Input on Social Health Insurance (A1-A3)	**Input on Social Health Insurance (A1-A3)**
1.	Mohon dijelaskan tugas dan fungsi BPJS Kesehatan dalam keterkaitanya dengan Jaminan kesehatan sosial Nasional.	Please explain the duties and functions of BPJS Kesehatan in relation to the National social health insurance.
2.	Mohon dijelaskan, bagaimanakah BPJS Kesehatan dalam menghadapi era reformasi dari sebelum dan sesudah JKN.	Please explain, how is BPJS Kesehatan facing the reformation era prior to and after JKN?
3.	Bagaimana koordinasi yang dilakukan oleh BPJS Kesehatan dalam perencanaan implementasi JKN? Siapa saja yang terlibat dalam koordinasi tersebut.	How is the coordination conducted by BPJS Kesehatan in planning the implementation of JKN? Who involved in such activities?
4.	Mohon dijelaskan kendala yang dihadapi saat proses transformasi sebelum dan sesudah JKN?	Please explain the obstacles faced during the transformation process prior to and after JKN?
5.	Bagaimana upaya BPJS Kesehatan dalam menghadapi kendala tersebut?	How BPJS Kesehatan deal with these obstacles?
6.	Bagaimana perencanaan BPJS Kesehatan dalam mengimplementasikan JKN, dalam hal ini termasuk peraturan-peraturan yang dibuat oleh BPJS Kesehatan untuk implementasi program jaminan kesehatan sosial	How is the BPJS Kesehatan planning to implement JKN, in this case including the regulations made by BPJS Kesehatan for the implementation of social health insurance programs?
7.	Bagaimana dalam melakukan sosialisasi perencanaan yang telah dibuat untuk program JKN kepada staf BPJS Kesehatan, dan pihak terkait?	How about in conducting the socialisation of planning that has been made for the JKN program to BPJS Kesehatan staff and related parties?
8	Bagaimana upaya BPJS Kesehatan anda dalam melakukan sosialisasi perencanaan dalam implementasi JKN kepada masyarakat?	What is your BPJS Kesehatan effort in conducting socialisation planning for JKN implementation to the public?

A.2. Demand on Social Health Insurance Programme

No	Indonesian Version	English Version
1.	Menurut anda, apakah premi dan paket Jaminan kesehatan sosial di Indonesia sudah sesuai dengan kebutuhan serta harapan masyarakat Indonesia?	In your opinion, are the premium and package of social health insurance in Indonesia in accordance with the needs and expectations of Indonesian people?
2	Menurut anda, apakah semua kelompok masyarakat telah tercakup dalam target kepesertaan JKN?	In your opinion, are all community groups already included in the JKN membership target?
3.	Mohon dijelaskan bagaimana BPJS Kesehatan menentukan premi serta paket JKN yang saat ini diimplementasikan?	Please explain how the BPJS Kesehatan determines the JKN premiums and packages which are currently implemented?
4	Mohon dijelaskan perbedaan premi dan paket jaminan kesehatan yang pernah dikelola BPJS Keseahatan sebelum JKN serta setelah JKN diimplementasikan	Please explain the differences between health insurance premiumsand packages that have been managed by BPJS Kesehatan prior to and after the implementation of JKN?
5	Apakah secara khusus instansi anda melakukan analisis kemampuan (ATP) serta kemauan membayar (WTP) jaminan kesehatan sosial sebelum dilaksanakannya JKN?	Did your agency specifically conduct the analyses of Ability To Pay (ATP) and Willingness To Pay (WTP) for social health insurance prior to the implementation of JKN?
6.	Jika melakukan analisis ATP/WTP, kapan dilakukan analisis tersebut, bagaimana mekanismenya, serta hasilnya?	If doing ATP/WTP analyses, when were the analyses conducted, what was the mechanism, and the results?
7.	**Bagaimana (prosedur) penentuan kepesertaan JKN? Apa perbedaan (prosedur) penentuan kepesertaan sebelum JKN diimplementasikan?**	How to determine the JKN membership? What is the difference in the determination of membership prior to JKN's implementation?
8.	**Bagaimana dalam menentukan kepesertaan bagi masyarakat miskin yang di subsidi oleh pemerintah?**	How to determine membership for the government-subsidised poors?

A.3. Supply on Social Health Insurance Programme

No	Indonesian Version	English Version
1.	Mohon dijelaskan dari segi keuangan, bagaimana kontribusi BPJS Kesehatan dalam implementasi jaminan sosial kesehatan sosial, serta pengalaman BPJS Kesehatan pada saat menjadi BAPEL pada jaminan kesehatan sebelum JKN?	Please explain in terms of finance, how is the contribution of BPJS Kesehatan in the implementation of social health insurance and the experience of BPJS Kesehatan when becoming BAPEL in health insurance prior to JKN?
2.	**Mohon dijelaskan bagaimanakah upaya BPJS Kesehatan dalam memastikan ketersediaan untuk akses pelayanan kesehatan, jumlah Sumber daya manusia, sarana prasarana, serta system informasi sudah mencukupi untuk pelaksanaan jaminan kesehatan sosial baik sebelum dan sesudah JKN?**	Please explain how are the BPJS's efforts in ensuring the availability for access to health services, number of human resources, facilities and and information systems is sufficient for the implementation of social health insurance prior to and after JKN?
3.	Mohon dijelaskan bagaimana koordinasi BPJS Kesehatan dengan pihak pihak terkait dalam pelaksanaan JKN.	Please explain how is the coordination of BPJS Kesehatan and with related parties in implementing JKN.
4.	Mohon dijelaskan, apakah sudah tersedia system informasi yang memadai dalam implementasi jaminan kesehatan (contoh untuk pendataan kepesertaan jaminan kesehatan)	Please explain whether there is an adequate information system in the implementation of health insurance (example for data collection on health insurance membership).
5.	Mohon dijelaskan kendala dari segi pendanaan, penyediaan sarana prasarana maupun system informasi pada program jaminan kesehatan sosial sebelum dan sesudah JKN?	Please explain the obstacles in terms of funding, the provision of facilities and infrastructure, as well as information system on the social health insurance program prior to and after JKN?
6.	Bagaimana upaya dalam menyelesaikan kendala kendala yang dihadapi selama ini?	How is the effort to deal with the obstacles that have been faced so far?
7.	Apakah ada harapan atau saran khusus untuk pemerintah atau pihak terkait dalam hal supply pada implementasi program jaminan kesehatan sosial?	Are there any specific expectations or suggestions to the government or related parties in terms of supply at the implementation of social health insurance program?

B. Process (Implementation) of Social Health Insurance Programme

No	Indonesian Version	English Version
1	Bagaimanakah upaya BPJS Kesehatan dalam mengimplementasikan jaminan kesehatan sosial pada hal-hal berikut:	How are the efforts of BPJS Kesehatan in implementing social health insurance on the following matters:
1a	Peraturan-peraturan dalam implementasi program jaminan kesehatan sosial	Regulations in the implementation of social health insurance program.
1b	Pendanaan program jaminan kesehatan sosial	Funding of social health insurance program.
1c	Penyediaan tenaga sumber daya manusia	Provision of human resources
1.d	Penyediaan fasilitas serta sarana dan prasarana pelayanan kesehatan	Provision of facilities and infrastructures for healthcare services.
1.f	Sistem informasi pelayanan BPJS kesehatan	BPJS Kesehatan service information system.
2.	Mohon dijelaskan bagaimana pelaksanaan sosialisasi yang dilakukan oleh BPJS Keseahtan kepada masyarakat terkait dengan manfaat serta kepesertaan jaminan kesehatan sosial.	Please explain how the socialisation conducted by BPJS Kesehatan to the public related to the benefits and membership of social health insurance.
3.	Mohon dijelaskan keterkaitan program jaminan kesehatan sosial dengan program lainnya yang diimplementasikan oleh DJSN kesehatan (**contoh Sustainability Development Goals/SDGs)**	Please explain the relevance of social health insurance program to other programs implemented by DJSN Kesehatan (example: Sustainability Development Goals/SDGs)
4.	Mohon dijelaskan bagaimana mekanisme BPJS Kesehatan dalam melakukan monitoring dan evaluasi program jaminan kesehatan sosial (contoh Utilization Review)	Please explain how the mechanism of BPJS Kesehatan in monitoring and evaluating social health insurance program (example: Utilisation Review)
5.	Mohon dijelaskan parameter kementerian kesehatan untuk mengukur keberhasilan program jaminan kesehatan sosial	Please explain the ministry of health parameters to measure the success of social health insurance program.
6.	Pada program jaminan kesehatan sosial, apakah ada kendala selama pelaksanaan program, serta bagaimana cara mengatasi kendala tersebut?	In the social health insurance program, are there any obstacles during the implementation of the program? How to overcome these obstacles?

C. Outcome on Social Health Insurance Programme

No	Indonesian Version	English Version
1	Mohon jelaskan target BPJS Kesehatan dalam pelaksanaan program jaminan kesehatan sosial.	Please explain the target of BPJS Kesehatan in implementing social health insurance program
2.	Mohon dijelaskan apakah semua target programme telah tercapai? Termasuk target, manfaat kepesertaan, dan pendanaan.	Please explain if all program targets have been achieved? (Including targets, membership benefits, and funding.
3.	Mohon dijelaskan upaya yang dilakukan BPJS Kesehatan dalam mencapai target program JKN?	Please explain the efforts made by BPJS Kesehatan to achieve the JKN program target?
4.	Mohon dijelaskan, hasil evaluasi yang dilakukan BPJS kesehatan terhadap manfaat jaminan kesehatan sosial sosial pada era JKN ini.	Please explain the results of evaluation conducted by BPJS Kesehatan on the benefits of social health insurance in this era of JKN.
5.	Mohon dijelaskan, hasil evaluasi biasanya dilaporkan kepada siapa saja?	Please explain to whom the results of evaluation are usually reported?
6.	Mohon dijelaskan saran atau harapan untuk keberlangsungan jaminan kesehatan sosial di Indonesia	Please explain your suggestions and/or expectations for the sustainability of social health insurance in Indonesia.

IN-DEPTH INTERVIEW

Interviewees: Provincial Health Office D.I Yogyakarta

A.1. Regulations and Policy on Social Health Insurance Programme

No	Indonesian Version	English Version
	Input on Social Health Insurance (A1-A3)	**Input on Social Health Insurance (A1-A3)**
1.	Mohon dijelaskan tugas dan fungsi Dinas Kesehatan Propinsi Yogyakarta keterkaitanya dengan Jaminan kesehatan sosial Nasional.	Please explain the duties and functions of the Provincial Health Office Yogyakarta in relation to the National social health insurance.
2.	Mohon dijelaskan, bagaimanakah Dinas Kesehatan Propinsi Yogyakarta menghadapi era reformasi sebelum dan sesudah JKN.	Please explain, how is the Provincial Health Office Yogyakarta facing the reformation era prior to and after JKN?
3.	Bagaimana koordinasi yang dilakukan oleh Dinas Kesehatan Propinsi Yogyakarta dalam perencanaan implementasi JKN? Siapa saja yang terlibat dalam koordinasi tersebut.	How is the coordination conducted by the Provincial Health Office Yogyakarta in planning the implementation of JKN? Who involved in such activities?
4.	Mohon dijelaskan kendala yang dihadapi saat proses transformasi sebelum dan sesudah JKN?	Please explain the obstacles faced during the transformation process prior to and after JKN?
5.	Bagaimana upaya Dinas Kesehatan Propinsi Yogyakarta dalam menghadapi kendala tersebut?	How do Provincial Health Office Yogyakarta deal with these obstacles?
6	Bagaimana perencanaan Dinas Kesehatan Propinsi Yogyakarta dalam mengimplementasikan JKN, dalam hal ini termasuk peraturan-peraturan yang dibuat oleh Dinas Kesehatan Propinsi Yogyakarta untuk implementasi program jaminan kesehatan sosial sosial	How is the Provincial Health Office Yogyakarta planning to implement JKN, in this case including the regulations made by the ministry of health for the implementation of social health insurance programs?
7	Bagaimana dalam melakukan sosialisasi perencanaan yang telah dibuat untuk program JKN kepada staf anda, dan pihak terkait?	How about in conducting the socialisation of planning that has been made for the JKN program to your staff and related parties?
8	Bagaimana upaya Dinas Kesehatan Propinsi Yogyakarta dalam melakukan sosialisasi perencanaan dalam implementasi JKN kepada masyarakat?	How is effort of the Provincial Health Office Yogyakarta in conducting socialisation planning for JKN implementation to the public?

A.2. Demand on Social Health Insurance Programme

No	Indonesian Version	English Version
1.	Menurut anda, apakah premi dan paket Jaminan kesehatan sosial di Indonesia sudah sesuai dengan kebutuhan dan harapan masyarakat Indonesia?	In your opinion, are the premium and package of social health insurance in Indonesia in accordance with the needs and expectations of Indonesian people?
2.	Menurut anda, apakah premi serta paket jaminan kesehatan sosial yang selama ini diimplementasikan di Indonesia, sudah mewakili semua kebutuhan masyarakat Indonesia, termasuk bagi kelompok masyarakat miskin?	In your opinion, are the social health insurance premiums and packages implemented so far in Indonesia already representing all the needs of Indonesian people, including the poors?
3.	Apakah kementerian kesehatan dilibatkan dalam pendataan peserta jaminan kesehatan sosial terutama bagi kelompok miskin? Jika dilibatkan bagaimana mekanismenya?	Is the Provincial Health Office Yogyakarta involved in the data collection of participations in social health insurance, especially for the poor? If so, what is the mechanism?
4.	Apakah secara khusus instansi anda pernah melakukan analisis kemampuan (ATP) serta kemauan membayar (WTP) jaminan kesehatan sosial? Jika pernah lanjut pada (pertanyaan no.4,5)	Has your agency specifically conducted the analyses of Ability To Pay (ATP) and Willingness To Pay (WTP) for social health insurance? If so, continue to the questions no. 4, 5)
4.	Jika pernah, kapan dilakukan analisis tersebut, bagaimana mekanismenya, serta hasilnya?	If doing ATP/WTP analyses, when were the analyses conducted, what was the mechanism, and the results?
5.	Bagiamanakah Dinas Kesehatan Propinsi Yogyakarta menyampaikan hasil analisis ATP/WTP kepada pihak terkait sepertihalnya BPJS kesehatan?	How did the Provincial Health Office Yogyakarta inform the results of ATP/WTP analyses to the related parties like BPJS Kesehatan?

A.3. Supply on Social Health Insurance Programme

No	Indonesian Version	English Version
1.	Mohon dijelaskan dari segi keuangan, bagaimana kontribusi Dinas Kesehatan Propinsi Yogyakarta dalam implementasi jaminan sosial kesehatan baik sebelum dan sesudah JKN diimplementasikan.	Please explain in terms of finance, how is the contribution of ministry of health in the implementation of social health insurance prior to and after the implementation of JKN?
2.	Mohon dijelaskan bagimanakah upaya kementerian kesehatan dalam memastikan ketersediaan untuk akses pelayanan kesehatan, jumlah Sumber daya manusia, sarana prasarana, pengadaan/penyediaan obat serta system informasi sudah mencukupi untuk pelaksanaan jaminan kesehatan sosial baik sebelum dan sesudah JKN?	Please explain how the Provincial Health Office Yogyakarta`s efforts in ensuring the availability for access to health services, number of human resources, facilities and infrastructure, and information systems is sufficient for the implementation of social health insurance prior to and after JKN?
3.	Mohon dijelaskan, apakah sudah tersedia system informasi kesehatan yang memadai dalam implementasi pelayanan kesehatan? Baik di puskesmas atau rumah sakit.	Please explain whether there is an adequate information system in the implementation of health services (either in public health centre or hospital).
4.	Mohon dijelaskan kendala dari segi pendanaan, penyediaan pelayanan kesehatan di puskesmas/di rumah sakit, sarana prasarana maupun system informasi pada program jaminan kesehatan sosial sosial sesebul dan sesudah JKN?	Please explain the obstacles in terms of funding, the provision of health services in public health centre/hospital, facilities and infrastructure, as well as information system on the social health insurance program prior to and after JKN?
5.	Bagaimana upaya dalam menyelesaikan kendala kendala yang dihadapi selama ini?	How is the effort to solve the obstacles that have been faced so far?
6.	Apakah ada harapan atau saran khusus untuk pemerintah atau pihak terkait dalam hal supply pada implementasi program jaminan kesehatan sosial?	Are there any specific expectations or suggestions to the government or related parties in terms of supply at the implementation of social health insurance program?

B. Process (Implementation) of Social Health Insurance Programme

No	Indonesian Version	English Version
1	Bagaimanakah upaya kementerian kesehatan dalam mengimplementasikan jaminan kesehatan sosial sebelum dan sesudah JKN pada hal-hal berikut:	How are the efforts of the ministry of social in implementing social health insurance prior to and after JKN on the following matters:
1a	Peraturan-peraturan dalam implementasi program jaminan kesehatan sosial (termasuk Jamkesos)	Regulations in the implementation of social health insurance program (Including Jamkesos).
1b	Pendanaan program jaminan kesehatan sosial	Funding of social health insurance program.
1c	Penyediaan tenaga kesehatan	Provision of health personnels
1.d	Penyediaan fasilitas, sarana dan prasaran pelayanan kesehatan	Provision of facilities and infrastructures for health services.
1.e	Pengadaan obat	Procurement of medicines
1.f	Sistem informasi Kesehatan	Health information system
2.	Mohon dijelaskan bagaimana pelaksanaan sosialisasi yang dilakukan oleh kemterian kesehatan kepada masyarakat terkait dengan manfaat serta kepesertaan jaminan kesehatan sosial.	Please explain how the socialisation conducted by Provincial Health Office Yogyakarta to the public related to the benefits and membership of social health insurance.
3.	Mohon dijelaskan bagaimanakah implementasi rujukan bagi peserta jaminan kesehatan sosial di tingkat pelayanan primer sampai pada pelayanan lanjutan di rumah sakit.	Please explain how is the implementation of referrals for social health insurance participants at the primary care level to follow-up services at the hospital.
4.	Mohon dijelaskan keterkaitan program jaminan kesehatan sosial dengan program lainnya yang diimplementasikan oleh kementerian kesehatan (**contoh Sustainability Development Goals/SDGs)**	Please explain the relevance of social health insurance program to other programs implemented by the Provincial Health Office Yogyakarta (example: Sustainability Development Goals/SDGs)
5.	Mohon dijelaskan bagaimana mekanisme kementerian kesehatan dalam melakukan monitoring dan evaluasi program jaminan kesehatan sosial sosial	Please explain how the mechanism of the ministry of health in monitoring and evaluating social health insurance program.
6.	Mohon dijelaskan parameter Dinas Kesehatan Propinsi Yogyakarta untuk mengukur keberhasilan program jaminan kesehatan sosial	Please explain the ministry of health parameters to measure the success of social health insurance program.
7.	Pada program jaminan kesehatan sosial, apakah ada kendala selama pelaksanaan program, serta bagaimana cara mengatasi kendala tersebut?	In the social health insurance program, are there any obstacles during the implementation of the program? How to overcome these obstacles?

C. Outcome on Social Health Insurance Programme

No	Indonesian Version	English Version
1	Mohon jelaskan target kementerian kesehatan dalam pelaksanaan program jaminan kesehatan sosial.	Please explain the Provincial Health Office Yogyakarta`s target in the implementation of social health insurance program.
2.	Apakah target yang diharapkan telah tercapai? Jika belum mohon disampaikan kendalanya.	Have all program targets been achieved? If not, please explain the obstacles.
3.	Mohon dijelaskan, manfaat jaminan kesehatan sosial sosial dalam meningkatkan derajat kesehatan masyarakat Indonesia seperti kualitas hidup (Quality Adjustment Life Years)	Please explain the benefits of social health insurance in improving the standard of Indonesian public health such as quality of life (Quality Adjustment Life Years)
4.	Mohon dijelaskan manfaat program jaminan kesehatan sosial terhadap penurunan penyakit menular maupun tidak menular (DALY`s)	Please explain the benefits of social health insurance program in reducing communicable and non-communicable diseases (DALY's)
5.	Mohon dijelaskan, bagaimana manfaat program jaminan kesehatan sosial terhadap program lain yang diselenggarakan oleh kementerian kesehatan.	Please explain how are the benefits of social health insurance program to other programs conducted by the ministry of health.
6.	Mohon dijelaskan saran atau harapan untuk keberlangsungan jaminan kesehatan sosial di Indonesia	Please explain your suggestions and/or expectations for the sustainability of social health insurance in Indonesia.

Appendix 6. Focus Group Discussion (FGD)

FOCUS GROUP DISCUSSION

Interviewees: Health Financing and Insurance Devision of Yogyakarta City Health Centre (Puskesmas Kota Yogyakarta)

A.1. Regulations and Policy on Social Health Insurance Programme

No	Indonesian Version	English Version
	Input on Social Health Insurance (A1-A3)	**Input on Social Health Insurance (A1-A3)**
1.	Mohon dijelaskan tugas dan fungsi Puskesmas Kota Yogyakarta keterkaitanya dengan Jaminan kesehatan sosial Nasional.	Please explain the duties and functions of the Yogyakarta City Health Centre in relation to the National social health insurance.
2.	Mohon dijelaskan, bagaimanakah Puskesmas Kota Yogyakarta menghadapi era reformasi sebelum dan sesudah JKN.	Please explain, how is Yogyakarta City Health Centre facing the reformation era prior to and after JKN?
3.	Bagaimana koordinasi yang dilakukan oleh Puskesmas Kota Yogyakarta dalam perencanaan implementasi JKN? Siapa saja yang terlibat dalam koordinasi tersebut.	How is the coordination conducted by the Yogyakarta City Health Centre in planning the implementation of JKN? Who involved in such activities?
4.	Mohon dijelaskan kendala yang dihadapi saat proses transformasi sebelum dan sesudah JKN?	Please explain the obstacles faced during the transformation process prior to and after JKN?
5.	Bagaimana upaya dalam menghadapi kendala tersebut?	How do Yogyakarta City Health Centre deal with these obstacles?
6	Bagaimana perencanaan Puskesmas Kota Yogyakarta dalam mengimplementasikan JKN, dalam hal ini termasuk peraturan-peraturan yang dibuat oleh kementerian kesehatan untuk implementasi program jaminan kesehatan sosial sosial	How is the Yogyakarta City Health Centre planning to implement JKN, in this case including the regulations made by the ministry of health for the implementation of social health insurance programs?
7	Bagaimana Puskesmas Kota Yogyakarta dalam melakukan sosialisasi perencanaan yang telah dibuat untuk program JKN kepada staf anda, dan pihak terkait?	How about in conducting the socialisation of planning that has been made for the JKN program to your staff and related parties?
8	Bagaimana upaya Puskesmas Kota Yogyakarta dalam melakukan sosialisasi perencanaan dalam implementasi JKN kepada masyarakat?	How is effort of the Yogyakarta City Health Centre in conducting socialisation planning for JKN implementation to the public?

A.2. Demand on Social Health Insurance Programme

No	Indonesian Version	English Version
1.	Menurut anda, apakah premi dan paket Jaminan kesehatan sosial di Indonesia sudah sesuai dengan kebutuhan dan harapan masyarakat Indonesia?	In your opinion, are the premium and package of social health insurance in Indonesia in accordance with the needs and expectations of Indonesian people?
2.	Menurut anda, apakah premi serta paket jaminan kesehatan sosial yang selama ini diimplementasikan di Indonesia, sudah mewakili semua kebutuhan masyarakat Indonesia, termasuk bagi kelompok masyarakat miskin?	In your opinion, are the social health insurance premiums and packages implemented so far in Indonesia already representing all the needs of Indonesian people, including the poors?
3.	Apakah Puskesmas Kota Yogyakarta dilibatkan dalam pendataan peserta jaminan kesehatan sosial terutama bagi kelompok miskin? Jika dilibatkan bagaimana mekanismenya?	Is the ministry of health involved in the data collection of participations in social health insurance, especially for the poor? If so, what is the mechanism?
4.	Berapakah jumlah kunjungan peserta JKN di Puskesmas Kota Yogyakarta	How many patients (member of JKN) visit to Yogyakarta City Health Centre per month? Is there an increase in the number of referrals before JKN?
4.	Rata-rata sakit apa saja peserta JKN yang berobat di Puskesmas?	What are the most diagnosed diseases in the Yogyakarta city health center per month? is there a significant difference before JKN?
6.	Berapakah rata-rata rujukan ke rumah sakit per bulannya? Apakah ada peningkatan jumlah rujukan dari sebelum JKN?	How many JKN participants reffered by the Yogyakarta City Health centre to the hospital per month? is there an increase in the number of referrals before JKN

A.3. Supply on Social Health Insurance Programme

No	Indonesian Version	English Version
1.	Mohon dijelaskan dari segi keuangan, sumber-sumber keuangan Puskesmas Kota Yogyakarta dalam implementasi jaminan sosial kesehatan baik sebelum dan sesudah JKN diimplementasikan.	Please explain in terms of financial the Yogyakarta City Health Centre in in terms of financial resourches in the implementation of social health insurance prior to and after the implementation of JKN?
2.	Mohon dijelaskan bagimanakah upaya Puskesmas Kota Yogyakarta dalam memastikan ketersediaan untuk akses pelayanan kesehatan, jumlah Sumber daya manusia, sarana prasarana, pengadaan/penyediaan obat serta system informasi sudah mencukupi untuk pelaksanaan jaminan kesehatan sosial baik sebelum dan sesudah JKN?	Please explain how the Yogyakarta City Health Centre`s efforts in ensuring the availability for access to health services, number of human resources, facilities and infrastructure, and information systems is sufficient for the implementation of social health insurance prior to and after JKN?
3.	Mohon dijelaskan, apakah sudah tersedia system informasi kesehatan yang memadai dalam implementasi pelayanan kesehatan di Puskesmas Kota Yogyakarta?	Please explain whether there is an adequate information system in the implementation of health services in Yogyakarta City Health Centre?
4.	Mohon dijelaskan kendala dari segi pendanaan, penyediaan pelayanan kesehatan di puskesmas/di rumah sakit, sarana prasarana maupun system informasi pada program jaminan kesehatan sosial sebelum dan sesudah JKN?	Please explain the obstacles in terms of funding, the provision of health services in public health centre/hospital, facilities and infrastructure, as well as information system on the social health insurance program prior to and after JKN?
5.	Bagaimana upaya dalam menyelesaikan kendala kendala yang dihadapi selama ini?	How is the effort to solve the obstacles that have been faced so far?
6.	Apakah ada harapan atau saran khusus untuk pemerintah atau pihak terkait dalam hal supply pada implementasi program jaminan kesehatan sosial?	Are there any specific expectations or suggestions to the government or related parties in terms of supply at the implementation of social health insurance program?

B. Process (Implementation) of Social Health Insurance Programme

No	Indonesian Version	English Version
1	Bagaimanakah upaya Puskesmas Kota Yogyakarta dalam mengimplementasikan jaminan kesehatan sosial sebelum dan sesudah JKN pada hal-hal berikut:	How are the efforts of the Yogyakarta City Health centre in implementing social health insurance prior to and after JKN on the following matters:
1a	Peraturan-peraturan dalam implementasi program jaminan kesehatan sosial	Regulations in the implementation of social health insurance program.
1b	Pendanaan program jaminan kesehatan sosial	Funding of social health insurance program.
1c	Penyediaan tenaga kesehatan	Provision of health personnels
1.d	Penyediaan fasilitas, sarana dan prasaran pelayanan kesehatan	Provision of facilities and infrastructures for health services.
1.e	Pengadaan obat	Procurement of medicines
1.f	Sistem informasi Kesehatan	Health information system
2.	Mohon dijelaskan bagaimana pelaksanaan sosialisasi yang dilakukan oleh Puskesmas Kota Yogyakarta kepada masyarakat terkait dengan manfaat serta kepesertaan jaminan kesehatan sosial.	Please explain how the socialisation conducted by the Yogyakarta City Health centre to the public related to the benefits and membership of social health insurance.
3.	Mohon dijelaskan bagaimanakah implementasi rujukan bagi peserta jaminan kesehatan sosial di tingkat pelayanan primer sampai pada pelayanan lanjutan di rumah sakit.	Please explain how is the implementation of referrals for social health insurance participants at the primary care level to follow-up services at the hospital.
4.	Mohon dijelaskan keterkaitan program jaminan kesehatan sosial dengan program lainnya yang diimplementasikan oleh kementerian kesehatan (**contoh Sustainability Development Goals/SDGs)**	Please explain the relevance of social health insurance program to other programs implemented by the ministry of health (example: Sustainability Development Goals/SDGs)
5.	Mohon dijelaskan bagaimana mekanisme Puskesmas Kota Yogyakarta dalam melakukan monitoring dan evaluasi program jaminan kesehatan sosial sosial	Please explain how the mechanism of the the Yogyakarta City Health centre in monitoring and evaluating social health insurance program.
6.	Mohon dijelaskan parameter Puskesmas Kota Yogyakarta untuk mengukur keberhasilan program jaminan kesehatan sosial	Please explain the ministry of health parameters to measure the success of social health insurance program.
7.	Pada program jaminan kesehatan sosial, apakah ada kendala selama pelaksanaan program, serta bagaimana cara mengatasi kendala tersebut?	In the social health insurance program, are there any obstacles during the implementation of the program? How to overcome these obstacles?

C. Outcome on Social Health Insurance Programme

No	Indonesian Version	English Version
1	Mohon jelaskan target Puskesmas Kota Yogyakarta dalam pelaksanaan program jaminan kesehatan sosial.	Please explain the the Yogyakarta City Health centre `starget in the implementation of social health insurance program.
2.	Apakah target yang diharapkan telah tercapai? Jika belum mohon disampaikan kendalanya.	Have all program targets been achieved? If not, please explain the obstacles.
3.	Mohon dijelaskan, manfaat jaminan kesehatan sosial sosial dalam meningkatkan derajat kesehatan masyarakat Indonesia seperti kualitas hidup (Quality Adjustment Life Years)	Please explain the benefits of social health insurance in improving the standard of Indonesian public health such as quality of life (Quality Adjustment Life Years)
4.	Mohon dijelaskan manfaat program jaminan kesehatan sosial terhadap penurunan penyakit menular maupun tidak menular (DALY`s)	Please explain the benefits of social health insurance program in reducing communicable and non-communicable diseases (DALY's)
5.	Mohon dijelaskan, bagaimana manfaat program jaminan kesehatan sosial terhadap program lain yang diselenggarakan oleh Puskesmas Kota Yogyakarta.	Please explain how are the benefits of social health insurance program to other programs conducted by the ministry of health.
6.	Mohon dijelaskan saran atau harapan untuk keberlangsungan jaminan kesehatan sosial di Indonesia	Please explain your suggestions and/or expectations for the sustainability of social health insurance in Indonesia.

FOCUS GROUP DISCUSSION

Interviewees: Health Financing and Insurance Devision Yogyakarta Distric Hospital

A.1. Regulations and Policy on Social Health Insurance Programme

No	Indonesian Version	English Version
	Input on Social Health Insurance (A1-A3)	**Input on Social Health Insurance (A1-A3)**
1.	Mohon dijelaskan tugas dan fungsi RSUD Kota Yogyakarta keterkaitanya dengan Jaminan kesehatan sosial Nasional.	Please explain the duties and functions of the Yogyakarta District Hospital in relation to the National social health insurance.
2.	Mohon dijelaskan, bagaimanakah RSUD Kota Yogyakarta menghadapi era reformasi sebelum dan sesudah JKN.	Please explain, how is the Yogyakarta District Hospita facing the reformation era prior to and after JKN?
3.	Bagaimana koordinasi yang dilakukan oleh RSUD Kota Yogyakarta dalam perencanaan implementasi JKN? Siapa saja yang terlibat dalam koordinasi tersebut.	How is the coordination conducted by the Yogyakarta District Hospital in planning the implementation of JKN? Who involved in such activities?
4.	Mohon dijelaskan kendala yang dihadapi saat proses transformasi sebelum dan sesudah JKN?	Please explain the obstacles faced during the transformation process prior to and after JKN?
5.	Bagaimana upaya dalam menghadapi kendala tersebut?	How do Yogyakarta District Hospitadeal with these obstacles?
6	Bagaimana perencanaan RSUD Kota Yogyakarta dalam mengimplementasikan JKN, dalam hal ini termasuk peraturan-peraturan yang dibuat oleh kementerian kesehatan untuk implementasi program jaminan kesehatan sosial sosial	How is the Yogyakarta District Hospital planning to implement JKN, in this case including the regulations made by the ministry of health for the implementation of social health insurance programs?
7	Bagaimana RSUD Kota Yogyakarta dalam melakukan sosialisasi perencanaan yang telah dibuat untuk program JKN kepada staf anda, dan pihak terkait?	How about in conducting the socialisation of planning that has been made for the JKN program to your staff and related parties?
8	Bagaimana upaya RSUD Kota Yogyakarta dalam melakukan sosialisasi perencanaan dalam implementasi JKN kepada masyarakat?	How is effort of the Yogyakarta District Hospital conducting socialisation planning for JKN implementation to the public?

A.2. Demand on Social Health Insurance Programme

No	Indonesian Version	English Version
1.	Menurut anda, apakah premi dan paket Jaminan kesehatan sosial di Indonesia sudah sesuai dengan kebutuhan dan harapan masyarakat Indonesia?	In your opinion, are the premium and package of social health insurance in Indonesia in accordance with the needs and expectations of Indonesian people?
2.	Menurut anda, apakah premi serta paket jaminan kesehatan sosial yang selama ini diimplementasikan di Indonesia, sudah mewakili semua kebutuhan masyarakat Indonesia, termasuk bagi kelompok masyarakat miskin?	In your opinion, are the social health insurance premiums and packages implemented so far in Indonesia already representing all the needs of Indonesian people, including the poors?
3.	Apakah RSUD Kota Yogyakarta dilibatkan dalam pendataan peserta jaminan kesehatan sosial terutama bagi kelompok miskin? Jika dilibatkan bagaimana mekanismenya?	Is the ministry of health involved in the data collection of participations in social health insurance, especially for the poor? If so, what is the mechanism?
4.	Berapakah jumlah kunjungan peserta JKN di RSUD Kota Yogyakarta?	How many patients (member of JKN) visit to Yogyakarta District Hospital per month? Is there an increase in the number of referrals before JKN?
4.	Rata-rata sakit apa saja peserta JKN yang berobat di RSUD Kota Yogyakarta?	What are the most diagnosed diseases in the Yogyakarta District Hospital per month? Is there a difference numbers before JKN?
6.	Berapakah rata-rata rujukan ke rumah sakit per bulannya? Apakah ada peningkatan jumlah rujukan dari sebelum JKN?	How many JKN participants reffered by the Yogyakarta District Hospital to the hospital per month? is there an increase in the number of referrals before JKN

A.3. Supply on Social Health Insurance Programme

No	Indonesian Version	English Version
1.	Mohon dijelaskan dari segi keuangan, sumber-sumber keuangan RSUD Kota Yogyakarta dalam implementasi jaminan sosial kesehatan baik sebelum dan sesudah JKN diimplementasikan.	Please explain in terms of financial the Yogyakarta District Hospital in in terms of financial resourches in the implementation of social health insurance prior to and after the implementation of JKN?
2.	Mohon dijelaskan bagimanakah upaya RSUD Kota Yogyakarta dalam memastikan ketersediaan untuk akses pelayanan kesehatan, jumlah Sumber daya manusia, sarana prasarana, pengadaan/penyediaan obat serta system informasi sudah mencukupi untuk pelaksanaan jaminan kesehatan sosial baik sebelum dan sesudah JKN?	Please explain how the Yogyakarta District Hospital`s efforts in ensuring the availability for access to health services, number of human resources, facilities and infrastructure, and information systems is sufficient for the implementation of social health insurance prior to and after JKN?
3.	Mohon dijelaskan, apakah sudah tersedia system informasi kesehatan yang memadai dalam implementasi pelayanan kesehatan di Puskesmas Kota Yogyakarta?	Please explain whether there is an adequate information system in the implementation of health services in Yogyakarta City Health Centre?
4.	Mohon dijelaskan kendala dari segi pendanaan, penyediaan pelayanan kesehatan di puskesmas/di rumah sakit, sarana prasarana maupun system informasi pada program jaminan kesehatan sosial sebelum dan sesudah JKN?	Please explain the obstacles in terms of funding, the provision of health services in public health centre/hospital, facilities and infrastructure, as well as information system on the social health insurance program prior to and after JKN?
5.	Bagaimana upaya RSUD Kota Yogyakarta dalam menyelesaikan kendala kendala yang dihadapi selama ini?	How is the effort to solve the obstacles that have been faced so far?
6.	Apakah ada harapan atau saran khusus untuk pemerintah atau pihak terkait dalam hal supply pada implementasi program jaminan kesehatan sosial?	Are there any specific expectations or suggestions to the government or related parties in terms of supply at the implementation of social health insurance program?

B. Process (Implementation) of Social Health Insurance Programme

No	Indonesian Version	English Version
1	Bagaimanakah upaya RSUD Kota Yogyakarta dalam mengimplementasikan jaminan kesehatan sosial sebelum dan sesudah JKN pada hal-hal berikut:	How are the efforts of the Yogyakarta District Hospital in implementing social health insurance prior to and after JKN on the following matters:
1a	Peraturan-peraturan dalam implementasi program jaminan kesehatan sosial	Regulations in the implementation of social health insurance program.
1b	Pendanaan program jaminan kesehatan sosial	Funding of social health insurance program.
1c	Penyediaan tenaga kesehatan	Provision of health personnels
1.d	Penyediaan fasilitas, sarana dan prasaran pelayanan kesehatan	Provision of facilities and infrastructures for health services.
1.e	Pengadaan obat	Procurement of medicines
1.f	Sistem informasi Kesehatan	Health information system
2.	Mohon dijelaskan bagaimana pelaksanaan sosialisasi yang dilakukan oleh RSUD Kota Yogyakarta kepada masyarakat terkait dengan manfaat serta kepesertaan jaminan kesehatan sosial.	Please explain how the socialisation conducted by the Yogyakarta District Hospital to the public related to the benefits and membership of social health insurance.
3.	Mohon dijelaskan bagaimanakah implementasi rujukan bagi peserta jaminan kesehatan sosial di tingkat pelayanan primer sampai pada pelayanan lanjutan di rumah sakit.	Please explain how is the implementation of referrals for social health insurance participants at the primary care level to follow-up services at the hospital.
4.	Mohon dijelaskan keterkaitan program jaminan kesehatan sosial dengan program lainnya yang diimplementasikan oleh RSUD Kota Yogyakarta (**contoh Sustainability Development Goals/SDGs)**	Please explain the relevance of social health insurance program to other programs implemented by the ministry of health (example: Sustainability Development Goals/SDGs)
5.	Mohon dijelaskan bagaimana mekanisme RSUD Kota Yogyakarta dalam melakukan monitoring dan evaluasi program jaminan kesehatan sosial sosial	Please explain how the mechanism of the the Yogyakarta District Hospital in monitoring and evaluating social health insurance program.
6.	Mohon dijelaskan parameter RSUD Kota Yogyakarta untuk mengukur keberhasilan program jaminan kesehatan sosial	Please explain the Yogyakarta District Hospital parameters to measure the success of social health insurance program.
7.	Pada program jaminan kesehatan sosial, apakah ada kendala selama pelaksanaan program, serta bagaimana cara mengatasi kendala tersebut?	In the social health insurance program, are there any obstacles during the implementation of the program? How to overcome these obstacles?

C. Outcome on Social Health Insurance Programme

No	Indonesian Version	English Version
1	Mohon jelaskan target RSUD Kota Yogyakarta dalam pelaksanaan program jaminan kesehatan sosial.	Please explain the the Yogyakarta District Hospital s`starget in the implementation of social health insurance program.
2.	Apakah target yang diharapkan telah tercapai? Jika belum mohon disampaikan kendalanya.	Have all program targets been achieved? If not, please explain the obstacles.
3.	Mohon dijelaskan, manfaat jaminan kesehatan sosial sosial dalam meningkatkan derajat kesehatan masyarakat Indonesia seperti kualitas hidup (Quality Adjustment Life Years).	Please explain the benefits of social health insurance in improving the standard of Indonesian public health such as quality of life (Quality Adjustment Life Years)
4.	Mohon dijelaskan manfaat program jaminan kesehatan sosial terhadap penurunan penyakit menular maupun tidak menular (DALY`s).	Please explain the benefits of social health insurance program in reducing communicable and non-communicable diseases (DALY's)
5.	Mohon dijelaskan, bagaimana manfaat program jaminan kesehatan sosial terhadap program lain yang diselenggarakan oleh RSUD Kota Yogyakarta.	Please explain how are the benefits of social health insurance program to other programs conducted by the ministry of health.
6.	Mohon dijelaskan saran atau harapan untuk keberlangsungan jaminan kesehatan sosial di Indonesia.	Please explain your suggestions and/or expectations for the sustainability of social health insurance in Indonesia.

FOCUS GROUP DISCUSSION

Interviewees: Health Financing and Insurance DR.Sardjito Government Hospital

A.1. Regulations and Policy on Social Health Insurance Programme

No	Indonesian Version	English Version
	Input on Social Health Insurance (A1-A3)	**Input on Social Health Insurance (A1-A3)**
1.	Mohon dijelaskan tugas dan fungsi RSUP Dr. Sardjito Keterkaitanya dengan Jaminan kesehatan sosial Nasional.	Please explain the duties and functions of the DR.Sardjito Government Hospital in relation to the National social health insurance.
2.	Mohon dijelaskan, bagaimanakah RSUP Dr. Sardjito menghadapi era reformasi sebelum dan sesudah JKN.	Please explain, how is DR.Sardjito Government Hospital facing the reformation era prior to and after JKN?
3.	Bagaimana koordinasi yang dilakukan oleh RSUP Dr. Sardjito Hospital dalam perencanaan implementasi JKN? Siapa saja yang terlibat dalam koordinasi tersebut.	How is the coordination conducted by the DR.Sardjito Government Hospital in planning the implementation of JKN? Who involved in such activities?
4.	Mohon dijelaskan kendala yang dihadapi saat proses transformasi sebelum dan sesudah JKN?	Please explain the obstacles faced during the transformation process prior to and after JKN?
5.	Bagaimana upaya dalam menghadapi kendala tersebut?	How do DR.Sardjito Government Hospital deal with these obstacles?
6	Bagaimana perencanaan RSUP Dr. Sardjito dalam mengimplementasikan JKN, dalam hal ini termasuk peraturan-peraturan yang dibuat oleh kementerian kesehatan untuk implementasi program jaminan kesehatan sosial sosial	How is the DR.Sardjito Government Hospital planning to implement JKN, in this case including the regulations made by the ministry of health for the implementation of social health insurance programs?
7	Bagaimana RSUP Dr. Sardjito dalam melakukan sosialisasi perencanaan yang telah dibuat untuk program JKN kepada staf anda, dan pihak terkait?	How about in conducting the socialisation of planning that has been made for the JKN program to your staff and related parties?
8	Bagaimana upaya RSUP Dr. Sardjito dalam melakukan sosialisasi perencanaan dalam implementasi JKN kepada masyarakat?	How is effort of the DR.Sardjito Government Hospital n conducting socialisation planning for JKN implementation to the public?

A.2. Demand on Social Health Insurance Programme

No	Indonesian Version	English Version
1.	Menurut anda, apakah premi dan paket Jaminan kesehatan sosial di Indonesia sudah sesuai dengan kebutuhan dan harapan masyarakat Indonesia?	In your opinion, are the premium and package of social health insurance in Indonesia in accordance with the needs and expectations of Indonesian people?
2.	Menurut anda, apakah premi serta paket jaminan kesehatan sosial yang selama ini diimplementasikan di Indonesia, sudah mewakili semua kebutuhan masyarakat Indonesia, termasuk bagi kelompok masyarakat miskin?	In your opinion, are the social health insurance premiums and packages implemented so far in Indonesia already representing all the needs of Indonesian people, including the poors?
3.	Apakah RSUP Dr. Sardjito dilibatkan dalam pendataan peserta jaminan kesehatan sosial terutama bagi kelompok miskin? Jika dilibatkan bagaimana mekanismenya?	Is the DR.Sardjito Government Hospital involved in the data collection of participations in social health insurance, especially for the poor? If so, what is the mechanism?
4.	Berapakah jumlah kunjungan peserta JKN di RSUP Dr. Sardjito	How many patients (member of JKN) visit to DR.Sardjito Government Hospital? Is there an increase in the number of referrals before JKN?
4.	Rata-rata sakit apa saja peserta JKN yang berobat di RSUP Dr. Sardjito?	What are the most diagnosed diseases in the DR.Sardjito Government Hospital r per month? Is there a significant difference before JKN?
6.	Berapakah rata-rata rujukan ke rumah sakit per bulannya? Apakah ada peningkatan jumlah rujukan dari sebelum JKN?	How many JKN participants reffered by the DR.Sardjito Government Hospital to the hospital per month? is there an increase in the number of referrals before JKN

A.3. Supply on Social Health Insurance Programme

No	Indonesian Version	English Version
1.	Mohon dijelaskan dari segi keuangan, sumber-sumber keuangan Puskesmas Kota Yogyakarta dalam implementasi jaminan sosial kesehatan baik sebelum dan sesudah JKN diimplementasikan.	Please explain in terms of financial the DR.Sardjito Government Hospital in in terms of financial resourches in the implementation of social health insurance prior to and after the implementation of JKN?
2.	Mohon dijelaskan bagimanakah upaya RSUP Dr. Sardjito dalam memastikan ketersediaan untuk akses pelayanan kesehatan, jumlah Sumber daya manusia, sarana prasarana, pengadaan/penyediaan obat serta system informasi sudah mencukupi untuk pelaksanaan jaminan kesehatan sosial baik sebelum dan sesudah JKN?	Please explain how the DR.Sardjito Government Hospital **`s** efforts in ensuring the availability for access to health services, number of human resources, facilities and infrastructure, and information systems is sufficient for the implementation of social health insurance prior to and after JKN?
3.	Mohon dijelaskan, apakah sudah tersedia system informasi kesehatan yang memadai dalam implementasi pelayanan kesehatan di RSUP Dr. Sardjito?	Please explain whether there is an adequate information system in the implementation of health services in the DR.Sardjito Government Hospital?
4.	Mohon dijelaskan kendala dari segi pendanaan, penyediaan pelayanan kesehatan di puskesmas/di rumah sakit, sarana prasarana maupun system informasi pada program jaminan kesehatan sosial sebelum dan sesudah JKN?	Please explain the obstacles in terms of funding, the provision of health services in public health centre/hospital, facilities and infrastructure, as well as information system on the social health insurance program prior to and after JKN?
5.	Bagaimana upaya dalam menyelesaikan kendala kendala yang dihadapi selama ini?	How is the effort to solve the obstacles that have been faced so far?
6.	Apakah ada harapan atau saran khusus untuk pemerintah atau pihak terkait dalam hal supply pada implementasi program jaminan kesehatan sosial?	Are there any specific expectations or suggestions to the government or related parties in terms of supply at the implementation of social health insurance program?

B. Process (Implementation) of Social Health Insurance Programme

No	Indonesian Version	English Version
1	Bagaimanakah upaya RSUP Dr. Sardjito dalam mengimplementasikan jaminan kesehatan sosial sebelum dan sesudah JKN pada hal-hal berikut:	How are the efforts of the DR.Sardjito Government Hospital in implementing social health insurance prior to and after JKN on the following matters:
1a	Peraturan-peraturan dalam implementasi program jaminan kesehatan sosial	Regulations in the implementation of social health insurance program.
1b	Pendanaan program jaminan kesehatan sosial	Funding of social health insurance program.
1c	Penyediaan tenaga kesehatan	Provision of health personnels
1.d	Penyediaan fasilitas, sarana dan prasaran pelayanan kesehatan	Provision of facilities and infrastructures for health services.
1.e	Pengadaan obat	Procurement of medicines
1.f	Sistem informasi kesehatan	Health information system
2.	Mohon dijelaskan bagaimana pelaksanaan sosialisasi yang dilakukan oleh RSUP Dr. Sardjito kepada masyarakat terkait dengan manfaat serta kepesertaan jaminan kesehatan sosial.	Please explain how the socialisation conducted by the DR.Sardjito Government Hospital to the public related to the benefits and membership of social health insurance.
3.	Mohon dijelaskan bagaimanakah implementasi rujukan bagi peserta jaminan kesehatan sosial di tingkat pelayanan primer sampai pada pelayanan lanjutan di rumah sakit.	Please explain how is the implementation of referrals for social health insurance participants at the primary care level to follow-up services at the hospital.
4.	Mohon dijelaskan keterkaitan program jaminan kesehatan sosial dengan program lainnya yang diimplementasikan oleh RSUP Dr. Sardjito (**contoh Sustainability Development Goals/SDGs)**	Please explain the relevance of social health insurance program to other programs implemented by the ministry of health (example: Sustainability Development Goals/SDGs)
5.	Mohon dijelaskan bagaimana mekanisme RSUP Dr. Sardjito dalam melakukan monitoring dan evaluasi program jaminan kesehatan sosial sosial	Please explain how the mechanism of the the DR.Sardjito Government Hospital in monitoring and evaluating social health insurance program.
6.	Mohon dijelaskan parameter RSUP Dr. Sardjito untuk mengukur keberhasilan program jaminan kesehatan sosial	Please explain the ministry of health parameters to measure the success of social health insurance program.
7.	Pada program jaminan kesehatan sosial, apakah ada kendala selama pelaksanaan program, serta bagaimana cara mengatasi kendala tersebut?	In the social health insurance program, are there any obstacles during the implementation of the program? How to overcome these obstacles?

C. Outcome on Social Health Insurance Programme

No	Indonesian Version	English Version
1	Mohon jelaskan target RSUP Dr. Sardjito dalam pelaksanaan program jaminan kesehatan sosial.	Please explain the the DR.Sardjito Government Hospital**`s** target in the implementation of social health insurance program.
2.	Apakah target yang diharapkan telah tercapai? Jika belum mohon disampaikan kendalanya.	Have all program targets been achieved? If not, please explain the obstacles.
3.	Mohon dijelaskan, manfaat jaminan kesehatan sosial sosial dalam meningkatkan derajat kesehatan masyarakat Indonesia seperti kualitas hidup (Quality Adjustment Life Years)	Please explain the benefits of social health insurance in improving the standard of Indonesian public health such as quality of life (Quality Adjustment Life Years)
4.	Mohon dijelaskan manfaat program jaminan kesehatan sosial terhadap penurunan penyakit menular maupun tidak menular (DALY`s)	Please explain the benefits of social health insurance program in reducing communicable and non-communicable diseases (DALY's)
5.	Mohon dijelaskan, bagaimana manfaat program jaminan kesehatan sosial terhadap program lain yang diselenggarakan oleh RSUP Dr. Sardjito	Please explain how are the benefits of social health insurance program to other programs conducted by the ministry of health.
6.	Mohon dijelaskan saran atau harapan untuk keberlangsungan jaminan kesehatan sosial di indonesia	Please explain your suggestions and/or expectations for the sustainability of social health insurance in Indonesia.

Appendix 7a. Focus Group Discussion Guidelines (English)

GUIDE FOR FOCUS GROUP DISCUSSION

EVALUATION OF THE INSURANCE IMPLEMENTATION MODEL

OF SOCIAL HEALTH IN INDONESIA

Date	:
Facilitator	:
Translator	:
Age Range	:

A. Introduction

1. Thank you for the presence of Mr./Mrs./Ms.
2. Your (Mr./Mrs./Ms.) presence is very important to support the implementation of the National Health Insurance (JKN) in Indonesia
3. Let me introduce myself, my name is Rosyidah, currently I am taking Doctoral Studies at the Faculty of Health Sciences, Coventry University, England.
4. Today we will conduct a Focus Group Discussion to explore the opinions or experiences of Mr./Mrs./Ms. about the implementation of social health insurance in Indonesia (Yogyakarta)
5. Our discussion time is approximately 60 minutes or 1 hour.

B. Purpose

We will discuss about the application of the Social Security model in Indonesia. The focus of this research is social health insurance in the health sector. The implementation is specifically related to:

1. Differences between the social health insurance system before and after the National Health Insurance were implemented on January 1st, 2014 by the Indonesian government.
2. Differences in patient behaviour (social health insurance participants) in accessing health care facilities, before and after the implementation of UHC in 2014.

3. To evaluate the extent to which the objectives of the National Health Insurance policy have been achieved (access to health services, quality of health services, equity (justice in utilizing health services, efficiency, and health level status)

C. Procedure

1. Please complete the consent form to be a resource in this discussion before the discussion begins.
2. We will be interested in all opinions, comments, criticisms and suggestions from Mr./Mrs./Ms.
3. In this discussion there are no right or wrong answers.
4. All positive or negative comments can be received.
5. Please be free to disagree with other opinions. We would love to get various opinions, criticisms, suggestions or experiences about the implementation of social health insurance in Indonesia (Yogyakarta).
6. Everything that happens here is confidential, all the results of this discussion will only be used for research purposes. We ask permission for this discussion to be recorded.
7. Mr./Mrs./Ms. who will express their opinions, are welcome to speak one by one and raise their hands so the speaker can be seen.
8. We have a lot to discuss, so we can change topics or continue. Please interrupt us, if you will add comments or suggestions.
9. After this opening session, Mr./Mrs./Ms. will be divided into smaller groups according to the duties and functions of the respective institutions (DIY Health Office, Private Hospital, Primary Hospital with Puskesmas (Jatis and Umbul Harjo), Yogyakarta District Hospital with Dr. Sardjito Public Hospital

D. Introduction

1. Mr./Mrs./Ms. are welcome to use identification
2. Mr./Mrs./Ms. are welcome to introduce themselves before each discussion is held.

E. Division of Groups

The groups in the Focused Discussion are divided into 4 groups as follows:

- Group 1 is the Yogyakarta City Health Office
- Group 2 is Puskesmas
- Group 3 is the District Hospital (RSUD) of Yogyakarta City and the Government Hospital (RSUP) Dr. Sardjito
- Group 4 is PKU Muhammadiyah Yogyakarta Private Hospital

Each group will be guided by a facilitator until the FGDs event is finished.

F. Focused Discussion Questions

The Focused Discussion Questions include the following:

1. Regulations and policies in the implementation of Social Health Insurance in Indonesia. This discussion is also related to Demand and Supply in the implementation of Social Security before and after the National Health Insurance (JKN) is implemented.
2. The process of implementing Social Security before and after JKN, including obstacles and the efforts of the relevant agencies in handling it.
3. Outcome includes the benefits of the National Health Insurance

G. Closing

1. Before this discussion ends, I would like to ask once again whether there are still opinions, comments or suggestions that need to be conveyed about the implementation of social health insurance in Indonesia? Something that we have not discussed that in your opinion, are important to say.
2. Thank you for your time, attendance and participation of in this FGD. All opinions, suggestions or criticisms of you are very useful in this research.

Appendix 7b. Focus Group Discussion Guidelines (Indonesia)

PANDUAN FOCUS GROUP DISCUSION
EVALUASI TERHADAP MODEL IMPLEMENTASI JAMINAN KESEHATAN SOSIAL DI INDONESIA

Tanggal	:
Fasilitator	:
Translator	:
Kisaran Umur	:

H. Pendahuluan

1. Terimakasih atas kehadiran Bapak/Ibu/Saudara/i
2. Kehadiran Bapak/Ibu/Saudara/i sangat penting untuk mendukung implementasi Jaminan Kesehatan Nasional (JKN) di Indonesia
3. Perkenalkan nama saya Rosyidah, saat ini saya sedang menempuh Studi Doctoral di Fakultas Ilmu Ilmu Kesehatan, Coventry University, Inggris. Saat ini,
4. Hari ini kita akan melakukan Diskusi Kelompok Terarah untuk menggali pendapat ataupun pengalaman Bapak/Ibu/Saudara/I tentang implementasi jaminan kesehatan sosial di Indonesia (Yogyakarta)
5. Waktu diskusi kita kurang lebih 60 menit atau 1 Jam.

I. Tujuan

Kita akan mendiskusikan tentang penerapan model Jaminan sosial di Indonesia. Fokus pada penelitian ini adalah asuransi kesehatan sosial bada bidang kesehatan. Terutama implementasi terkait dengan :

1. Perbedaan antara sistem asuransi kesehatan sosial sebelum dan sesudah Jaminan Kesehatan Nasional di implementasikan pada 1 Januari 2014 oleh pemerintah Indonesia.
2. Perbedaan perilaku pasien (peserta asuransi kesehatan sosial) dalam mengakses fasilitas layanan kesehatan, sebelum dan sesudah implementasi UHC pada 2014.
3. Untuk mengevaluasi sejauh mana tujuan kebijakan Jaminan Kesehatan Nasional telah tercapai (akses pelayanan kesehatan, mutu pelayanan kesehatan, equity (keadilan/dalam memanfaatkan pelayanan kesehatan, efisiensi, serta status derajat kesehatan.

J. Prosedur

1. Mohon Bapak/Ibu/Saudara/i untuk melengkapi lembar persetujuan menjadi narasumber dalam diskusi ini sebelum acara dimulai.
2. Kami akan tertarik terhadap semua pendapat, komentar, kritik maupun saran dari Bapak/Ibu/Saudara/i.
3. Pada diskusi ini tidak ada jawaban benar atau salah.
4. Semua komentar baik positif atau negative dapat diterima.
5. Silahkan Bapak/Ibu/Saudara/I secara bebas untuk tidak setuju dengan pendapat yang lain. Kami akan senang mendapat berbagai macam pendapat, kritik, saran ataupun pengalaman tentang pelaksanaan jaminan kesehatan sosial di Indonesia (Yogyakarta).
6. Semua yang terjadi disini adalah rahasia, semua hasil diskusi ini hanya akan digunakan untuk keperluan penelitian. Kami mohon izin untuk pelaksanaan diskusi ini untuk direkam.
7. Bapak/Ibu/Saudara/I yang akan menyampaikan pendapat, dipersilahkan berbicara satu persatu dan menunjukan tangan sehingga pembicara jelas
8. Kita mempunyai banyak hal untuk didiskusikan, sehingga kami dapat mengubah topik atau melanjutkan. Mohon untuk interupsi kami, jika Bapak/Ibu/Saudara/i akan menambahkan kementar atau saran.
9. Setelah sesi pembukaan ini, Bapak/Ibu/saudara/i akan dibagi pada kelompok kelompok yang lebih kecil sesuai dengan tugas serta fungsi pada instansi

bapak/Ibu/saudara/I masing-masing (Dinkes Kota DIY, RS Swasta, RS Pratama dengan Puskesmas (Jatis dan Umbul Harjo), RSUD Jogja dengan RSUP Dr. Sardjito

K. Perkenalan

1. Bapak/Ibu/Saudara/i dipersilahkan untuk menggunakan tanda pengenal
2. Bapak/Ibu/Saudara/I dipersilahkan untuk mengenalkan diri masing-masing sebelum diskusi dilaksanakan.

L. Pembagian Kelompok

Kelompok dalam Diskusi Terarah ini dibagi menjadi 4 kelompok sebagai berikut:

- Kelopmpok 1 adalah Dinas Kesehatan Kota Yogyakarta
- Kelompok 2 adalah Puskesmas
- Kelompok 3 adalah Rumah Sakit Umum Daerah (RSUD) Kota Yogyakarta dan Rumah Sakit Pemerintah (RSUP) Dr. Sardjito
- Kelopompok 4 adalah Rumah Sakit Swasta PKU Muhammadiyah Yogyakarta

Masing-masing kelompok akan dipandu oleh seorang fasilitator sampai acara FGD selesai dilaksanakan.

M. Pertanyaan Diskusi Terarah

Pertanyaan Diskusi Terarah meliputi hal-hal sebagai berikut:

1. Regulasi dan kebijakan dalam implementasi Jaminan Kesehatan Sosial di Indonesia.Diskusi ini juga terkait dengan Demand dan Supply dalam pelaksanaan Jaminan Sosial sebelum dan sesuadah Jaminan Kesehatan Nasional (JKN) diimplementasikan.
2. Proses pelaksanan Jaminan Sosial sebelum dan sesudah JKN, termasuk kendala dan upaya instansi bersangkutan dalam menanganinya.
3. Outcome termasuk manfaat Jaminan Kesehatan Nasional

N. Penutup

1. Sebelum diskusi ini berakhir saya ingin menanyakan sekali lagi apakah masih ada pendapat, komentar atau saran yang perlu untuk disampaikan tentang implementasi jaminan kesehatan sosial di Indonesia? Sesuatu yang belum kita bahas yang menurut Bapak/Ibu/saudara/i penting untuk disampaikan.
2. Terimakasih atas waktu, kehadiran serta partisipasi Bapak/Ibu/Saudara/i dalam acara FGD ini. Semua pendapat, saran ataupun kritik Bapak/Ibu/Saudara/i sangat bermanfaat dalam penelitian ini.

Appendix 8a. In-depth Interview Timelines and Activities

Activities	Agustus				September				October				November				December			
	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Week 9	Week 10	Week 11	Week 12	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14	Week 15	Week 16
Finalise time, date and venue																				
Participants Recruitment																				
1. Fixing a list of eligible participats																				
2. Coordinating, phone, call and meeting appoitment																				
3. Documents and research instruments																				
Conducting In-depth Interview																				
1. National Sosial Security Board (DJSN)																				
2. BPJS Kesehatan																				
3. Ministry of Health Republic of Indonesia																				
4. Ministry of Social Walfare Republic of Indonesia																				
5. Yogyakarta Provincial Health Office																				
Data transcription																				

Appendix 8b. Focus Group Discussion Timelines and Activities

Activities	September				October				November				December			
	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Week 9	Week 10	Week 11	Week 12	Week 11	Week 12	Week 13	Week 14
Facilitators Recruitment and Training Process																
Finalise time, date and venue																
Participants Recruitment																
1. Fixing a list of eligible participats																
2. Coordinating, phone, call and registration																
end letter of invitation																
Final Checking for FGD Preparation																
1. Final briefing to the facilitators and team																
2. Checking venue																
3. Checking documents and intruments																
4. Checking equipments																
Conducting FGD																
Checking all the data/documents after FGD																
Data transcription																

Appendix 8c. Qualitative Data Analysis Timeline

Activities	JANUARY				FEBRUARY				March				April			
	Week 15	Week 16	Week 19	Week 20	Week 21	Week 22	Week 23	Week 24	Week 25	Week 26	Week 23	Week 27	Week 28	Week 29	Week 30	Week 31
Data translation																
Data Analysis with N-Vivo																
Data Intepretation																

Appendix 9. Quantitative Data Analysis Using Stata

```
----------------------------------------------------------------------------------------------------
      name:  <Rosyidah_UHC>
       log:  D:\Rosyidah\management dan analisis _final.log
  log type:  text
 opened on:  5 Jul 2020, 13:32:01

. do "C:\Users\Rosyidah\AppData\Local\Temp\STD2698_000000.tmp"

.         tab insurance_type year, col chi

+-------------------+
| Key               |
|-------------------|
|     frequency     |
| column percentage |
+-------------------+
```

insurance type	year 2012	2013	2014	2015	2016	2017	2018	Total
out of pocket	593,447	496,802	485,949	495,759	461,408	436,882	386,661	3,356,908
	53.25	45.40	44.25	45.16	41.58	38.57	34.16	43.15
public insurnce	432,599	549,273	551,481	583,559	634,865	649,020	709,563	4,110,360
	38.82	50.20	50.21	53.16	57.21	57.30	62.69	52.84
private insurance	64,029	33,266	45,167	15,431	9,616	39,031	26,315	232,855
	5.75	3.04	4.11	1.41	0.87	3.45	2.33	2.99
both insurance	24,370	14,838	15,683	2,970	3,860	7,816	9,286	78,823
	2.19	1.36	1.43	0.27	0.35	0.69	0.82	1.01
Total	1,114,445	1,094,179	1,098,280	1,097,719	1,109,749	1,132,749	1,131,825	7,778,946
	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00

```
         Pearson chi2(18) =   2.2e+05   Pr = 0.000
```

```
.         tab insurance_membership year, col chi

+-------------------+
| Key               |
|-------------------|
|     frequency     |
| column percentage |
+-------------------+

     insurance |                                        year
     membership|      2012       2013       2014       2015       2016       2017       2018 |     Total
---------------+-----------------------------------------------------------------------------+----------
 out of pocket |   593,447    496,802    485,949    495,759    461,408    436,882    386,661 | 3,356,908
               |     53.25      45.40      44.25      45.16      41.58      38.57      34.16 |     43.15
---------------+-----------------------------------------------------------------------------+----------
have insurance |   520,998    597,377    612,331    601,960    648,341    695,867    745,164 | 4,422,038
               |     46.75      54.60      55.75      54.84      58.42      61.43      65.84 |     56.85
---------------+-----------------------------------------------------------------------------+----------
         Total | 1,114,445  1,094,179  1,098,280  1,097,719  1,109,749  1,132,749  1,131,825 | 7,778,946
               |    100.00     100.00     100.00     100.00     100.00     100.00     100.00 |    100.00

          Pearson chi2(6) =  9.9e+04   Pr = 0.000

.         tab geographic_st  year , col chi

.                   .


+-------------------+
| Key               |
|-------------------|
|     frequency     |
| column percentage |
+-------------------+

     insurance |                                        year
     membership|      2012       2013       2014       2015       2016       2017       2018 |     Total
---------------+-----------------------------------------------------------------------------+----------
 out of pocket |   593,447    496,802    485,949    495,759    461,408    436,882    386,661 | 3,356,908
               |     53.25      45.40      44.25      45.16      41.58      38.57      34.16 |     43.15
---------------+-----------------------------------------------------------------------------+----------
have insurance |   520,998    597,377    612,331    601,960    648,341    695,867    745,164 | 4,422,038
               |     46.75      54.60      55.75      54.84      58.42      61.43      65.84 |     56.85
---------------+-----------------------------------------------------------------------------+----------
         Total | 1,114,445  1,094,179  1,098,280  1,097,719  1,109,749  1,132,749  1,131,825 | 7,778,946
               |    100.00     100.00     100.00     100.00     100.00     100.00     100.00 |    100.00

          Pearson chi2(6) =  9.9e+04   Pr = 0.000

.         tab geographic_st  year , col chi

.                   .
```

```
+-------------------+
| Key               |
|-------------------|
|     frequency     |
| column percentage |
+-------------------+

Territoria |                                 year
    status |      2012       2013       2014       2015       2016       2017       2018 |      Total
-----------+--------------------------------------------------------------------------------+----------
     rural |   636,514    627,300    630,575    626,624    637,503    650,452    651,356 | 4,460,324
           |     57.11      57.33      57.41      57.08      57.45      57.42      57.55 |     57.34
-----------+--------------------------------------------------------------------------------+----------
     urban |   477,931    466,879    467,705    471,095    472,246    482,297    480,469 | 3,318,622
           |     42.89      42.67      42.59      42.92      42.55      42.58      42.45 |     42.66
-----------+--------------------------------------------------------------------------------+----------
     Total | 1,114,445  1,094,179  1,098,280  1,097,719  1,109,749  1,132,749  1,131,825 | 7,778,946
           |    100.00     100.00     100.00     100.00     100.00     100.00     100.00 |    100.00

          Pearson chi2(6) =  83.4551   Pr = 0.000

. 		tab Gender tahun , col chi
```

```
+-------------------+
| Key               |
|-------------------|
|     frequency     |
| column percentage |
+-------------------+

           |                                 year
    gender |      2012       2013       2014       2015       2016       2017       2018 |      Total
-----------+--------------------------------------------------------------------------------+----------
    Female |   556,001    545,899    548,148    546,688    552,830    565,823    564,541 | 3,879,930
           |     49.89      49.89      49.91      49.80      49.82      49.95      49.88 |     49.88 -----------
-----------------------------------------------------------------------------------------+----------
      Male |   558,444    548,280    550,132    551,031    556,919    566,926    567,284 | 3,899,016
           |     50.11      50.11      50.09      50.20      50.18      50.05      50.12 |     50.12
-----------+--------------------------------------------------------------------------------+----------
     Total | 1,114,445  1,094,179  1,098,280  1,097,719  1,109,749  1,132,749  1,131,825 | 7,778,946
           |    100.00     100.00     100.00     100.00     100.00     100.00     100.00 |    100.00

          Pearson chi2(6) =   7.2630   Pr = 0.297

. 		tab age_cat tahun , col chi
```

```
.         tab age_cat tahun , col chi

+-------------------+
| Key               |
|-------------------|
|     frequency     |
| column percentage |
+-------------------+
```

Age category	year 2012	2013	2014	2015	2016	2017	2018	Total
young_age	340,297	327,409	327,159	320,713	316,359	321,758	327,122	2,280,817
	30.54	29.92	29.79	29.22	28.51	28.41	28.90	29.32
productive age	721,440	713,360	717,725	725,383	739,671	754,203	747,734	5,119,516
	64.74	65.20	65.35	66.08	66.65	66.58	66.06	65.81
elderly	52,708	53,410	53,396	51,623	53,719	56,788	56,969	378,613
	4.73	4.88	4.86	4.70	4.84	5.01	5.03	4.87
Total	1,114,445	1,094,179	1,098,280	1,097,719	1,109,749	1,132,749	1,131,825	7,778,946
	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00

```
        Pearson chi2(12) =  2.2e+03   Pr = 0.000

.               tab edu_higher_recode  year , col chi
```

```
+-------------------+
| Key               |
|-------------------|
|     frequency     |
| column percentage |
+-------------------+
```

Education Category	year 2012	2013	2014	2015	2016	2017	2018	Total
notedu/ not attend school	190,644	181,170	177,362	177,185	156,035	171,856	178,715	1,232,967
	17.11	16.56	16.15	16.14	14.06	15.17	15.79	15.85
Elementery School	452,856	447,226	440,372	429,559	509,120	429,775	434,508	3,143,416
	40.64	40.87	40.10	39.13	45.88	37.94	38.39	40.41
Junior high school	184,520	179,863	183,163	188,694	123,076	199,113	184,040	1,242,469
	16.56	16.44	16.68	17.19	11.09	17.58	16.26	15.97
Senior high school	207,944	205,063	210,262	220,254	222,200	242,174	241,796	1,549,693
	18.66	18.74	19.14	20.06	20.02	21.38	21.36	19.92
Higher Education/ University	78,481	80,857	87,121	82,027	99,318	89,831	92,766	610,401
	7.04	7.39	7.93	7.47	8.95	7.93	8.20	7.85
Total	1,114,445	1,094,179	1,098,280	1,097,719	1,109,749	1,132,749	1,131,825	7,778,946
	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00

```
         Pearson chi2(24) =  4.4e+04   Pr = 0.000

.         tab edu_cat  year , col chi
```

```
+-------------------+
| Key               |
|-------------------|
|     frequency     |
| column percentage |
+-------------------+
```

Education category	year 2012	2013	2014	2015	2016	2017	2018	Total
not education	643,500	628,396	617,734	606,744	665,155	601,631	613,223	4,376,383
	57.74	57.43	56.25	55.27	59.94	53.11	54.18	56.26
lower level education	392,464	384,926	393,425	408,948	345,276	441,287	425,836	2,792,162
	35.22	35.18	35.82	37.25	31.11	38.96	37.62	35.89
higher level education	78,481	80,857	87,121	82,027	99,318	89,831	92,766	610,401
	7.04	7.39	7.93	7.47	8.95	7.93	8.20	7.85
Total	1,114,445	1,094,179	1,098,280	1,097,719	1,109,749	1,132,749	1,131,825	7,778,946
	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00

```
         Pearson chi2(12) =  2.2e+04   Pr = 0.000

.                 tab outpatient year, col chi
```

```
+-------------------+
| Key               |
|-------------------|
|     frequency     |
| column percentage |
+-------------------+
```

Ever access to health services for outpatient services	year							
	2012	2013	2014	2015	2016	2017	2018	Total
never access	977,259	952,563	950,499	926,054	943,373	993,224	969,403	6,712,375
	87.69	87.06	86.54	84.36	85.01	87.68	85.65	86.29
ever access	137,186	141,616	147,781	171,665	166,376	139,525	162,422	1,066,571
	12.31	12.94	13.46	15.64	14.99	12.32	14.35	13.71
Total	1,114,445	1,094,179	1,098,280	1,097,719	1,109,749	1,132,749	1,131,825	7,778,946
	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00

```
          Pearson chi2(6) =  9.7e+03   Pr = 0.000

.                tab inpatient year, col chi
```

```
+-------------------+
| Key               |
|-------------------|
|     frequency     |
| column percentage |
+-------------------+
```

Ever access to health services for inpatient services	year							
	2012	2013	2014	2015	2016	2017	2018	Total
never access	1,094,022	1,069,979	1,072,546	1,060,431	1,070,043	1,088,367	1,081,131	7,536,519
	98.17	97.79	97.66	96.60	96.42	96.08	95.52	96.88
ever access	20,423	24,200	25,734	37,288	39,706	44,382	50,694	242,427
	1.83	2.21	2.34	3.40	3.58	3.92	4.48	3.12
Total	1,114,445	1,094,179	1,098,280	1,097,719	1,109,749	1,132,749	1,131,825	7,778,946
	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00

```
          Pearson chi2(6) =  2.2e+04   Pr = 0.000

.         tab ever_access  year , col chi
```

```
+-------------------+
| Key               |
|-------------------|
|     frequency     |
| column percentage |
+-------------------+
```

Ever access to health services	year							Total
	2012	2013	2014	2015	2016	2017	2018	
never access	966,077	938,822	935,916	906,749	922,530	958,407	938,594	6,567,095
	86.69	85.80	85.22	82.60	83.13	84.61	82.93	84.42
ever access	148,368	155,357	162,364	190,970	187,219	174,342	193,231	1,211,851
	13.31	14.20	14.78	17.40	16.87	15.39	17.07	15.58
Total	1,114,445	1,094,179	1,098,280	1,097,719	1,109,749	1,132,749	1,131,825	7,778,946
	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00

Pearson chi2(6) = 1.3e+04 Pr = 0.000

```
.         tab employment_st  year , col chi
```

```
+-------------------+
| Key               |
|-------------------|
|     frequency     |
| column percentage |
+-------------------+
```

Employment status	year							Total
	2012	2013	2014	2015	2016	2017	2018	
unemployment	382,931	364,806	379,453	385,600	391,188	403,769	398,971	2,706,718
	42.88	41.23	42.63	43.17	43.07	43.59	43.47	42.87
employment	510,008	520,100	510,733	507,684	517,160	522,449	518,857	3,606,991
	57.12	58.77	57.37	56.83	56.93	56.41	56.53	57.13
Total	892,939	884,906	890,186	893,284	908,348	926,218	917,828	6,313,709
	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00

Pearson chi2(6) = 1.4e+03 Pr = 0.000

```
.         tab percentile_exp  year , col chi
```

```
| Key               |
|-------------------|
|     frequency     |
| column percentage |
+-------------------+

Percentile |
expenditur |                                    year
         e |      2012       2013       2014       2015       2016       2017       2018 |     Total
-----------+-----------------------------------------------------------------------------+----------
         1 |   394,332    313,390    267,721    200,588    154,157    126,037     99,566 | 1,555,791
           |     35.38      28.64      24.38      18.27      13.89      11.13       8.80 |     20.00
-----------+-----------------------------------------------------------------------------+----------
         2 |   240,842    248,067    248,197    237,449    220,731    189,743    170,761 | 1,555,790
           |     21.61      22.67      22.60      21.63      19.89      16.75      15.09 |     20.00
-----------+-----------------------------------------------------------------------------+----------
         3 |   194,882    210,693    217,118    241,594    222,655    234,172    234,674 | 1,555,788
           |     17.49      19.26      19.77      22.01      20.06      20.67      20.73 |     20.00
-----------+-----------------------------------------------------------------------------+----------
         4 |   158,880    176,836    195,126    222,380    253,322    272,230    277,014 | 1,555,788
           |     14.26      16.16      17.77      20.26      22.83      24.03      24.47 |     20.00
-----------+-----------------------------------------------------------------------------+----------
         5 |   125,509    145,193    170,118    195,708    258,884    310,567    349,810 | 1,555,789
           |     11.26      13.27      15.49      17.83      23.33      27.42      30.91 |     20.00
-----------+-----------------------------------------------------------------------------+----------
     Total | 1,114,445  1,094,179  1,098,280  1,097,719  1,109,749  1,132,749  1,131,825 | 7,778,946
           |    100.00     100.00     100.00     100.00     100.00     100.00     100.00 |    100.00

          Pearson chi2(24) =  6.0e+05   Pr = 0.000

.         tab desil_exp  year , col chi
```

Key
frequency
column percentage

Desil expenditure	Year							
	2012	2013	2014	2015	2016	2017	2018	Total
1	141,049	137,985	139,545	109,772	110,976	113,275	113,188	865,790
	12.66	12.61	12.71	10.00	10.00	10.00	10.00	11.13
2	128,276	125,680	126,563	109,774	110,977	113,277	113,177	827,724
	11.51	11.49	11.52	10.00	10.00	10.00	10.00	10.64
3	121,695	120,076	121,138	109,772	110,973	113,282	113,186	810,122
	10.92	10.97	11.03	10.00	10.00	10.00	10.00	10.41
4	117,135	115,197	116,896	109,770	110,975	113,266	113,179	796,418
	10.51	10.53	10.64	10.00	10.00	10.00	10.00	10.24
5	112,451	111,076	111,130	109,775	110,976	113,277	113,186	781,871
	10.09	10.15	10.12	10.00	10.00	10.00	10.00	10.05
6	108,245	106,251	106,964	109,774	110,973	113,276	113,180	768,663
	9.71	9.71	9.74	10.00	10.00	10.00	10.00	9.88
7	104,455	102,237	101,397	109,767	110,976	113,277	113,185	755,294
	9.37	9.34	9.23	10.00	10.00	10.00	10.00	9.71
8	99,948	97,891	97,247	109,776	110,974	113,270	113,181	742,287
	8.97	8.95	8.85	10.00	10.00	10.00	10.00	9.54
9	94,795	92,973	93,069	109,770	110,975	113,276	113,181	728,039
	8.51	8.50	8.47	10.00	10.00	10.00	10.00	9.36
10	86,396	84,813	84,331	109,769	110,974	113,273	113,182	702,738
	7.75	7.75	7.68	10.00	10.00	10.00	10.00	9.03
Total	1,114,445	1,094,179	1,098,280	1,097,719	1,109,749	1,132,749	1,131,825	7,778,946
	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00

Pearson chi2(54) = 3.7e+04 Pr = 0.000

.

```
         Pearson chi2(54) =  3.7e+04   Pr = 0.000

.
end of do-file

. do "C:\Users\Rosyidah\AppData\Local\Temp\STD2698_000000.tmp"

.         svyset _n, strata(domisili) weight(fwt_tahun) vce(linearized) singleunit(missing)

      pweight: <none>
          VCE: linearized
  Single unit: missing
     Strata 1: domisili
         SU 1: <observations>
        FPC 1: <zero>
     Weight 1: fwt_year

.
.                 svy : logit insurance_membership i.year , or
(running logit on estimation sample)

Survey: Logistic regression

Number of strata   =         2              Number of obs     =      7,778,946
Number of PSUs     = 7,778,946              Population size   =  1,784,784,699
                                            Design df         =      7,778,944
                                            F(   6,7778939)   =        9944.06
                                            Prob > F          =         0.0000

                |             Linearized
insurance_memb| Odds Ratio   Std. Err.      t    P>|t|     [95% Conf. Interval]
--------------+----------------------------------------------------------------
        Year |
        2013  |    1.35299   .0050937    80.30   0.000     1.343044    1.363011
        2014  |   1.428823   .0053275    95.71   0.000     1.418419    1.439303
        2015  |   1.327406   .0049478    75.98   0.000     1.317744    1.337139
        2016  |   1.589565   .0059907   122.97   0.000     1.577867     1.60135
        2017  |    1.90027   .0072293   168.75   0.000     1.886154    1.914493
        2018  |   2.318184   .0088965   219.08   0.000     2.300812    2.335686
              |
        _cons |   .7701413   .0020042  -100.36   0.000     .7662231    .7740795
--------------------------------------------------------------------------------
Note: _cons estimates baseline odds.

.         svy : logit insurance_membership uhc_st , or
(running logit on estimation sample)

Survey: Logistic regression

Number of strata   =         2              Number of obs     =      7,778,946
Number of PSUs     = 7,778,946              Population size   =  1,784,784,699
                                            Design df         =      7,778,944
                                            F(   1,7778944)   =       26561.92
                                            Prob > F          =         0.0000

--------------------------------------------------------------------------------
                |             Linearized
insurance_memb| Odds Ratio   Std. Err.      t    P>|t|     [95% Conf. Interval]
--------------+----------------------------------------------------------------
      bpjs_st |   1.440065   .0032224   162.98   0.000     1.433763    1.446395
        _cons |   .8973352   .0016847   -57.70   0.000     .8940394    .9006432
--------------------------------------------------------------------------------
Note: _cons estimates baseline odds.
```

```
Survey: Logistic regression

Number of strata   =         2              Number of obs     =      7,778,946
Number of PSUs     = 7,778,946              Population size   =  1,784,784,699
                                            Design df         =      7,778,944
                                            F(   1,7778944)   =       15174.23
                                            Prob > F          =         0.0000

------------------------------------------------------------------------------
             |             Linearized
insurance_own | Odds Ratio   Std. Err.      t    P>|t|     [95% Conf. Interval]
-------------+----------------------------------------------------------------
geographic_st |   1.284557   .0026113   123.18   0.000     1.279449    1.289685
        _cons |   1.026799   .0013423    20.23   0.000     1.024172    1.029433
------------------------------------------------------------------------------
Note: _cons estimates baseline odds.

.         svy : logit insurance_membership gender , or
(running logit on estimation sample)

Survey: Logistic regression

Number of strata   =         2              Number of obs     =      7,778,946
Number of PSUs     = 7,778,946              Population size   =  1,784,784,699
                                            Design df         =      7,778,944
                                            F(   1,7778944)   =          45.28
                                            Prob > F          =         0.0000

------------------------------------------------------------------------------
             |             Linearized
insurance_memb| Odds Ratio   Std. Err.      t    P>|t|     [95% Conf. Interval]
-------------+----------------------------------------------------------------
       Gender |   .9863914   .0020085    -6.73   0.000     .9824627    .9903357
        _cons |   1.175281   .0016907   112.27   0.000     1.171971    1.178599
------------------------------------------------------------------------------
```

```
------------------------------------------------------------------------------
             |             Linearized
insurance_memb| Odds Ratio   Std. Err.      t    P>|t|     [95% Conf. Interval]
-------------+----------------------------------------------------------------
       age_cat |
productive age |   1.178727   .0026826    72.25   0.000      1.17348    1.183996
      elderly |   1.297937   .0063754    53.09   0.000     1.285502    1.310493
              |
        _cons |   1.032253    .001962    16.70   0.000     1.028414    1.036105
------------------------------------------------------------------------------
Note: _cons estimates baseline odds.

.         svy : logit insurance_membership i.edu_higher_recode , or
(running logit on estimation sample)

Survey: Logistic regression

Number of strata   =         2             Number of obs     =      7,778,946
Number of PSUs     = 7,778,946             Population size   =  1,784,784,699
                                           Design df         =      7,778,944
                                           F(   4,7778941)   =       11344.10
                                           Prob > F          =         0.0000

------------------------------------------------------------------------------
             |             Linearized
insurance_own | Odds Ratio   Std. Err.      t    P>|t|     [95% Conf. Interval]
-------------+----------------------------------------------------------------
Edu_Hihger_recode |
Elementary School |   1.244697   .0037636    72.39   0.000     1.237342    1.252096
Junior high school |   1.210609   .0043648    53.01   0.000     1.202084    1.219194
Senior high school |   1.487486   .0051337   115.06   0.000     1.477459    1.497582
Higher Educatin/ |   2.591675   .0122883   200.85   0.000     2.567702    2.615872
University  |
              _cons |   .8903378   .0022895   -45.17   0.000     .8858618    .8948365
------------------------------------------------------------------------------
```

```
Number of strata   =         2              Number of obs     =      7,778,946
Number of PSUs     = 7,778,946              Population size   =  1,784,784,699
                                            Design df         =      7,778,944
                                            F(   2,7778943)   =       18365.60
                                            Prob > F          =         0.0000

------------------------------------------------------------------------------
                             |             Linearized
              insurance_own | Odds Ratio   Std. Err.      t    P>|t|     [95% Conf. Interval]
-----------------------------+------------------------------------------------
                   edu_cat   |
     lower level education   |   1.159002   .0025172    67.94   0.000     1.154079    1.163946
    higher level education   |   2.215977    .009321   189.17   0.000     2.197784    2.234322
                             |
                       _cons |   1.041286   .0014068    29.94   0.000     1.038532    1.044047
------------------------------------------------------------------------------
Note: _cons estimates baseline odds.

.                svy : logit insurance_membership outpatient , or
(running logit on estimation sample)

Number of strata   =         2              Number of obs     =      7,778,946
Number of PSUs     = 7,778,946              Population size   =  1,784,784,699
                                            Design df         =      7,778,944
                                            F(   1,7778944)   =        4325.20
                                            Prob > F          =         0.0000

------------------------------------------------------------------------------
                  |             Linearized
insurance_memb| Odds Ratio   Std. Err.      t    P>|t|     [95% Conf. Interval]
--------------+---------------------------------------------------------------
   outpatient |   1.216003    .003616    65.77   0.000     1.208936    1.223111
        _cons |   1.135342   .0012432   115.92   0.000     1.132907    1.137781
------------------------------------------------------------------------------
Note: _cons estimates baseline odds.

.         svy : logit insurance_membership inpatient , or
(running logit on estimation sample)

Survey: Logistic regression

Number of strata   =         2              Number of obs     =      7,778,946
Number of PSUs     = 7,778,946              Population size   =  1,784,784,699
                                            Design df         =      7,778,944
                                            F(   1,7778944)   =       10054.89
                                            Prob > F          =         0.0000

------------------------------------------------------------------------------
                  |             Linearized
insurance_memb| Odds Ratio   Std. Err.      t    P>|t|     [95% Conf. Interval]
--------------+---------------------------------------------------------------
    inpatient |   1.862549   .0115524   100.27   0.000     1.840044    1.885329
        _cons |    1.14484   .0011826   130.95   0.000     1.142525     1.14716
------------------------------------------------------------------------------
Note: _cons estimates baseline odds.
```

```
Survey: Logistic regression

Number of strata   =         2              Number of obs     =      7,778,946
Number of PSUs     = 7,778,946              Population size   =  1,784,784,699
                                            Design df         =      7,778,944
                                            F(   1,7778944)   =        8202.06
                                            Prob > F          =         0.0000

------------------------------------------------------------------------------
             |             Linearized
insurance_memb| Odds Ratio   Std. Err.      t    P>|t|     [95% Conf. Interval]
-------------+----------------------------------------------------------------
  ever_access |   1.291954   .0036542    90.57   0.000     1.284811    1.299136
        _cons |    1.12012   .0012399   102.47   0.000     1.117693    1.122553
------------------------------------------------------------------------------
Note: _cons estimates baseline odds.

.         svy : logit insurance_ membership employment_st , or
(running logit on estimation sample)



Survey: Logistic regression

Number of strata   =         2              Number of obs     =      6,313,709
Number of PSUs     = 6,313,709              Population size   =  1,453,997,187
                                            Design df         =      6,313,707
                                            F(   1,6313707)   =          38.45
                                            Prob > F          =         0.0000

------------------------------------------------------------------------------
             |             Linearized
insurance_memb| Odds Ratio   Std. Err.      t    P>|t|     [95% Conf. Interval]
-------------+----------------------------------------------------------------
employment_st |   .9859393   .0022516    -6.20   0.000     .9815361    .9903622
        _cons |   1.236573   .0021406   122.67   0.000     1.232384    1.240775
------------------------------------------------------------------------------
Note: _cons estimates baseline odds.
```

```
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. do "C:\Users\dRosyidah\AppData\Local\Temp\STD2698_000000.tmp"

.                tab membership insurance_membership

           |  insurance membership
     Years | out of po  have insu |     Total
-----------+----------------------+----------
      2012 |   593,447    520,998 | 1,114,445
      2013 |   496,802    597,377 | 1,094,179
      2014 |   485,949    612,331 | 1,098,280
      2015 |   495,759    601,960 | 1,097,719
      2016 |   461,408    648,341 | 1,109,749
      2017 |   436,882    695,867 | 1,132,749
      2018 |   386,661    745,164 | 1,131,825
-----------+----------------------+----------
     Total | 3,356,908  4,422,038 | 7,778,946

.         tab uhc_st insurance_membership



Number of strata   =         2             Number of obs     =     7,778,946
Number of PSUs     = 7,778,946             Population size   = 1,784,784,699
                                           Design df         =     7,778,944
                                           F(   4,7778941)   =      11241.94
                                           Prob > F          =        0.0000

------------------------------------------------------------------------------
                |             Linearized
 insurance_memb| Odds Ratio   Std. Err.      t    P>|t|     [95% Conf. Interval]
---------------+--------------------------------------------------------------
percentile_exp |
             2 |   .9256248   .0029235   -24.47   0.000     .9199126    .9313724
             3 |    .930497   .0029537   -22.69   0.000     .9247259    .9363042
             4 |   1.088162   .0034904    26.34   0.000     1.081342    1.095024
             5 |   1.688674   .0055343   159.87   0.000     1.677862    1.699556
               |
         _cons |    1.06039    .002366    26.28   0.000     1.055763    1.065037
------------------------------------------------------------------------------
Note: _cons estimates baseline odds.

.
```

```
.          tab uhc_st insurance_membership

                    |  insurance membership
   Status BPJS era | out of po  have insu |     Total
-------------------+----------------------+----------
 Priorto bpjs era  | 1,090,249  1,118,375 | 2,208,624
          BPJS era | 2,266,659  3,303,663 | 5,570,322
-------------------+----------------------+----------
             Total | 3,356,908  4,422,038 | 7,778,946

.          tab geographic_st insurance_membership

Territoria |  insurance membership
    status | out of po  have insu |     Total
-----------+----------------------+----------
     rural | 2,015,129  2,445,195 | 4,460,324
     urban | 1,341,779  1,976,843 | 3,318,622
-----------+----------------------+----------
     Total | 3,356,908  4,422,038 | 7,778,946

.          tab gender insurance_membership

           |  insurance membership
    Gender | out of po  have insu |     Total
-----------+----------------------+----------
    Female | 1,667,949  2,211,981 | 3,879,930
      Male | 1,688,959  2,210,057 | 3,899,016
-----------+----------------------+----------
     Total | 3,356,908  4,422,038 | 7,778,946

.          tab age_cat insurance_membership
```

```
           |  insurance membership
    Gender | out of po  have insu |     Total
-----------+----------------------+----------
    Female | 1,667,949  2,211,981 | 3,879,930
      Male | 1,688,959  2,210,057 | 3,899,016
-----------+----------------------+----------
     Total | 3,356,908  4,422,038 | 7,778,946

.         tab age_cat insurance_membership

              |  insurance membership
  Age category | out of po  have insu |     Total
---------------+----------------------+----------
     young_age | 1,041,654  1,239,163 | 2,280,817
productive age | 2,162,205  2,957,311 | 5,119,516
       elderly |   153,049    225,564 |   378,613
---------------+----------------------+----------
         Total | 3,356,908  4,422,038 | 7,778,946

.       tab education_higher_recode insurance_membership

         lower edu               |  insurance membership
          higher edu             | out of po  have insu |     Total
--------------------------------+----------------------+----------
notedu/not attend school         |   612,871    620,096 | 1,232,967
       elementary School         | 1,388,686  1,754,730 | 3,143,416
      Junior high school         |   556,949    685,520 | 1,242,469
      Senior high school         |   631,039    918,654 | 1,549,693
   higher education/University   |   167,363    443,038 |   610,401
-------------------+----------------------+----------
                            Total| 3,356,908  4,422,038 | 7,778,946

.         tab edu_cat insurance_membership
```

```
.         tab edu_cat insurance_membership

                      |  insurance membership
   Education category | out of po  have insu |     Total
----------------------+----------------------+----------
       not education | 2,001,557  2,374,826 | 4,376,383
lower level education | 1,187,988  1,604,174 | 2,792,162
higher level educatio |   167,363    443,038 |   610,401
----------------------+----------------------+----------
               Total | 3,356,908  4,422,038 | 7,778,946

.                 tab outpatient insurance_membership

 Ever access |
   to health |
services for |
  outpatient |  insurance membership
    services | out of po  have insu |     Total
-------------+----------------------+----------
never access | 2,952,909  3,759,466 | 6,712,375
 ever access |   403,999    662,572 | 1,066,571
-------------+----------------------+----------
       Total | 3,356,908  4,422,038 | 7,778,946

.         tab inpatient insurance_own

 Ever access |
   to health |
services for |
   inpatient |  insurance membership
    services | out of po  have insu |     Total
-------------+----------------------+----------
never access | 3,287,319  4,249,200 | 7,536,519
 ever access |    69,589    172,838 |   242,427
-------------+----------------------+----------
       Total | 3,356,908  4,422,038 | 7,778,946
```

```
 Ever access |
   to health |  insurance membership
    services | out of po  have insu |     Total
-------------+----------------------+----------
never access | 2,909,496  3,657,599 | 6,567,095
 ever access |   447,412    764,439 | 1,211,851
-------------+----------------------+----------
       Total | 3,356,908  4,422,038 | 7,778,946

.         tab employment_st insurance_membership

  Employment |  insurance membership
      status | out of po  have insu |     Total
-------------+----------------------+----------
unemployment | 1,126,241  1,580,477 | 2,706,718
  employment | 1,524,930  2,082,061 | 3,606,991
-------------+----------------------+----------
       Total | 2,651,171  3,662,538 | 6,313,709

.         tab percentile_exp insurance_membership

Percentile  |
expenditure |  insurance membership
            | out of po  have insu |     Total
------------+----------------------+----------
         1  |   693,533    862,258 | 1,555,791
         2  |   724,833    830,957 | 1,555,790
         3  |   729,335    826,453 | 1,555,788
         4  |   677,856    877,932 | 1,555,788
         5  |   531,351  1,024,438 | 1,555,789
------------+----------------------+----------
      Total | 3,356,908  4,422,038 | 7,778,946

.
.      tab Years insurance_membership, row nof
```

Year	insurance membership: out of po	have insu	Total
2012	53.25	46.75	100.00
2013	45.40	54.60	100.00
2014	44.25	55.75	100.00
2015	45.16	54.84	100.00
2016	41.58	58.42	100.00
2017	38.57	61.43	100.00
2018	34.16	65.84	100.00
Total	43.15	56.85	100.00

```
.         tab uhc_st insurance_membership, row nof
```

Status UHC era	insurance membership: out of po	have insu	Total
perior to UHC era	49.36	50.64	100.00
UHC era	40.69	59.31	100.00
Total	43.15	56.85	100.00

```
.     tab geographic_st insurance_membership, row nof
```

Territoria l status	insurance membership: out of po	have insu	Total
rural	45.18	54.82	100.00
urban	40.43	59.57	100.00
Total	43.15	56.85	100.00

```
.             tab gender insurance_own , row nof
```

```
.            tab gender insurance_own , row nof

           |  insurance membership
    Gender | out of po  have insu |     Total
-----------+----------------------+----------
    Female |     42.99      57.01 |    100.00
      Male |     43.32      56.68 |    100.00
-----------+----------------------+----------
     Total |     43.15      56.85 |    100.00

.         tab age_cat insurance_membership, row nof

               |  insurance membership
  Age category | out of po  have insu |     Total
---------------+----------------------+----------
     young_age |     45.67      54.33 |    100.00
productive age |     42.23      57.77 |    100.00
       elderly |     40.42      59.58 |    100.00
---------------+----------------------+----------
         Total |     43.15      56.85 |    100.00

.         tab education_higest_recode insurance_membership, row nof

         pendidikan |  insurance ownership
          tertinggi | out of po  have insu |     Total
--------------------+----------------------+----------
not education/not attend school |     49.71      50.29 |    100.00
     Elementary School          |     44.18      55.82 |    100.00
     Junior School              |     44.83      55.17 |    100.00
     Senior high school         |     40.72      59.28 |    100.00
     Higher Education/University|     27.42      72.58 |    100.00
--------------------+----------------------+----------
              Total |     43.15      56.85 |    100.00

.         tab edu_cat insurance membership, row nof
```

```
                    |  insurance membership
  Education category | out of po  have insu |     Total
---------------------+----------------------+----------
       not education |     45.74      54.26 |    100.00
lower level education |     42.55      57.45 |    100.00
higher level educatio |     27.42      72.58 |    100.00
---------------------+----------------------+----------
               Total |     43.15      56.85 |    100.00

.                tab outpatient insurance_membership, row nof

 Ever access |
   to health |
services for |
  outpatient |  insurance membership
    services | out of po  have insu |     Total
-------------+----------------------+----------
never access |     43.99      56.01 |    100.00
 ever access |     37.88      62.12 |    100.00
-------------+----------------------+----------
       Total |     43.15      56.85 |    100.00

.         tab inpatient insurance_membership, row nof

 Ever access |
   to health |
services for |
   inpatient |  insurance membership
    services | out of po  have insu |     Total
-------------+----------------------+----------
never access |     43.62      56.38 |    100.00
 ever access |     28.71      71.29 |    100.00
-------------+----------------------+----------
       Total |     43.15      56.85 |    100.00

.         tab ever_access insurance_membership, row nof
```

```
 Ever access |
   to health |  insurance membership
    services | out of po  have insu |     Total
-------------+----------------------+----------
never access |     44.30      55.70 |    100.00
 ever access |     36.92      63.08 |    100.00
-------------+----------------------+----------
       Total |     43.15      56.85 |    100.00

.          tab employment_st insurance_membership, row nof

  Employment |  insurance membership
      status | out of po  have insu |     Total
-------------+----------------------+----------
unemployment |     41.61      58.39 |    100.00
  employment |     42.28      57.72 |    100.00
-------------+----------------------+----------
       Total |     41.99      58.01 |    100.00

.          tab percentile_exp insurance_membership, row nof

Percentile |
expenditure|  insurance membership
           | out of po  have insu |     Total
-----------+----------------------+----------
         1 |     44.58      55.42 |    100.00
         2 |     46.59      53.41 |    100.00
         3 |     46.88      53.12 |    100.00
         4 |     43.57      56.43 |    100.00
         5 |     34.15      65.85 |    100.00
-----------+----------------------+----------
     Total |     43.15      56.85 |    100.00


.
end of do-file

. do "C:\Users\Rosyidah\AppData\Local\Temp\STD2698_000000.tmp"

.        svy : logit insurance_membership uhc_st, or
(running logit on estimation sample)

Survey: Logistic regression

Number of strata   =         2             Number of obs     =      7,778,946
Number of PSUs     = 7,778,946             Population size   =  1,784,784,699
                                           Design df         =      7,778,944
                                           F(   1,7778944)   =       26561.92
                                           Prob > F          =         0.0000

------------------------------------------------------------------------------
             |             Linearized
insurance_own | Odds Ratio   Std. Err.      t    P>|t|     [95% Conf. Interval]
-------------+----------------------------------------------------------------
      uhc_st |   1.440065   .0032224   162.98   0.000     1.433763    1.446395
       _cons |   .8973352   .0016847   -57.70   0.000     .8940394    .9006432
------------------------------------------------------------------------------
Note: _cons estimates baseline odds.
```

```
                                        Prob > F          =         0.0000

------------------------------------------------------------------------------
                   |             Linearized
insurance_member | Odds Ratio   Std. Err.      t    P>|t|     [95% Conf. Interval]
-------------+----------------------------------------------------------------
      uhc_st     |   1.435127   .0032186   161.08   0.000     1.428833    1.441449
geographic_st    |   1.279363   .0026103   120.75   0.000     1.274257     1.28449
        _cons    |   .7929836   .0016449  -111.82   0.000     .7897662    .7962141
------------------------------------------------------------------------------
Note: _cons estimates baseline odds.

.         svy : logit insurance_membership UHC_st sex, or
(running logit on estimation sample)

Survey: Logistic regression

Number of strata   =         2              Number of obs     =      7,778,946
Number of PSUs     = 7,778,946              Population size   =  1,784,784,699
                                            Design df         =      7,778,944
                                            F(   2,7778943)   =       13302.11
                                            Prob > F          =         0.0000

------------------------------------------------------------------------------
               |             Linearized
insurance_memb| Odds Ratio   Std. Err.      t    P>|t|     [95% Conf. Interval]
--------------+---------------------------------------------------------------
      uhc_st b|   1.440071   .0032224   162.98   0.000     1.433769      1.4464
      gender  |   .9863106   .0020159    -6.74   0.000     .9823674    .9902697
        _cons |   .9035709     .00193   -47.47   0.000      .899796    .9073616
------------------------------------------------------------------------------
Note: _cons estimates baseline odds.

.         svy : logit insurance_membership uhc_st i.age_cat, or
(running logit on estimation sample)

Survey: Logistic regression
```

```
Survey: Logistic regression

Number of strata   =         2              Number of obs     =      7,778,946
Number of PSUs     = 7,778,946              Population size   =  1,784,784,699
                                            Design df         =      7,778,944
                                            F(   3,7778942)   =       10778.19
                                            Prob > F          =         0.0000

------------------------------------------------------------------------------
                |             Linearized
  insurance_memb| Odds Ratio   Std. Err.      t    P>|t|     [95% Conf. Interval]
----------------+-------------------------------------------------------------
        bpjs_st |   1.438049   .0032229   162.10   0.000     1.431746    1.444379
                |
        age_cat |
productive age  |   1.175931   .0026925    70.78   0.000     1.170666     1.18122
       elderly  |    1.29042   .0063547    51.78   0.000     1.278025    1.302935
                |
          _cons |   .7958669   .0019713   -92.18   0.000     .7920125      .79974
------------------------------------------------------------------------------
Note: _cons estimates baseline odds.

.             svy : logit insurance_membership uhc_st i.Education_higher_recode, or
(running logit on estimation sample)

Survey: Logistic regression

Number of strata   =         2              Number of obs     =      7,778,946
Number of PSUs     = 7,778,946              Population size   =  1,784,784,699
                                            Design df         =      7,778,944
                                            F(   5,7778940)   =       13959.76
                                            Prob > F          =         0.0000

------------------------------------------------------------------------------
                        |             Linearized
        insurance_memb | Odds Ratio   Std. Err.      t    P>|t|     [95% Conf. Interval]
-----------------------+------------------------------------------------------
```

```
.         svy : logit insurance_own bpjs_st i.edu_cat, or
(running logit on estimation sample)

Survey: Logistic regression

Number of strata   =         2              Number of obs     =      7,778,946
Number of PSUs     = 7,778,946              Population size   =  1,784,784,699
                                            Design df         =      7,778,944
                                            F(   3,7778942)   =       20592.83
                                            Prob > F          =         0.0000

------------------------------------------------------------------------------
                             |             Linearized
          insurance_memb     | Odds Ratio   Std. Err.      t    P>|t|     [95% Conf. Interval]
-----------------------------+------------------------------------------------------------------
                  uhc_st     |   1.432601   .0032235   159.77   0.000     1.426297    1.438933
                             |
                  edu_cat    |
 lower level education       |   1.153435   .0025133    65.51   0.000      1.14852    1.158372
higher level education       |   2.201936   .0092837   187.22   0.000     2.183815    2.220207
                             |
                    _cons    |   .8053533   .0016757  -104.04   0.000     .8020757    .8086443
------------------------------------------------------------------------------
Note: _cons estimates baseline odds.

.                 svy : logit insurance_own bpjs_st outpatient, or
(running logit on estimation sample)

Survey: Logistic regression

Number of strata   =         2              Number of obs     =      7,778,946
Number of PSUs     = 7,778,946              Population size   =  1,784,784,699
                                            Design df         =      7,778,944
                                            F(   2,7778943)   =       15163.04
                                            Prob > F          =         0.0000
```

```
Survey: Logistic regression

Number of strata   =         2              Number of obs     =      7,778,946
Number of PSUs     = 7,778,946              Population size   =  1,784,784,699
                                            Design df         =      7,778,944
                                            F(   5,7778940)   =       13959.76
                                            Prob > F          =         0.0000

------------------------------------------------------------------------------
                     |             Linearized
       insurance_memb | Odds Ratio   Std. Err.      t    P>|t|     [95% Conf. Interval]
---------------------+--------------------------------------------------------------
             uhc_st  |   1.429871   .0032245   158.56   0.000     1.423565    1.436205
                     |
Education_higher_recode|
    Elementary school  |    1.24339   .0037904    71.46   0.000     1.235983    1.250841
    Junior high school |   1.207886   .0043839    52.04   0.000     1.199325    1.216509
    Senior high school |   1.475267   .0051243   111.94   0.000     1.465258    1.485345
    Higher Ed/Univ     |   2.573343   .0122556   198.47   0.000     2.549434    2.597476
                     |
               _cons  |   .6900649   .0021023  -121.77   0.000     .6859567    .6941978
------------------------------------------------------------------------------
Note: _cons estimates baseline odds.

.         svy : logit insurance_own bpjs_st i.edu_cat, or
(running logit on estimation sample)

Survey: Logistic regression

Number of strata   =         2              Number of obs     =      7,778,946
Number of PSUs     = 7,778,946              Population size   =  1,784,784,699
                                            Design df         =      7,778,944
                                            F(   3,7778942)   =       20592.83
                                            Prob > F          =         0.0000
```

```
Number of strata   =         2              Number of obs     =      7,778,946
Number of PSUs     = 7,778,946              Population size   =  1,784,784,699
                                            Design df         =      7,778,944
                                            F(   2,7778943)   =       17647.44
                                            Prob > F          =         0.0000

------------------------------------------------------------------------------
             |             Linearized
insurance_memb| Odds Ratio   Std. Err.      t    P>|t|     [95% Conf. Interval]
--------------+---------------------------------------------------------------
      uhc_st |   1.427903   .0032009   158.90   0.000     1.421644    1.434191
    inpatient |   1.799742   .0111774    94.62   0.000     1.777967    1.821783
        _cons |   .8864948   .0016696   -63.97   0.000     .8832284    .8897733
------------------------------------------------------------------------------
Note: _cons estimates baseline odds.

.         svy : logit insurance_membership uhc_st ever_access, or
(running logit on estimation sample)

Survey: Logistic regression

Number of strata   =         2              Number of obs     =      7,778,946
Number of PSUs     = 7,778,946              Population size   =  1,784,784,699
                                            Design df         =      7,778,944
                                            F(   2,7778943)   =       16820.75
                                            Prob > F          =         0.0000

------------------------------------------------------------------------------
             |             Linearized
insurance_memb| Odds Ratio   Std. Err.      t    P>|t|     [95% Conf. Interval]
--------------+---------------------------------------------------------------
      uhc_st |   1.431174   .0032072   159.97   0.000     1.424902    1.437474
  ever_access |   1.274465   .0036181    85.43   0.000     1.267394    1.281576
        _cons |   .8668814   .0016647   -74.39   0.000     .8636248    .8701503
------------------------------------------------------------------------------
Note: _cons estimates baseline odds.
```

```
(running logit on estimation sample)

Survey: Logistic regression

Number of strata   =         2              Number of obs     =      7,778,946
Number of PSUs     = 7,778,946              Population size   =  1,784,784,699
                                            Design df         =      7,778,944
                                            F(   2,7778943)   =       15163.04
                                            Prob > F          =         0.0000

------------------------------------------------------------------------------
             |             Linearized
insurance_memb| Odds Ratio   Std. Err.      t    P>|t|     [95% Conf. Interval]
-------------+----------------------------------------------------------------
      uhc_st |   1.435934   .0032154   161.58   0.000     1.429646     1.44225
  outpatient |   1.204848   .0035977    62.41   0.000     1.197817     1.21192
       _cons |    .875783   .0016785   -69.21   0.000     .8724994    .8790789
------------------------------------------------------------------------------
Note: _cons estimates baseline odds.

.         svy : logit insurance_own bpjs_st inpatient, or
(running logit on estimation sample)

Survey: Logistic regression

Number of strata   =         2              Number of obs     =      7,778,946
Number of PSUs     = 7,778,946              Population size   =  1,784,784,699
                                            Design df         =      7,778,944
                                            F(   2,7778943)   =       17647.44
                                            Prob > F          =         0.0000

------------------------------------------------------------------------------
             |             Linearized
insurance_memb| Odds Ratio   Std. Err.      t    P>|t|     [95% Conf. Interval]
-------------+----------------------------------------------------------------
      uhc_st |   1.427903   .0032009   158.90   0.000     1.421644    1.434191
    inpatient |   1.799742   .0111774    94.62   0.000     1.777967    1.821783
```

```
(running logit on estimation sample)

Survey: Logistic regression

Number of strata   =         2              Number of obs     =      6,313,709
Number of PSUs     = 6,313,709              Population size   =  1,453,997,187
                                            Design df         =      6,313,707
                                            F(   2,6313706)   =       15371.06
                                            Prob > F          =         0.0000

------------------------------------------------------------------------------
             |             Linearized
insurance_memb| Odds Ratio   Std. Err.      t    P>|t|     [95% Conf. Interval]
--------------+---------------------------------------------------------------
      uhc_st |   1.545715   .0038412   175.24   0.000     1.538204    1.553262
employment_st |   .9899475   .0022728    -4.40   0.000     .9855028    .9944122
        _cons |   .9012695   .0022305   -42.00   0.000     .8969084    .9056518
------------------------------------------------------------------------------
Note: _cons estimates baseline odds.

.         svy : logit insurance_membership uhc_st i.percentile_exp, or
(running logit on estimation sample)

Survey: Logistic regression

Number of strata   =         2              Number of obs     =      7,778,946
Number of PSUs     = 7,778,946              Population size   =  1,784,784,699
                                            Design df         =      7,778,944
                                            F(   5,7778940)   =       12728.01
                                            Prob > F          =         0.0000

------------------------------------------------------------------------------
             |             Linearized
 insurance_memb| Odds Ratio   Std. Err.      t    P>|t|     [95% Conf. Interval]
---------------+---------------------------------------------------------------
       uhc_st |   1.373073   .0031604   137.75   0.000     1.366893    1.379281
              |
```

```
Number of strata   =         2              Number of obs     =      7,778,946
Number of PSUs     = 7,778,946              Population size   =  1,784,784,699
                                            Design df         =      7,778,944
                                            F(   5,7778940)   =       12728.01
                                            Prob > F          =         0.0000

------------------------------------------------------------------------------
               |             Linearized
 insurance_memb| Odds Ratio   Std. Err.      t    P>|t|     [95% Conf. Interval]
---------------+--------------------------------------------------------------
       uhc_st  |   1.373073   .0031604   137.75   0.000     1.366893    1.379281
               |
percentile_exp |
            2  |   .8838213   .0028185   -38.73   0.000     .8783144    .8893627
            3  |   .8724709   .0028098   -42.36   0.000     .8669811    .8779955
            4  |   1.006392   .0032917     1.95   0.051     .9999611    1.012864
            5  |   1.544555   .0051724   129.82   0.000      1.53445    1.554726
               |
         _cons |   .8924116   .0022769   -44.61   0.000     .8879601    .8968855
------------------------------------------------------------------------------
Note: _cons estimates baseline odds.

.
.
end of do-file

. do "C:\Users\Rosyidah\AppData\Local\Temp\STD2698_000000.tmp"

. ***     Analysis difference in differences
.
end of do-file

. do "C:\Users\Rosyidah\AppData\Local\Temp\STD2698_000000.tmp"

. **      employment
.
```

```
(running logit on estimation sample)

Survey: Logistic regression

Number of strata   =         2              Number of obs     =      6,313,709
Number of PSUs     = 6,313,709              Population size   =  1,453,997,187
                                            Design df         =      6,313,707
                                            F(   3,6313705)   =       10269.72
                                            Prob > F          =         0.0000

------------------------------------------------------------------------------
                     |             Linearized
       insurance_memb| Odds Ratio   Std. Err.      t    P>|t|     [95% Conf. Interval]
---------------------+--------------------------------------------------------------
             uhc_st  |
            uhc era  |   1.515147   .0057962   108.62   0.000     1.503829     1.52655
                     |
        employment_st |
          employment |   .9654514   .0040798    -8.32   0.000     .9574881    .9734809
                     |
uhc_st#employment_st |
 uhc era#employment  |   1.035379   .0052099     6.91   0.000     1.025218    1.045641
                     |
               _cons |   .9144082   .0029439   -27.79   0.000     .9086564    .9201964
------------------------------------------------------------------------------
Note: _cons estimates baseline odds.

.
.
end of do-file

. do "C:\Users\Rosyidah\AppData\Local\Temp\STD2698_000000.tmp"

.         svy : logit insurance_own bpjs_st##percentile_exp, or
(running logit on estimation sample)

Survey: Logistic regression
```

Survey: Logistic regression

Number of strata	= 2	Number of obs	= 7,778,946
Number of PSUs	= 7,778,946	Population size	= 1,784,784,699
		Design df	= 7,778,944
		F(9,7778936)	= 7077.12
		Prob > F	= 0.0000

insurance_memb	Odds Ratio	Linearized Std. Err.	t	P>|t|	[95% Conf.	Interval]
UHC_st						
UHC era	1.383205	.0062087	72.27	0.000	1.37109	1.395428
percentile_exp						
2	.8774525	.0045124	-25.42	0.000	.8686528	.8863414
3	.8781296	.0048203	-23.68	0.000	.8687325	.8876283
4	1.070233	.0063239	11.49	0.000	1.05791	1.082699
5	1.488963	.0095492	62.07	0.000	1.470364	1.507797
bpjs_st#percentile_exp						
uhc era#2	1.008921	.0066399	1.35	0.177	.9959901	1.022019
uhc era#3	.9894038	.006751	-1.56	0.118	.9762603	1.002724
uhc era#4	.9229776	.0066052	-11.20	0.000	.9101219	.9360149
uhc era#5	1.043147	.0079273	5.56	0.000	1.027725	1.0588
_cons	.888855	.0029045	-36.06	0.000	.8831805	.894566

Note: _cons estimates baseline odds.

```
end of do-file

. do "C:\Users\Rosyidah\AppData\Local\Temp\STD2698_000000.tmp"

.         svy : logit insurance_own bpjs_st##percentile_exp, or
(running logit on estimation sample)

Survey: Logistic regression

Number of strata   =         2              Number of obs     =      7,778,946
Number of PSUs     = 7,778,946              Population size   =  1,784,784,699
                                            Design df         =      7,778,944
                                            F(   9,7778936)   =        7077.12
                                            Prob > F          =         0.0000

------------------------------------------------------------------------------
                     |             Linearized
      insurance_memb | Odds Ratio   Std. Err.      t    P>|t|     [95% Conf. Interval]
---------------------+--------------------------------------------------------------
             uhc_st  |
          uhc era    |   1.383205   .0062087    72.27   0.000      1.37109    1.395428
                     |
      percentile_exp |
                   2 |   .8774525   .0045124   -25.42   0.000     .8686528    .8863414
                   3 |   .8781296   .0048203   -23.68   0.000     .8687325    .8876283
                   4 |   1.070233   .0063239    11.49   0.000      1.05791    1.082699
                   5 |   1.488963   .0095492    62.07   0.000     1.470364    1.507797
                     |
bpjs_st#percentile_exp |
          uhc era#2  |   1.008921   .0066399     1.35   0.177     .9959901    1.022019
          uhc era#3  |   .9894038    .006751    -1.56   0.118     .9762603    1.002724
          uhc era#4  |   .9229776   .0066052   -11.20   0.000     .9101219    .9360149
          uhc era#5  |   1.043147   .0079273     5.56   0.000     1.027725      1.0588
                     |
               _cons |    .888855   .0029045   -36.06   0.000     .8831805     .894566
------------------------------------------------------------------------------
```