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

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

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

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

Introduction

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Method

Research Design and Strategy

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

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

Respondents

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

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

Data Collection Techniques

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

Data Processing and Analysis

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

Results

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

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

Revenue Collection

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

Table 1. Revenue collection performance's indicators

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

Source: Processed data, 2019

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

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

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

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

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

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

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

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

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

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

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

Pooling

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

Table 2. Pooling performance's indicator

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

Source: Processed data, 2019

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

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

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

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

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

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

Purchasing

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

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

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

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

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

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

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

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

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

dissatisfaction with BPJS. (Source: interview excerpt)

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

Discussion

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

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

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

Conclusion

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

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

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

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

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

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

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

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