

Thesis

**Moving toward universal health coverage of
Indonesia: where is the position?**

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Umar bin Khattab ra. relates that the Prophet *shallallahu 'alayhi wasallam* said:
“All deeds depend on intention. Therefore a person, who migrated for the sake of Allah and His Messenger shallallahu 'alayhi wasallam, his migration will then be for Allah and His Messenger shallallahu 'alayhi wasallam. And if someone migrated for the sake of the world, or to marry a woman, then his migration will be for whatever he had intended.”

[Hadits narrated by Bukhari and Muslim]

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Abstract

The intention to provide the people's rights to health has driven any attempts to achieve universal health coverage. The right to health is not right to be healthy, but the State must secure citizen's rights to access health care services and any underlying determinants of health. The Indonesian health care reform accelerated since 1998 is intended to provide universal health coverage. It is one of attempts to fulfill the right to the highest attainable standard of health as mandated by international and national legal instruments. This thesis attempts to explore whether the health care reform toward universal health coverage in Indonesia improves the fulfillment of the right to the highest attainable standard of health. This thesis assesses the impacts from policy and legal perspective through literature review to describe the history of the reform, the legal and policy instruments developed during the health care reform, the interaction among policy actors, and human right assessment on three dimensions of coverage, availability, accessibility, acceptability and quality. During the movement toward universal health coverage, some improvements have achieved, supported by community pressure, including improvement of the three dimensions of coverage, availability, accessibility, and acceptability. Decentralization, in some extent, has a pivotal role in the reform to improve universal access, but it also creates unequal access countrywide. However, the movement to achieve universal health coverage and fulfill the rights to the highest standard of health is still challenging. Some shortages are evident, such as remained high proportion of uncovered people, lacking health care professionals and their unequal distribution, physical and financial constraints to access health care, and poor quality of health care services. Some recommendations are provided to improve the movement toward universal health coverage including how to improve coverage, increase availability, facilitate accessibility, and improve the quality of health services.

Keywords

Health care reform, Indonesia, right to health, universal health coverage.

Abbreviations

Askes	: <i>Asuransi Kesehatan</i> , Health Insurance
Askeskin	: <i>Asuransi Kesehatan Rakyat Miskin</i> , Health Insurance for the Poor
BPJS	: <i>Badan Penyelenggara Jaminan Sosial</i> , Social Security Agency
BPS	: <i>Badan Pusat Statistik</i> , Central Statistic Agency
DGHE	: Directorate General of Higher Education
DHO	: District Health Office
IBI	: <i>Ikatan Bidan Indonesia</i> , Indonesian Midwifery Association
IMA	: Indonesian Medical Association
ILO	: International Labor Organization
Jamkesda	: <i>Jaminan Kesehatan Daerah</i> , Local Health Insurance
Jamkesmas	: <i>Jaminan Kesehatan Masyarakat</i> , Community Health Insurance
Jamsostek	: <i>Jaminan Sosial Tenaga Kerja</i> , Workforce Social Security
JLN	: Joint Learning Network
JPKM	: <i>Jaminan Pemeliharaan Kesehatan Masyarakat</i> , Community managed health care
JPS	: <i>Jaringan Pengaman Sosial</i> , Social Safety Net
KAJS	: <i>Komite Aksi Jaminan Sosial</i> , Social Security Action Committee
KKI	: <i>Konsil Kedokteran Indonesia</i> , Indonesian Medical Council
MKDKI	: <i>Majelis Kehormatan Disiplin Kedokteran Indonesia</i> , Indonesian Medical Disciplinary Board
MKKI	: <i>Majelis Kolegium Kedokteran Indonesia</i> , Academy of Medicine of Indonesia
MoH	: Ministry of Health
NGO	: Non Government Organization
PHO	: Provincial Health Office
PPNI	: <i>Persatuan Perawat Nasional Indonesia</i> , Indonesian Nurse Association
Puskesmas	: <i>Pusat Kesehatan Masyarakat</i> , Primary Health Centre
Pustu	: <i>Puskesmas pembantu</i> , supported Primary Health Centre
SJSN	: <i>Sistem Jaminan Sosial Nasional</i> , National Social Security System
WHO	: World Health Organization

1. Introduction

After the implementation in high-income countries, universal health coverage becomes a trend in low-middle income countries to be implemented¹⁻³ including Indonesia. The World Health Organization (WHO) Director General, Margaret Chan, also asserted that universal health coverage is “the single most powerful concept that public health has to offer”.⁴ Each country has each current health system and implements health care system reform in different ways with no-uniformity of the structure to move toward universal health coverage. Some developing countries such as India and Thailand have implemented the universal health coverage. They have had some lesson learned from early results of the change while some developing countries such as Indonesia and Philippines have moved toward.^{1,5-7}

The intention to provide the people’s rights to health has driven any attempts to achieve universal health coverage. The right to health is not right to be healthy, but the State must secure citizen’s rights to access health care services and any underlying determinants of health.⁸⁻¹⁰ The right to health goes beyond only access to health care services but includes freedom from discrimination and involuntary medical treatment, entitlements to essential primary care and drugs, and particular concerns for the disadvantaged, the vulnerable and the poor.⁹ Since everyone has right to the enjoyment of the highest attainable standard of physical and mental health including entitlements to essential primary health care and access to essential drugs, it requires an effective health system developed by States.⁹ The right to health contains essential elements including availability, accessibility, acceptability, and quality of health care services. Health care facilities, goods, and services must be also affordable for all and be based on the principle of equity.^{8,11} Some international instruments emphasize the importance of compliance with this human right including the WHO Constitution (1946), the International Covenant on Economic, Social, and Cultural Right, Article 12 (1966), the Declaration of Alma-Ata (1978), and the Ottawa Charter of Health Promotion (1986)¹².

In the course of providing rights to health Indonesia has accelerated health care reform after the economic crisis in 1998. The government had developed some pro-poor national insurance schemes in order to secure the poor’s access to health care services. The health care reform has continued and has changed the structure with the passage of National Social Security System Act (Sistem Jaminan Sosial Nasional, SJSN) in 2004. Through a political struggle, Indonesia eventually passed the Social Security Agency Law (Badan Penyelenggara Jaminan Sosial, BPJS) in 2011 and planned for the implementation of universal health coverage in 2014.¹³ There are some key policy actors beyond the government who have taken part in governing the wave toward the universal health coverage. Some interactions have resulted in policies and regulations supporting the reform. However, while Indonesia has struggled to move towards the universal coverage, it is crucial to assess whether the effort comply with the rationale of providing the right to the highest attainable standard of health.

Some questions arise to be answered. Has the health care reform in Indonesia including its attempt to provide universal health coverage truly fulfilled the right to the highest attainable standard of health? Have the actors of governance developed appropriate policies and regulations to ensure citizen's right in accessing health care services during the reform wave?

The analysis will compare information collected on potential right to health impacts from some publication with the State's legal obligations for the right to health.¹⁰ In order to obtain impact assessment of the reform, this study will explore literatures from some sources including Indonesia databases, scientific journals (searched by Google Scholar, PubMed, and WebScience), WHO databases, and the Joint Learning Network (JLN) for Universal Health Coverage databases. Also, in some extent, this study will compare the achievement with other developing countries, such as Thailand and Philippines, as a benchmark to elaborate lesson learned and provide more powerful recommendations. By assessing the Indonesian moving toward universal health coverage, this study will provide a base of knowledge of the reform and recommendations prior to the implementation of universal health coverage.

2. Research Questions

This thesis attempts to answer the question whether the health care reform toward universal health coverage in Indonesia improves the fulfillment of the right to the highest attainable standard of health. In order to answer the question, this thesis assesses the impacts on the Indonesian health care reform wave toward universal health coverage so that can provide some recommendations related to the fulfillment of the right to the highest attainable standard of health.

The structure of this thesis also provides parts to answer some specific aims below.

1. Describing legal and policy instruments developed during the health reform to secure citizen's rights to the highest attainable standard of health.
2. Exploring the interaction between policy actors during the reform and its impacts to reform.
3. Assessing the policy and regulation impacts on coverage in terms of "who is covered", "what service is covered", and "what proportion of financial contribution".
4. Assessing the policy and regulation effects to rights to the highest attainable standard of health in terms of availability, accessibility, acceptability, and quality of health care.
5. Providing some recommendations to Indonesian government related to the fulfillment of the right to the highest attainable standard of health.

3. Theoretical framework

3.1 Health as a human right

Health is a fundamental human right which is well recognized in numerous international instruments. Since the Universal Declaration of Human Rights affirms that everyone has the right to a standard of living adequate for health including medical care, State parties have to take steps to achieve the full realization of this right as stated on article 12.1 of the International Covenant on Economic, Social and Cultural Rights.^{8,11,14} However, the right to health is not a right to be healthy. It contains freedom to control someone's health and body, as well as to be free from any negative interventions. It also contains entitlements to the health system which provides equality of opportunity to enjoy the highest attainable standard of health.^{8,11}

Since everyone has right to the enjoyment of the highest attainable standard of physical and mental health including entitlements to essential primary health care and access to essential drugs, it requires an effective health system developed by States.⁹ The right to health contains essential elements which have to be applied including availability, accessibility, acceptability, and quality of health care services. Health care facilities, goods, and services must be affordable for all and be based on the principle of equity.^{8,11} Some international instruments emphasize the importance of compliance with this human right including the WHO Constitution (1946), the International Covenant on Economic, Social, and Cultural Right, Article 12 (1966), the Declaration of Alma-Ata (1978), and the Ottawa Charter of Health Promotion (1986).¹² These international laws are supported by local legal instruments. Indonesia has defined the rights of citizens, particularly right to health and social security, under the 1945 Constitution and some Acts developed after the health care reform.

3.2 Universal health coverage and the right to health

The Universal Declaration of Human Rights affirms that everyone has the right to a standard of living adequate for health including medical care so that State parties have to take steps to achieve the full realization of this right as stated on article 12.1 of the International Covenant on Economic, Social and Cultural Rights.^{8,11,14} Some international instruments emphasize the importance of compliance with this human right including the WHO Constitution (1946), the International Covenant on Economic, Social, and Cultural Right, Article 12 (1966), the Declaration of Alma-Ata (1978), and the Ottawa Charter of Health Promotion (1986).¹² Local legal instruments also encourages the State to establish an effective, integrated, and accessible health care systems.¹² Otherwise, the right will be a little more than a slogan.

The State cannot ensure people's good health, nor can State protect the people completely against every possible cause of sickness. The highest attainable standard of health, as explained in

General Comment No. 14, includes individual biological and socio-economic preconditions and a State's available resources so that many aspects cannot be addressed solely within State and individual relationship.¹¹ The right to health does not mean right to healthy but means the enjoyment of facilities, goods, and services required for the realization of the highest attainable standard of health. Here is the State's role to provide those necessary for the highest attainable standard of health. Providing universal health coverage is one of promising attempts to fulfill the right to health. However, the right to highest attainable standard of health for all cannot be achieved immediately and requires long-term efforts. Implementing universal health coverage is a part of the process of which the right to health is the main motivation. Reduce negative spillovers (externalities) resulted from poor health is additional economic motivation.¹⁵

In economic and policy perspectives universal health coverage comprises to three dimensions which are the extent of population coverage (who is covered), the extent of the benefit package coverage (what is covered), and the extent of proportion of cost (what proportion of cost is covered).¹⁶ (See Figure 1) International organizations such as International Labour Organization (ILO) have developed standard of the benefit package in medical care through Social Security (Minimum Standards) Convention, 1952 (No. 102) and Medical Care and Sickness Benefits Convention, 1969 (No. 130). The benefit standard includes at least (a) morbid condition and (b) pregnancy and confinement and their consequences, ranged from a general practitioner care including domiciliary visiting the medical rehabilitation.^{17,18} Countries then translate various benefit package according to their resources. However, the most noteworthy is how delivered benefit package may enhance people rights to health and how health system can ensure the delivery.

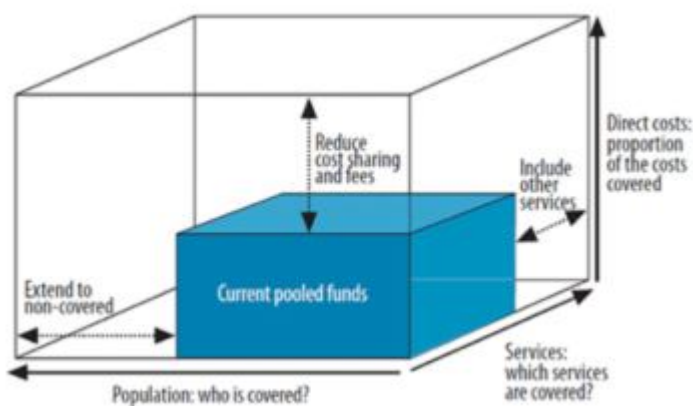


Figure 1. Three dimension of coverage which should be considered when moving toward universal health coverage.

Considering the three dimensions of coverage, moving toward universal health coverage must include strengthening the health system rather than only providing a wide large health insurance to the whole population in terms of universal health coverage. The health system must place a person “as a

whole, whose body and mind are linked and who needs to be treated with dignity and respect”,¹⁹ as well as must guarantee the equality and non-discrimination to access health care services. In its attempts to enforce this right, the State should adjust to State’s available resources and may not be able to fulfill all of the elements of the right. The right to health also must ensure the development of the six building blocks of health systems including health care delivery, health workforce, health information systems, access to essential medicines, health systems financing, and leadership and governance. These all blocks are crucial to be applied and integrated with the right to the highest attainable standard of health.¹² Therefore, assessing the four basic elements of the rights to health would answer the six building blocks of health systems.²⁰ For example, a building block of “leadership, governance, and stewardship” encompasses many elements including planning, monitoring, and accountability. Fulfilling the right to the highest attainable standard of health requires effective planning.¹² Without good planning, the government cannot address progressive realization and resource availability which are crucial as the basic element of the right to health.

That important is ensuring that every attempt through improving three dimensions of coverage and strengthening the health system should provide essential elements explained in General Comment No. 14. Fulfilling the right to health has to contain four interrelated and essential elements and requires precise application according to prevailing conditions in each country.

3.2.1 Availability

Providing universal health coverage, the State should ensure that functioning public health and health care facilities, goods, and services are available sufficiently in terms of quantity within the State party. These will vary which depend on various factors, such as State’s resources and its developmental level. Moreover, the availability is not merely about health care, but includes the underlying determinants of health, such as adequate sanitation facilities, safe and potable drinking water, trained medical and professional health workers with domestically competitive salaries, and essential drugs.^{11,12}

3.2.2 Accessibility

Universal health coverage should provide health facilities, goods, and services which are accessible to all groups and consider the four overlapping dimensions.¹¹

a. Non discrimination.

The discrimination, especially to the most vulnerable or marginalized groups of the populations should be diminished. The State must provide those needed to fulfill the right to health without discrimination on any of the prohibited grounds.

b. Physical accessibility

Providing health care facilities, goods, and services should also consider that those are within safe physical reach for all, particularly vulnerable or marginalized groups. Those should be

placed in an accessible location and equipped by adequate access to building for persons with disabilities.

c. Economic accessibility

It is important to ensure that health facilities, goods, and services are affordable for all. Providing universal health coverage should consider the payment for health care services and any underlying determinants of health which is based on principle of equity. Universal health coverage has to solve affordability problems, particularly for the worse-off household who should not be burdened disproportionately with health expenses as compared to the better-off.

d. Information accessibility

People have the right to look for, receive, and disseminate information and ideas related to health issues. However, it should not infringe the confidentiality issues.

3.2.3 Acceptability

Providing universal health coverage should consider that health facilities, goods, and services are respectful of medical ethics and culturally appropriate. Cultures may vary across countries, even within a country, so that the State should regard the health care delivery to be respectful to cultures of individuals, minorities, gender, and any aspects related to confidentiality.

3.2.4 Quality

One of problems while providing universal health coverage is lacking quality of health care facilities, goods, and services. Whereas the quality of those needed to acquire good health status is required, the State has to ensure that health facilities, goods, and services are “scientifically and medically appropriate and of good quality”.¹¹ Universal health coverage must include provision of skilled health care workers, scientifically approved drugs and hospital equipment, and good building and facilities.

3.3 The role of policy actors in fulfilling the right to health

Fulfilling the right to health involves many policy actors while they altogether govern the health care. In recent years, the right to the highest attainable standard of health has become fundamental reasoning to strengthen the health system including providing universal health coverage. The national and international policy makers, together with courts, non-governmental organisations, and other stakeholders have attempted to adopt and apply features of the right into policy construction.²¹ They already recognize that a strong health system and policy alignment to the right to health is an essential element of a healthy and equitable society is growing. However, each policy actors play their roles considering their each perspective in governing health care. Some result in debates, clashes, coercions, or even promotion of smoothly democratization processes.

The first step to objectify the right to health is legal recognition. It does not need significant measures from the government, but also follow up actions from other policy actors including social

movements, health workers, activists, and Non-Government Organizations (NGOs). Otherwise, the legal recognition would be likely an empty promise. It is fascinating to look up the dynamic process among actors in enforcing legal recognition and how the legal basis for the implementation of universal health coverage is established. Further processes in setting the standard of more detailed provisions of health-related services and facilities also involve many policy actors.

Principally, there are three policy actors that are State, community and market.²² State, as a mode of governance, has hierarchical control and has the authority to develop regulation in governing health care. The motive of the State through the central and local government regulation is minimizing risk of the uncovered people²² and ensuring the compliance to health rights. Forced by international and local legal instruments to provide the highest attainable standard of health, the government also considers that neglecting poor people to keep paying their health expenses out-of-pocket results in negative national financial effect. However, the government has to deal with limited resources. The governments, particularly in low-income countries, often lack sufficient domestic budget revenues to ensure the basic benefit package of health services.¹⁵

In the other hand, community has another power to influence health policy. Community includes lay people, labor or workers, social organization, NGOs, or activist basing their work in the community. The influences often come from labor community who force the government to establish social protection for them although other communities may have other potential influences. The community involvement is certainly a principal aspect in obtaining the highest attainable standard of health. The States also have a human right responsibility to encourage community participation including disadvantaged communities.¹² A long run health care reform shows dynamic interactions between State and community. Community may force the State to introduce legal and policy products as tools of governance during the reform.²³ Whereas, State through its legal and policy products also affect community behavior in seeking health care services.

The third actors in governing health care, *the market*, may not have a direct relationship like State and community. It lies in a more complicated circumstance which also include the campaigned policy of candidate of president, governor, or regent as well as decentralization issue which have recently appeared since 2001. Decentralization has a critical role in achieving universal health coverage since decentralization is considered to be able to improve the provision of social services.²⁴ It gives more authorities to local government to administer health program than before including its budget to provide health services to local citizens. Decentralization may deliver positive results in some extents, but also raises a problem in terms of equality. Some province or district may be able to provide universal access to health care, whereas the remaining may not. Decentralization also allows governor or mayor/regent candidate to campaign their promises on “health for free” regardless its local financial capacity. These are policy dynamism which may affect the implementation of universal health coverage. Whether this dynamic process, including development of local legal and policy

instruments, is attempted to fulfill the right to the highest attainable standard of health should be analyzed.

The market may be also potential beneficiaries of health insurance scheme. In particular, formal workers and employers, as well as informal workers, are 'market' of government's health insurance products. Using common pattern of social insurance scheme for formal worker, setting 'premium' and benefit package may lead to debates. In addition, informal workers lie on difficult position in terms of using financing scheme. Whether they are included to social insurance scheme or tax-revenue generated scheme remains debatable in many countries and challenging. How policy actors respond to these issues may also vary among countries.

These three actors interact with each others in their attempts to fulfill the right to health. How they influence each other to develop legal and policy instruments is one of examples promoting the health care reform. Other interaction, which is potential to induce clash, is how they manage priority setting to fulfill the right to health and providing universal access. Some policy actors rather use legal and human right perspective to set the priority, whereas others may prefer to consider economic perspective and regard to States' resources. Universal health coverage, in a particular issue, manages packages of health-care interventions at public health care facilities to all beneficiaries. To some extent it burdens resources either financial, health workers or facilities which enforces the priority setting. The government then requires to clarify the benefit package, especially for high-cost interventions, to contain costs²⁵ and provision of health workers and facilities to handle the numbers of patients.

It is interesting to analyze the interaction among actors whether it would be favorable or unfavorable factor in attempts to fulfill the right to health through universal health coverage. Thailand and Philippines, for instance, have a different pattern of interactions among policy actors. While Thailand's health system reform was part of large design to restructure the relationship between the State and civil society and democratization process, Philippines' health system reform was considered as business-as-usual and was not a monumental process.²⁶ Four groups of actors played prominent roles in Thailand's progress towards universal coverage. The researchers provide the evidence and the design of the system, the politicians made the decision to develop universal coverage, allocate resources and enact legislation, the reformists aided to bridge the gap between researchers and politicians, and the constituencies and civil organizations insisted pressure on the politicians.²⁷ Clashes among actors are inevitable process. While Philippines run the reform finer than Thailand, the health care reform to fulfill the right to health through universal health coverage in Indonesia requires to be explored.

4. Method

4.1 Study design

This is a literature review to analyze the achievement and weaknesses of the health care reform wave in Indonesia in terms of providing the right to health, then to provide recommendations prior to the implementation of universal health coverage. This study limits time framework included in exploration of health care reform from 1998 to 2013. The 1998 era was an important point since the Indonesian reform took place at that year after the economic crisis. This period also urged policy makers to begin an accelerated health care reform with a main goal to achieve universal health coverage.

In order to obtain an adequate analysis, a systematic literature review is required²⁸. This study will explore literatures from some sources including Indonesian databases, scientific databases (searched by Google Scholar, PubMed, and WebScience), local and international case law, as well as WHO, World Bank and the Joint Learning Network (JLN) for Universal Health Coverage databases. This study also set Thailand and Philippines, neighbored developing countries, as the benchmarks to recognize whether Indonesian efforts genuinely improve and realize progressively the right to the highest attainable standard of health.²⁹

4.2 Literature and data collection

This study uses some keywords while searching in scientific databases which are “health care reform” OR “universal coverage” AND “Indonesia” to find relevant literatures then expands to other related articles. This study includes only books, articles, reports, and data published in English and Bahasa Indonesia. The chosen scientific databases are Web Science, PubMed, and Google Scholar. This study obtains local data from Ministry of Health of Republic Indonesia as well as looks for articles, books and data from international databases, such as WHO, United Nations, World Bank and JLN, in order to strengthen the exploration. Because of its time framework, this study will only take books, articles, reports, and data launched from 2000 to 2013. This study excludes editorials, comments, and letters obtained from literature searching. Books, articles, reports, and data which do not explicitly describe or analyze Indonesian health care reform situation are noted as irrelevant literatures and are excluded.

4.3 Literature and data analysis

Literatures obtained from literature searching are filtered according to language (only literature in English and Bahasa Indonesia included), study population, and precise topic. The filtered literatures and data are analyzed to describe policy perspective (history of the reform, the legal and policy instruments developed during the health care reform, and the interaction among policy actors) and legal perspective (human right assessment on three dimensions of coverage, availability, accessibility,

acceptability and quality). Data of coverage, health expenditure, and benefit package are obtained from the most available valid sources which provide continuous publication from 2000 to 2012. This study adapts guideline questionnaire of impact assessment, poverty and human rights from Hunt (2006)¹⁰ to assess the achievement of health care reform in fulfilling the right to health (Table 1). Analysis is exploratory to find out history, current status, shortcomings, and recommendation. This study also compares Indonesia with other developing country, such as Thailand and Philippines in order to strengthen explanation. Thailand and Philippines are designated as the benchmark because both are developing countries like Indonesia and are neighboring to Indonesia in South-East Asia region.

Table 1. Guideline assessment of four important elements, adapted from Hunt (2006).

Right to Health	Health goods, facilities and services
Available	Does the policy enhance or jeopardize the availability, throughout the country, of <ul style="list-style-type: none"> - (functioning) health care services including Puskesmas and hospitals? - trained health professionals receiving domestically competitive salaries? - essential medicines as defined by the World Health Organization? - programmes for prevention, treatment and control of epidemic and endemic diseases?
Accessible	Does the policy enhance or jeopardize accessibility of health goods, facilities and services <ul style="list-style-type: none"> - without discrimination on any of the prohibited grounds? - in terms of the physical distance from, and the public transportation available to access, facilities, goods and services, particularly in rural and poor areas? - in economic terms, including potential health care-related impacts on resource allocations, health insurance, free health care or user fees?
Acceptable	Does the policy enhance or jeopardize the acceptability of health facilities goods and services, specifically by respecting <ul style="list-style-type: none"> - the requirement of informed consent for all medical treatment? - the confidentiality of personal health information? - the cultures of individuals, minorities, peoples and communities?
Quality	Does the policy enhance or jeopardize the quality of <ul style="list-style-type: none"> - health care to address the physical and mental health needs in the country? - Puskemas, hospitals, and other health related buildings? - scientifically and medically appropriate hospital, clinic and laboratory equipment? - skilled health professionals trained to address the health needs in the community?

5. Indonesian health care reform: a brief history

A long history of Indonesian health care reform began after its independence. The government established Asuransi Kesehatan (Askes) Persero as health insurance agency for civil servants and their families in 1968 and Jaminan Sosial Tenaga Kerja (Jamsostek) for private employees and employers in 1992. These two insurance schemes and private health insurance have run until 2013. An economic crisis occurred in 1998 was a critical point to accelerate health care reform. The crisis influenced people's health status through diminished household purchasing power to obtain commodities influencing health status including foods, good housing and preventive health care services.^{30,31} Health insurance scheme limited to Askes and Jamsostek, whereas the majority of people remained rely on out-of-pocket payments instead of having covered by any health insurance system. This condition let people set accessing health care service in low priority after other main daily needs.^{13,30-32} Despite the negative situation after the crisis, the Indonesian health policy makers viewed an opportunity to accelerate health care reform³¹.

In response to the economic crisis, this health care financing reform then introduced some pro-poor financing health insurance. The first immediate response was the development of Social Safety Net for Health (Jaringan Pengaman Sosial, JPS) which was followed by various community-based and voluntary initiatives programs including Village Community Development (Pembangunan Kesehatan Masyarakat Desa) and community-managed health care (Jaminan Pemeliharaan Kesehatan Masyarakat, JPKM) scheme, a model copied from health maintenance organizations in the US.^{13,30,33} These schemes increased health insurance coverage from 14% up to 20% of the total population in 2000.

After the passage of National Social Security System (Sistem Jaminan Sosial Nasional, SJSN) Act in 2004, the government introduced a new pro-poor health insurance scheme, Health Insurance for the Poor (Asuransi Kesehatan Masyarakat Miskin, Askeskin). This scheme was different from the previous insurance schemes since it provided a block grant to PT Askes instead of a purely government-directed program. PT Askes took over government role in targeting the poor with Askeskin card which were individually targeted and refunded hospital claims. In 2008, the government changed Askeskin to Community Health Security (Jaminan Kesehatan Masyarakat, Jamkesmas) with some improvements including the widening coverage to poor and near-poor households.¹³ Jamkesmas used data from a national poverty census of Indonesian Central Statistic Agency (Badan Pusat Statistik, BPS) conducted in 2005 to identify the poor and near-poor. By a combination of means testing and local government eligibility criteria, a list of quotas for the eligible beneficiaries of Jamkesmas for each district was produced.³⁴ This scheme had been successful in increasing insurance coverage from 36.1 million to 76.4 million in 2008.

5.1 Indonesian health care system

While the health care financing system has changed progressively overtime, Indonesian health care delivery system has changed in very modest way. The Ministry of Health (MoH) is fully responsible for national health policy and management of public health care services. The MoH has the authority to employ public health care professional and other key staffs and to manage main vertical control programs such as tuberculosis, malaria, and HIV/AIDS.³³ In some extent, despite decentralization policy, the MoH remains to allocate public health care professionals resulting in some problems as explained below. Since the implemented decentralization policy, the MoH does not run national health insurance itself, but local governments and private sectors play their significant role as financiers.

Health care delivery system in Indonesia is a mixed public-private health care provision.³⁴ While public providers have dominated the health care services in a rural area and secondary-level health care services, private providers are much concentrated in the urban area and are mostly for secondary and tertiary-level health care services. The MoH and local governments set the primary health centers, named as Pusat Kesehatan Masyarakat (Puskesmas), as the linchpin of basic and primary care services and provide wide-range program from preventive to rehabilitative care. Puskesmas operate in sub-district and village level while some districts provide supported Puskesmas (Puskesmas Pembantu, Pustu) to reach remote area. The MoH and local government establish public district-level hospitals for curative care ranging in secondary and tertiary-level, supported by private hospital.

A good health system should build a good referral system. In fact, the government has developed referral system through health care regulation, but the system has not functioned properly, particularly in the urban area. People may seek care directly to secondary health care services without any referrals from primary health care services. Primary care service does not function as gate keeper except for those who are covered with Askes and Jamsostek. The insurance coverage has influenced the health seeking behavior and the implementation of referral system in Indonesia. Since most people spend their health care cost by out-of-pocket payment, they are not restricted to access secondary and tertiary-level. Implementing health insurance should avoid the infringement of primary-level care because the health insurance scheme will not cover or reimburse beneficiaries' health care cost without referral. The new insurance scheme of Jamkesmas may resolve the problem and improve the referral system. Beside it allows free access to Puskesmas for its beneficiary, it also requires Puskesmas as gate keeper to screen the cases which should be referred to the higher-level of care. However, it is not applicable for private primary health care services so that the appropriate referral system runs in limited public services.

Askes, Jamsostek, and Jamkesmas cover both outpatient and inpatient services costs at secondary and tertiary public hospital as well as some designated private hospitals. The government is

fully responsible to finance Jamkesmas program from national revenues and cover health care costs without cost sharing for its beneficiaries. It is different from Askes and Jamsostek program at which the beneficiaries should contribute monthly premium (See further *Three dimensions of coverage*).

5.2 *The policy actors and developed legal instruments*

There are some policy actors playing roles during the Indonesian health care reform including central and local governments, political parties, and community pressure groups. The central government plays the most prominent role in Indonesian health care reform through its hierarchical control and authority to develop regulation. The ultimate motive is providing the right to health to all population and minimizing risk of the uncovered people.²² The decentralization regulation gives more mandates to local government than before in managing provinces or districts health policies. Besides the government, the social domestic pressure are widespread, varied and persistent to achieve universal health coverage in Indonesia.³⁵ Some political parties in House of Representative and some pressure groups from communities, identified as “cause groups”, also force the government to ensure the implementation of universal health coverage.³⁶ While political parties force the government through legislation issue in parliamentary, community pressure groups which are voluntary and do not attempt to become part of formal government machinery force the government through demonstrations, public criticisms, and files lawsuit to public court. These groups establish and continue to grow after the political reform which overthrew a long dictatorship of New Order regime and provided freedom of speech in public area (Figure 2).

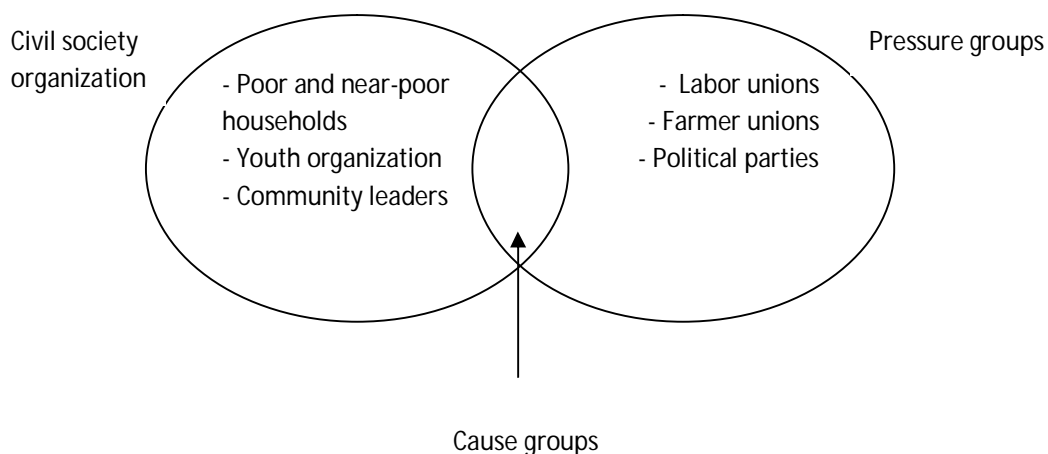


Figure 2. The construction of civil society organizations and pressure groups as policy actors within Indonesian movement toward universal health coverage. Labor and farmer unions are identified as market-related sectional pressure groups while others are civil society organization. The combination creates “cause groups” which force the implementation of universal health coverage.³⁶

This interaction encouraged the government and the House of Representatives to issue some legal and policy instruments regarding universal health coverage (Table 2). The first attempt was amending the 1945 Constitution which prescribed the rights to health care and the right to social security.³⁵ The amendment underlines that “each citizens has rights to social security which allows their self development as a human being with dignity” and “the State develops social security system to all Indonesia people and empowers the weak that is incapable in accordance with human dignity”.³⁷ The government then passed The National Social Security Act No 40 of 2004 as a basic platform of universal coverage which mandates the development of several social security schemes for citizens including old-age pension and savings, national health insurance, and work accident insurance. This Act also prosecutes that national health insurance should cover all Indonesian citizens including the informal workers, the unemployed, and the poor.

However, the efforts have to deal with various constraints. Financial constraints made the government delay the implementation of universal health coverage and prefer to launch Askeskin scheme instead of providing universal health coverage as mandated by The National Social Security Act. Although Askeskin was considered as initial platform of universal coverage,³³ this scheme is different from universal health coverage. This scheme only provided social health insurance for the poor while the near-poor people remained struggling to access health care services. They were excluded from Askes and Jamsostek beneficiaries while obtaining private health insurances were nearly impossible regarding the premium. Dealing with these conditions, the government responded the criticism by changing Askeskin to Jamkesmas in 2008 which has enlarged beneficiaries reaching the near-poor household.

Despite this success of enlarging coverage, criticism remains persistent. Even, the number of private employers which comply with Jamsostek was very small resulting in the high number of uncovered labor. Labor and farmer unions, student and youth organizations, and community leaders establish a “pressure group” (Figure 1), Social Security Action Committee (Komite Aksi Jaminan Sosial, KAJS). The principal criticisms are (1) Jamkesmas is not a universal health coverage program as mandated by Act of 2004 and (2) the government does not truly establish active implementing regulation and national insurance agency regulation. They filed a lawsuit to public court in 2010 with registration number of 278/PDT.G/PN.JKT.PST in order to sue Indonesian president, vice president, head of House of Representative, and some ministers in the cabinet because of failure to implement universal health coverage. This suit resulted an enormous pressure for the government to carry out the Act of 2004 mandate. The public court decided in favor that the government must enact Social Security Agency Act, create implementing regulation of social security, and adjust existing insurance companies according to the Act of 2004.

This pressure resulted in the passage of Social Security Agency Act No 24 of 2011. The passage was monumental when thousands of labor workforces demonstrated in front of House of Representative building to force the passage of the Act, supported by few of political figures.

However, social movement keeps struggling to monitor the implementation of the Act. Debates remain in public area to define benefit package, amount of premium, and additional number of beneficiaries.

Table 2. History of Indonesian health care reform and developed legal and policy instruments

Year	Initiatives
1968	Health insurance for civil servants – Asuransi Kesehatan (Askes).
1992	Social security for private sector employees – Jaminan Sosial Tenaga Kerja (Jamsostek).
1997-1998	Economic crisis.
1999	The initiation of Social Safety Net – Jaminan Pengaman Sosial (JPS), assisted by Asian Development Bank loan.
2000	The amendment of 1945 Constitution including prescribing the rights to health care. JPS scheme was changed into community-managed health care scheme – Jaminan Pemeliharaan Kesehatan Masyarakat (JPKM)
2001	The passage of Decentralization Act.
2002	The amendment of 1945 Constitution on the right to social security.
2004	The passage of National Social Security System Act – Sistem Jaminan Sosial Nasional (SJSN).
2005	The implementation of Askeskin. Extension of insurance coverage to 36.4 million poor people.
2008	Askeskin scheme was changed into Community Health Insurance – Jaminan Kesehatan Masyarakat (Jamkesmas). Extension of coverage for poor and near-poor up to 76.4 million people.
2009	Implementation of Local Health Insurance – Jaminan Kesehatan Daerah (Jamkesda). Because of decentralization, this scheme has been delivered by provincial/district government.
2010	The citizen lawsuit which demanded the implementation of universal coverage. The lawsuit was granted by public court in 2011.
2011	The passage of Social Security Agency Act No 24 of 2011 – Badan Penyelenggara Jaminan Sosial (BPJS).
2012-2013	The preparation of BPJS, including formulation of benefit packages and premium.
2014	Planned implementation.

Source: Adapted from Thabrany (2003) and Rokx et al (2009).^{30,33}

5.3 Decentralization: a confounding issue

Attempts to provide large access to health care have also coincided in local level. After the enactment of Decentralization Act in 2001, profound changes in the responsibility for the provision of health care services are applied. Both provincial and district level governments have larger authority to manage and regulate their financial system, including their health care system, workforces, and spending. Under decentralization policy, districts have independence and responsibility to manage employment, deployment, and payments of health care professionals.³⁸ However, local capacities to manage their systems vary across the country. Local capacity empowerment, coaching, monitoring, and training from central government were exceedingly limited including in health sector.³⁹ Considering this condition, the MoH is still involved in planning and managing local health care resources and programs. It results in overlapping authorities in managing health care and complicates the implementation.

Decentralization is initially assumed to address local needs while the local governments have the authority to align provision of health care services and resources. Prior to the introduction of Jamkesmas, local governments were allowed to introduce their own local insurance scheme for the poor if they wanted. However, some studies suggest that decentralization in Indonesia much depends on temporary local elite interests rather than establishing sustainable system which promotes pro-poor policy. Jembrana and Tabanan cases were the example of high-dependency policy to local elite interest. These two districts lie on similar province, but Jembrana's health policy was much more pro-poor than Tabanan because of its elite interest.⁴⁰ The regent of Jembrana who was a dentist developed a local-based insurance scheme which provided free access to health care services. This local policy was a monumental because it was launched much before Jamkesda policy was issued. However, the regent did not develop a strong local legal instrument and left it depending on elite interest. After the tenure of Jembrana regent expired, the policy was changed and became more unfavorable for the poor.

Moreover, decentralization has changed the mode of the governor and regent/mayor elections. Health insurance coverage is one of the most popular issues in elections. Each candidate may promise to provide free health care services to their constituents, regardless its local financial capability. When elected, the candidates pawned by their promises and have to deal with factual financial constraints. Poorly, their promises have overlapped with Jaminan Kesehatan Daerah (Jamkesda) scheme, a local health insurance designated by central government regulation to cover those who have not been covered with Jamkesmas. As results, some provinces/districts may manage their local resources effectively to provide local health insurance, whereas others have to face the chaos of the health system. The most recent case is 'Jakarta Health Card' promoted by Jakarta elected governor in 2012. It has resulted in poor quality of health care services instead of providing more access to people.

Decentralization causes some problems in availability and quality of health care professionals and facilities. Since the authorities for employment, deployment, and payment of health care professionals shift to local government,³⁸ availability of health care professionals and facilities vary among provinces and districts. Each local government has each capacity to employ health care professionals as civil workers, as well as has each resource to build public health facilities. Unlinked coordination between central and local authorities aggravates the availability (See further *Availability*). In terms of quality, some district offices take dubious measures by establishing new district-level health schools for nurses and midwives. By only providing Diploma-1 courses (one-year course) with poor facilities and teachers, the quality of graduates is under standard. This worsens the health care delivery instead of providing more health care professionals in local level (See further *Quality*).

6. Impacts of health care reform on right to the highest attainable standard of health

The basic motivation of Indonesian moving toward universal health coverage is the fulfillment of citizen's right to the highest attainable standard of health. However, most studies capture it from the economic perspective instead of whether the movement has truly fulfilled people's rights to health in terms of legal and human right perspective. Universal health coverage itself is defined in its simplest form as a system which produces access to health care for everyone without incurring financial hardship. Then, its achievement is assessed by three main factors which are "who is covered", "which services are covered", and "what proportion of financial contribution".^{35,41}

6.1 Three dimensions of coverage

Health insurance schemes produced during the reform have been successful to increase the number of beneficiaries, particularly the worse-off. A covered people increase from 41.7% before the introduction of Askeskin to 63.2% after the implementation of Jamkesmas and Jamkesda. Even though the government has claimed that there was a significant increase of beneficiaries from 36.1 million in initial Askeskin scheme to 76.4 million in Jamkesmas scheme, the change has not been fundamentally striking. Calculated from JPKM and health card schemes which have been gradually removed, the increase of beneficiaries has been 10 million (15.1%) from 2005 to 2012. That play a significant role in covering the uncovered people has been Jamkesda scheme from local government. This scheme has supported to overcome Jamkesmas shortage in terms of coverage. Its expansion has been able to cover additional 21 million people (210.0%) within four years (Table 3).

Table 3. The estimated number of health insurance beneficiaries.

Schemes	2005	2008	2012	2014	Thailand	Philippines
Askes	14,612,789	13,619,991	17,274,520	^c	9% ^d	6% ^g
Asabri		2,000,000	2,200,000	^c		
Jamsostek	4,515,254	5,393,151	5,600,000	7,700,000	10% ^e	18.5% ^h
Private insurance	5,438,801	6,192,982	15,351,532	^c	2%	10.1% ⁱ
Jamkesmas, national	66,233,472*	76,400,000	76,400,000	86,400,000	73% ^f	39.4% ^j
Jamkesda, local	^a	10,800,000	31,866,390	^c		
Commercial Askes	^b	^b	2,856,539	^c		6.2% ^k
Total covered (%)	90,330,308 (41.7%)	114,406,124 (50.1%)	151,548,981 (63.2%)	176,948,981 (73.4%)	95%	80.2%
Total uncovered (%)	126,469,634 (58.3%)	114,033,148 (49.9%)	88,209,619 (36.8%)	64,051,019 (26.6%)	5%	19.8%

^aJamkesmas and Jamkesda were not introduced yet in 2005. The previous schemes were JPKM and health card; ^bCommercial Askes has been launched in 2009, ^cNo data estimation, ^dCivil servant medical benefit scheme, ^eSocial security scheme, ^fUniversal coverage scheme, ^gGovernment employed, ^hPrivate employed, ⁱIndividually-paying program, ^jSponsored program, ^kOthers (overseas workers program and lifetime program). Sources: Ministry of Health Republic of Indonesia,^{42,43} Evans et al (2012),⁴⁴ and Philippine Health Insurance Corporation⁴⁵.

Decentralization, in one hand, aids the central government to improve insurance coverage through Jamkesda scheme which has been implemented in 33 provinces and 349 districts. However, in the other hand, it also creates disparities among provinces which rely heavily on their financial resources. Some provinces, such as Nanggroe Aceh Darussalam (NAD), South Sumatra, Bali, and South Sulawesi provinces, have been successful to promote their local universal coverage through local political power, whereas other provinces like Jambi, Jakarta and Banten provinces has still struggled with their under-50% coverage.

Another insurance scheme which has increased its beneficiaries significantly is private insurance. The increase has been 300% within 7 years meaning that there have been increased people's financial capabilities to buy private insurance premium and improved awareness to cover themselves by private insurance, particularly in urban cities.

These trends had increased significantly Indonesian health expenditure per capita from US\$ 15.8 in 2000 to US\$ 76.9 in 2010. Health expenditure as a percentage of GDP had increased from 1.97% in 2000 to 2.61% in 2012. The government has shown a vast intention to provide larger access to health care service as indicated by increased public health expenditure as both percentage of government expenditure and total health expenditure. The public share has shown

an increase from 36.6% in 2000 to 49.1% in 2012 even though private health expenditure has remained greater than public health expenditure until 2010 (Table 4).

Private health expenditure has played a more decisive role than public health spending before 2005. However, this trend started to change in 2005. The introduction of Askeskin, followed by Jamkesmas, scheme was the important starting point, which increased public health expenditure and total health expenditure, while the share of OOP spending dropped relatively to public and private shares of total health expenditure.³⁸ Compared to other developing countries in South East Asia, current public share of health expenditure is higher than Philippines (49.1% vs 35.3%), but is much less than Thailand (vs 75.0%) which has been successful to provide universal health coverage.

Despite improved coverage, the total health insurance coverage in Indonesia remains much lower than Thailand and Philippines. A low coverage to formal workers group may be the cause. The proportion of coverage for formal workers in Indonesia was only 2.3% in 2012 and will be proposed only up to 3% in 2014. It is much lower than Thailand and Philippines which are the proportion for formal sector coverage are 10% and 18.5%, respectively. The government should encourage more employers to involve in Jamsostek scheme and offer better benefit package to entice them to involve.

The informal worker group, the neglected group who are mostly not covered, is a challenge for the government to improve the coverage. The difficulty to reach this 'neglected group' is related to how to define its financing approach. Many countries use two common formal financing approaches that are social health insurance for formal workers and general tax finance for the poor and vulnerable groups. The informal workers are "squeezing the middle".⁴⁶ This group is not covered with Jamsostek, nor entitled to Jamkesmas scheme because most of them are not eligible as poor or near-poor. However, this group remains vulnerable to catastrophic health care spending. They will have difficulty to access appropriate health care services when experiencing chronic illness or high-cost treatment. A new scheme offering a low premium or 'similar' premium with Askes or Jamsostek beneficiaries to informal workers may be the alternative to solve.

In terms of "what services are covered" and "what proportion of financial contribution", the government has improved benefit package. Benefit packages of Askes and Jamsostek have been unchanged even with the reform. However, Jamkesmas scheme provides better benefit package for the poor than previous pro-poor scheme as JPKM or health card. Jamkesmas provides a comprehensive package from primary care in Puskesmas to secondary or tertiary care in hospital. The benefit package has not much differ from Askes and Jamsostek scheme, even better in some services. One of advantages of Jamkesmas compared to Askes is more options of hospital. Jamkesmas

beneficiaries may access private hospitals in addition to public hospitals while Askes can only access designated public health care services (See Annex 1).

Table 4. The Indonesian health expenditure and its comparison to neighboring countries.

Indicator	2000	2005	2010	Thailand (2010)	Philippines (2010)
Health expenditure per capita (current US\$)	15.84	26.84	76.89	179.15	77.33
Health expenditure per capita, PPP (constant 2005 international \$)	46.77	66.22	112.07	329.71	142.36
Health expenditure, private (% of GDP)	1.25	1.06	1.33	0.97	2.34
Health expenditure, public (% of GDP)	0.72	1.00	1.28	2.91	1.28
Health expenditure, public (% of government expenditure)	4.53	5.43	7.75	12.70	7.55
Health expenditure, public (% of total health expenditure)	36.60	48.47	49.08	75.04	35.34
Health expenditure, total (% of GDP)	1.97	2.06	2.61	3.88	3.61

Sources: World Development Index, World Bank.

Jamkesmas also provides access to health care service without cost sharing. Its beneficiaries may obtain primary care and full inpatient service in class 3 for free. The limitation is that they cannot upgrade to class 2 or 1, except there is epidemic state or exceptional circumstances which leads to overloaded of patients and fully charged class 3 services. Askes charges cost sharing, particularly for exceeding Askes package. The benefit package of Askes may differ depending on position and rank of civil servants as beneficiary. Compared to JPKM, Jamkesmas is much better for the poor in terms of the benefit package and cost-sharing. JPKM, adopted from American HMO-design, is more like a commercial health insurance rather than social health insurance. Therefore, considered as mistargeting and incomppliance to equitable-oriented health care system, JPKM for poor had been downgraded.

These differences among benefit packages provided by different scheme may raise equity issue. However, the gap of benefit packages among the schemes is still acceptable. The most important is everyone can access the primary to tertiary-level of care facilities. The difference in the class of a ward is nothing worth to be debated.

6.2 Availability

Using guideline assessment by Hunt (2006)¹⁰, this study assess the availability from four basic elements of availability which are (1) (functioning) health care facilities including Puskesmas and hospitals, (2) trained health care professionals and the salary, (3) essential medicines defined by the WHO, and (4) programs dealing with epidemic and endemic diseases.

The government has been successful to improve the number of public primary care which is the most essential care within community (See Table 5). Primary health care service growth has

occurred in both urban and rural area despite remaining insufficient number. Puskesmas with inpatient service has grown mainly in the urban area while Puskesmas without inpatient service and supported Puskesmas have shown a significant growth in the rural area. Pustu, supported Puskesmas without doctors, is designed by the government to reach remote area. It is still questionable policy regarding to attempts of providing universal health coverage since Pustu do not provide good quality of care, do not operate regularly, and lack of drugs and diagnostic kits. Moreover, Harimurti et al (2013) found that 25% of Puskesmas has been unattended by doctors.³⁴ This problem of absenteeism occurs in some other developing countries which may be caused by poor incentives, unfavorable limited access and designated bargaining between government and doctor.⁴⁷

Table 5. The growing number of health facilities.

Types	2001	2005	2011
Puskesmas			
With inpatient service	1818	2077	3019
Without inpatient service	5416	5592	6302
Supported Puskesmas (Pustu)	20286	22171	<i>No data</i>
Public hospital	527	564	751
Private hospital	618	704	970

Sources: Indonesian Health Profile 2001, 2006 and 2011.

Indonesia has had a consistent growth of both public and private hospital within 10 years, but it has been concentrated in the urban area resulting in high discrepancy between urban and rural area.^{38,42,43,48,49} Private hospital, in particularly, which is likely to be profit-oriented has preferred to operate in the urban city with better financial capacity of the market rather than in the rural area. Even newly public hospitals have been built in the urban-like area instead of reaching rural area. The government has planned a system of providing health care services including building the ‘pratama’ hospitals in new 42 districts and Puskesmas in 383 sub-districts. However, this plan remains unclear in terms of unclear responsibility between central and local government. The term of ‘pratama’ hospital is also debatable and is fully criticized in terms of its purpose and conformity with national health system.

Similar problem has occurred on available trained health care professionals (See Table 6). Despite the increase, ratio of doctor per 100,000 populations has remained low with a low production rate of new doctors and restricted capacity for the public employment.^{34,42,43,49,50} Data sources from the MoH show less doctor compared to data source from the Indonesian Medical Council (Konsil Kedokteran Indonesia, KKI).⁴⁸Data from the KKI which indicates registered and graduated doctor do not represent actual number of practicing doctors. Therefore, this study uses data of trained health care professionals from the MoH. However, the availability of trained health care professionals is

constrained by data validity and reliability. Number of general practitioners and nurses decrease from 2006 to 2011 which is questionable. Indonesia has 72 medical schools which certainly produce new graduated general practitioners every year. Negative growth of doctor stock influences is not likely to occur. This is a critical issue to be solved. The government should correct firstly the estimation of trained health care professionals before analyzes and develops some strategies to increase the number of trained health care professionals. Otherwise, strategies will not improve the stocks effectively. The government, the Indonesian Medical Association (IMA) and the KKI have to revise their method in registering the health care professional and complement which each other instead of solely relying on self-registry data. The database has to be updated regularly either in local and national level to portray the availability of health care professionals countrywide.

Nevertheless, the shortage of trained health care professional is evident. The stock of trained health care professional in Indonesia is lower than Thailand and Philippines. Thailand, which has already achieved universal health coverage, has provided a high number of health care professional above the minimum requirement (20:100,000 populations). Philippines is another case because of the high rate of migrated health care professional to other countries, particularly general practitioners and midwives. The shortage of health care professional in Philippines has been a foremost concern in other developing countries, called as 'brain drain', that worsen the already depleted healthcare professional resources in poor and developing countries and widens the gap in health inequities worldwide.⁵¹ Exporting health care professional has already happened in Indonesia since many years ago, but in a limited number with nurses as the majority of exported resources.

Regarding the shortage of quantity, the government through the MoH and the Ministry of Education and Culture (MoEC) has encouraged the development of new medical school to overcome the shortage, but other problems arise. First, new medical schools are dominated by private institutions in the urban area which require high tuition fee. It allows much more the better-off group who are mostly from the urban area to enter medical school. The graduates then prefer to practice in the urban area rather than in rural and remote area, coupled with economic reason to obtain higher wage. Second, the quality of new medical schools in a rural area is doubtful. With limited facilities and resources, they may produce low quality of health professionals (See further *Quality*).

Further challenge for the government is solving inequality problem. The inequality between urban and rural area occurs commonly in many countries, especially in countries with large territories. It is clear that local health development corresponds to local economic development. Remained economic development gap among provinces or districts causes trained health care professionals prefer to practice in urban than rural area.

The gap between urban and rural area is likely because of deployment policy. In the late 1960s and 1970s, the MoH launched a policy of mandatory work for civil workers to serve a certain period in determined health facilities. Until the late of 1990s, all fresh graduated medical students were obliged to serve 2-5 years at Puskesmas which its locations were designated by the MoH. After

serving in rural and remote area, they would be able to obtain a license to self-practice and were more likely to be accepted at specialist training. Doing this program, Indonesia was actually close to achieve universal coverage in terms of primary and basic care. However, the reform wave launched contradicting policy which terminated employment of new civil workers and placement of fresh graduated medical students to rural and remote area. This policy that has terminated the assignment of fresh-graduated general practitioners as temporary workers in a rural area resulting in shortage of general practitioners in rural and remote area.³⁸

Decentralization, in the other side, creates confusing coordination between central and local government. Diminished number of public employment including health care professionals as civil workers is evident.³⁴ Central government devolves authority of recruiting trained health care professionals as new civil servants to local government whereas there are limitations of local governments' financial capabilities to pay (new) health staff. These are contradicting policies produced by the government. While the availability of trained health care professionals is a critical element in providing universal health access, the government issues negative policies against the initial goal.

Table 6. The number of health care professionals in Indonesia.

Type	2001	2005	2011	Thailand (2007)	Philippines (2011)
	n (ratio) ^a	n (ratio) ^a	n (ratio) ^a	n (ratio) ^a	n (ratio) ^a
Specialist	6,039 (2.9)	11,765 (5.4)	16,836 (7.1)		12,701 (13.4)
General physician	15,428 (8.9)	40,963 (18.7)	32,492 (13.8)	22,000 (35.7) ^b	10,773 (11.4)
Nurse	70,857 (40.3)	284,039 (129.8)	220,575 (93.5)	110,000 (142.8)	
Midwife	16,103 (7.9)	73,201 (33.5)	124,164 (52.6)		522 (0.6)

^aRatio per 100,000 population, ^bNumber of total doctors (GP and specialist). Sources: Indonesian Health Profile,^{42,43,49} Evans et al (2012),⁴⁴ and PhilHealth⁵².

The salary of trained health care professional is also noteworthy. In promoting health rights, the government should not only ensure the availability of health care professional, but their salary should be competitive among local professional standard. The salary rate of general practitioners in Puskesmas is Rp 4,500,000 (US\$ 489) per month which is lower than the salary rate for nurses and midwives. With a high work burden, approximately 33 hours per week, this salary rate is extremely not competitive for trained health professional. Local government may give additional salary for those practicing in rural and remote area, but it remains insufficient because of the high price of basic commodities and transportation. The government must increase the salary rate for doctors in public health care services by developing a strong regulation about the standard of salary. A higher salary may invite more doctors to practice in rural and remote area as a good compensation.

The government has improved drugs availability in public health facilities. In 2010, the available essential medicine as defined by WHO in the majority of public health services was below 80% while only 15% of health facilities had 80% of essential medicines.³⁴ In 2011, 122 out of 135 (90.4%) essential medicine has already been available more than 80% from required medicines throughout the public health facilities.^{43,53} It has been a high rate of availability, but the classical problem of discrepancy between urban and rural has presented.

Unequal distribution of health care service, trained health care professionals, and available essential medicines are classical problems. These cause comprehensive benefit package meaningless for poor people in a rural area. Instead of obtaining comprehensive benefit package, they must receive limited health care services. They will not find hemodialysis, intensive or rehabilitative care, even they may not be able to access essential medicine and basic vaccination service because of limited access. Some diagnostic procedures such as sputum examination for diagnosing tuberculosis and malaria diagnostic kit are also scarce.

Regarding limited resources, the government has not taken action explicitly to ration health care. In demand side, the government provides access to health care access without cost sharing as a financial incentive. Limitation of the basic benefit package is also majorly modest (See *Annex*). It may be influenced by political pressure. While the government is forced to provide universal coverage, limitation to highly-needed treatment is not a popular policy which would reap a lot of public protests. In supply side, although health care resources are scarce, the government does not develop regulation to ration, for instance waiting list as many countries do. As the result, public health care services are not able to care patients which its number increases rapidly by the introduction of Jamkesmas. The implementation of 'Jakarta Health Card' is the most recent case. After the introduction of the program as additional local insurance scheme to Jamkesmas, the number of people seeking care has increased rapidly in both Puskesmas and hospital. The local government has developed a policy to increase supply of hospital instead of ration the health care on the grounds of human rights. This condition leads to low quality of care and inefficiency. About 16 private hospitals then decide to get out from Jamkesmas provider list since they are overwhelmed dealing with unusually high number of the patient and cannot contain the costs.

It is fascinating to analyze what the government's policy is to deal with this problem and what rationing policy will be taken. The most important policies are (1) strengthening Puskesmas function as gate keeper which should screen the cases properly prior to entering secondary and tertiary-level of care, (2) improving health care professional skills and primary health facilities which are considered as provided in low quality (See further *Quality*), and (3) strengthening the referral system from primary to secondary and tertiary-level of care. Demand-side rationing is likely not possible for Indonesian recent circumstances. Financial incentives and benefit package limitation would be considered as a negative-backward step while the government is attempting to provide universal health coverage.

6.3 Accessibility

Using guideline assessment by Hunt (2006),¹⁰ the accessibility is assessed in terms of (1) physically accessible which means that can be safely accessed by all section of the population including people in rural areas, (2) economically accessible which means that health care services are affordable to all population, and (3) accessible without discrimination on any of the prohibited grounds.

Physical accessibility is a critical problem particularly in a rural area while it is not a problematic issue for people in an urban area. This problem is also related to health care availability and financial constraints. In general, there is only one Puskesmas in each sub-district consisting of several villages. One public hospital may be operated for 1-3 neighboring districts. Physical constraints along with financial constraints because of transportation cost result in poor utilization of those existing public health facilities as Arifianto et al (2005) found after the introduction of JPK-Gakin, insurance scheme for poor in three rural district areas. Despite the free access to public health services, the physical constraint lead to high transportation costs which are not covered with any insurance scheme.⁵⁴ This problem also raised in national level and other schemes. Jamkesmas scheme indeed has improved its health care service network by involving more private hospitals.³⁴ However, using national data and in-depth interview, Utomo found that access gap between rich and poor has remained despite the improved access to health care after initializing Jamkesmas and Jamkesda. While the worse-off should spend health service cost which is not entirely free, they also have to deal with other cost during the health care visitation, such as medicine, transportation, food and drink.⁵⁵

The economical accessibility is closely related to groups and services covered by insurance scheme. Some legal instruments produced during the last 10 years have revealed improvement coverage as explained in previous sub-chapter. Almost all of studies showed that each insurance scheme improved health care utilization. However, despite it has been principally enacted by laws, the implementation may vary, and compliance to regulation remains unresolved. Arifianto (2005) found that although JPK-Gakin scheme has been addressed for the worse-off, its subsidy distribution is more pro-rich rather than pro-poor.⁵⁴ The government has remedied targeting problem in Askeskin and Jamkesmas scheme to become more pro-poor than pro-rich, but the indication of leakage to non-poor beneficiaries has remained high, up to 15.5%.^{34,56,57} These were aggravated by some indications of considerable illegal fees that the poor were required to buy Jamkesmas or Jamkesda card from a local official or community leaders.⁵⁷ It was proved that targeting beneficiaries depend highly on the strategy. Using respected community health workers named as “kader” was more effective to deliver the card appropriately rather than village officers.⁵⁴ The leakage problem should be immediately resolved by the government. Since universal health coverage should eliminate financial constraints in accessing health care services as much as possible, the leakage influences it negatively.

The efforts to relieve financial constraints are hampered by public health services which are widely perceived as delivering low quality service. People then prefer to seek care to private practices

at which social insurance cards are not acceptable.^{54,58} Another possible constraint for the poor to access public health care service is illegal fees which have remained widespread in public health care. Rosser (2012) reported that about 13.6% of public hospitals require illegal up-front payments before delivering services to poor people covered by either Jamkesmas or Jamkesda.⁵⁷ In addition to lowering accessibility, the illegal up-front payments also violate medical ethics. Since health care is health rights, health providers should not hinder anyone to obtain health care services because of financial, cultural, gender, or religion reasons. These problems create a paradoxical situation. While the government has tried to fulfill citizen's health right, health care services has not been economically accessible for the poor. Some solutions are proposed including the development of complaints mechanism as conducted in Jakarta health card program. People who are rejected from the hospital can easily send complaints via message center of "Jakarta Care". However, Provincial Health Office (PHO) has low capacity to handle the complaints so that leave the complaints neglected. In this case, NGOs have to play their important roles to hear people's problem in accessing health care services and advocate public interests in accessibility. Further, the government through the MoH and PHO has to ensure that no hospitals reject any cases for no reason and impose penalties for those violate the regulation including requiring illegal up-front payments.

In addition, Kristiansen and Santoso (2006) reported that attempt to provide universal health coverage has been more focus on treatment and curative care than preventive care. It implies a decreased 'social health services' priority including toilet and drinking water facilities which are also part of rights to health.⁵⁸ Preventive and social health services are substantial in fulfilling the right to health and assisting people to attain their good health status. Even, people in some region of Jakarta, the capital of Indonesia, have difficulties to access safe and potable drinking water. Those living near the Jakarta bay have to buy potable water in the barrel instead of drinking ground water mixed by salt-sea water. Greater problems are experienced by people in rural and remote area, for instance those living in Kalimantan close to the mining area or some arid regions.

In a comparative study across developing countries in South East Asia and Asia, unequal access much more for rich rather than poor is indicated in Indonesia because of the growing role of private care provision. There is a less domination of government in health care provision, particularly for poor.⁵⁹ Although all of insurance scheme has improved access to and utilization of health care services, the subsidy for non-hospital, hospital outpatient and hospital inpatient is unequal between the rich and the poor. Subsidy for poor is dominated for non-hospital care, whereas subsidy for hospital inpatient and outpatient care is pro-rich.⁶⁰ Some regulation indeed provide coverage guarantee for the poor, but physical and economical constraints have diminished factual accessibility.

In addition to physical and economical constraints, the accessibility is influenced by nontrivial administration matters, but published reports are limited. In the last two years, there were many published cases in the newspaper with indication of rejected cases to be hospitalized. The possible causes were holding 'false' or 'inappropriate' card and cross-district health care, regardless

the poor's right to receive any treatments. These indicate that many poor people remain neglected so that the discrimination, as many studies reported, is highly associated with economic status.

6.4 Acceptability

In terms of acceptability, health care facilities, goods, and services have to be respectful of medical ethics including the requirement of informed consent and confidentiality of personal health information, as well as culturally appropriate. Regarding to medical ethics consideration, the number of ethical violation has shown an increasing trend. Majelis Kehormatan Disiplin Kedokteran Indonesia (MKDKI), Indonesian medical disciplinary board, has received 182 complaints during 2006-2012 periods in its unpublished report. General practitioners have dominated ethical violence with 60 cases, followed by 49 cases of surgeons, 33 cases of obstetricians, and 6 cases of pediatricians. From 182 reported cases, MKDKI has decided that 29 (15.9%) doctors have been proven guilty, and their licenses have been revoked.^{61,62} However, the underlying problems are still unclear whether increasing awareness of the community to complaints or other factors have stimulated the increase. Some cases are referred to public court as criminal offenses are indicated. Analyzing the cases from Supreme Court Republic of Indonesia directory, most cases have been triggered by poor communication and unclear informed consents (See **Box. Legal case of Mrs Darmoko vs Pondok Indah hospital**). These problems influence acceptability of health care services despite the concern is still concentrated in the urban area.

Box. Legal case of Mrs Darmoko vs Pondok Indah hospital: unclear informed consent and incomplete information

One of legal cases because of inadequate informed consent was the case of Sita Dewati Darmoko vs Pondok Indah hospital. In February 2005, Mrs. Darmoko underwent a surgery to remove her ovary, and she was informed that the tumor was benign. In fact, the latest laboratory result showed that the tumor was malignant, but the gynecologist and pathologist did not inform the consent of malignancy. As a result, the patient did not receive adequate treatment and her condition worsened over time.

In February 2006, laboratory result showed that the patient had stage-4 liver cancer, suspected as metastasis from ovary cancer. The patient decided to go to Singapore for asking second opinion. The hospital in Singapore examined two samples of ovary tissue which were already examined in Pondok Indah hospital. The laboratory results from Singapore hospital showed that the samples were consistent with a moderately endometrioid carcinoma of the ovary and borderline malignancy with focal endocervical metaplasia. The cancer had already spread to the brain and caused her death in 2006.

This case was submitted to public court in 2007. Using Medical Practice Act focusing on informed consent and physician's obligation, the hospital was found guilty by the court. It was evident that doctor team did not give complete information about the result of examination and informed consent for further treatment. An appeal trial to Indonesian Supreme Court was filed, but it did not result in much different decision.⁶³

Other reports or studies regarding health care service acceptability are very limited. Most cases are disease-specific such as HIV/AIDS and tuberculosis which are highly stigma-related. Butt (2011) reported that there were evidences of poor confidentiality in HIV/AIDS counseling work in Papua and ignorance of the local culture in training modules development. Multiple violations of confidentiality often occur while trained health care professionals conduct participant observation in clinical settings.⁶⁴ Other evidence in practice includes the refusal to treat a person who was HIV-positive, differential treatment for people living with HIV/AIDS (PLWHA), the disclosure of a person's HIV status to others in breach of confidentiality, and physical isolation of PLWHA.⁶⁵

Health care provision which is culturally not appropriate is reported in a rural area. People compliance which relies more on traditional health care rather than modern health care is influenced by socio-cultural factors. Titaley (2010) reported delivery cases in a rural area in which women preferred to stay at home for a delivery rather than going to health care facilities. They perceive that they could take care of family members and manage their daily household chores if they deliver the baby at home. Taking women away from the family, even for labour purpose to health care facilities, might not be acceptable.⁶⁶ However, it should be noted that the cases is limited in rural and remote area while urban people is more open to modern care. Nevertheless, socio-cultural factors should be taken into account to careful planning development, particularly in rural and remote area regarding the cultural acceptability.

6.5 Quality

Quality is widely measured ranging from program, building, facilities, equipment, to health care professionals. Regarding the first four aspects, quality measurements may include internal water source, inpatient bed, functioning bed, tuberculosis service, measles vaccine, and hepatitis vaccine. The quality in terms of structural indicators has improved in both public and private care services. Surprisingly, tuberculosis service decreases in 2007 despite the national tuberculosis program has launched Directly Observed Tuberculosis Shortcourse (DOTS) as a national program. While tuberculosis program in a private setting has been less focused, public setting has not showed significant growth, even also has decreased in Pustu (See Table 7). This curious fact should be further questioned since Indonesia remains struggling to overcome tuberculosis program. Progressive NGOs

programs and hospital-based treatment may be the reasons which lead to various resources are less concentrated in public and private primary care.

Table 7. Structural indicators of quality, percent in 1997 (2007) of IFLS data.

Quality measures	Public settings		Private settings			All settings
	Puskesmas	Pustu	Private nurse	Private midwife	Private physician	
Internal water source	65 (89)	33 (71)	67 (80)	76 (84)	76 (89)	66 (84)
Inpatient bed	18 (28)	0 (3)	1 (3)	19 (28)	2 (3)	10 (18)
Functioning microscope	81 (79)	0 (5)	1 (1)	2 (3)	8 (7)	22 (25)
Tuberculosis service	96 (95)	53 (30)	16 (8)	6 (2)	56 (44)	46 (38)
Measles vaccines in stock	94 (97)	29 (51)	4 (45)	43 (48)	21 (11)	41 (51)
Hepatitis vaccine in stock	92 (97)	25 (55)	4 (9)	36 (59)	25 (12)	39 (55)

The first numbers are percentage in 1997 of IFLS data while numbers in parenthesis are percentage in 2007 of IFLS data. Source: Rokx (2010)³⁸ and Barber (2007)⁶⁷.

Health care facilities, goods, and services must be scientifically and medically appropriate. A wide geographical area and unequal distribution of health care services create a highly variable quality of health care providers across the country. It is believed that health providers in outer Java-Bali have worse quality than those practicing in Java-Bali because of limited facilities.⁴⁸ Prenatal, children and adult curative care are provided in low quality while quality of mental health services is not clear because of its limited study. Barber et al showed that there is evidence about low knowledge of evidence based practices in all professional groups, particularly for prenatal and adult curative treatment.⁶⁷ Prenatal care, in particularly, should be prioritized to be improved. Even private providers, which are considered to deliver better practice than public providers, deliver poor quality of practice. It is much worse in a rural area than urban area, compounded by lack of high-quality facilities and limited access.

Increasing number of private-solo practices which is much higher than public health providers worsen the quality of public health care service in a rural area. Paid with low wage rate, public health care professionals prefer to practice in their private-solo providers instead of practicing in public health care services in order to earn much more money. As the consequence, they delegate examination and treatment in public health care services to nurses, then monitored the nurses minimally and at distance.^{38,68,69} This problem lowers public providers' quality. The government should ensure that appointed trained health care professionals in public health services have to practice in accordance with their obligation. Some provinces, for instance Jakarta, would raise wage

rate for physicians practicing in Puskesmas and other public health care services. Current wages for physician practicing in public health care services are unusually low compared to their workload and to other profession. The wages are approximately Rp 1,800,000 (USD 195) per month for non-civil worker physician and Rp 2,500,000 (USD 271) per month for civil worker physician. Increasing wage may be an alternative to improve the quality of care, but some studies suggest that wage standard is not the only factor motivating or de-motivating a worker. An improved payment system and employee's contract should be more influential than salary raise.⁷⁰

Raising wage and developing performance-related or result-oriented payment method may help to solve motivation problem of health care professional, then improve the quality of care. However, it is certainly not that easy to measure health care professional performance. Some studies of pay for performance (P4P) suggest limited evidences. A strong health system supported by the readiness of information technology system is required. This mechanism is not likely to be performed in Indonesia regarding the shortage of information and technology infrastructure.

Even in the urban area, the government performs minimal monitoring and supervision to solo-providers.⁶⁸ Whereas, doctors have to meet some requirements prior to practicing and are monitored regularly. District health office (DHO) has the authority to perform the procedure, but the compliance is poor which causes many doctors practicing without sufficient accreditation and under-monitored. Moreover, solo-providers data managed by DHO are very poor, even in a big city like Jakarta. Therefore, provider's quality is out of control. Many complaints regarding providers' quality show that communication is a critical problem. For instance, Claramita et al found that patients dissatisfied with their doctors' paternalistic consultation style, but they are not able to express that in many circumstances.⁷¹

The central government has not yet developed the integrated system to control the quality of health care provision. Contracting system may be the solution. An increasing number of countries has turned to use this system to improve their health system performance over the last 10 years. In a contract system, the government as the purchaser provides compensation to health care providers (contractors) in exchange for a designated set of health services for specified target population under a "contractual arrangement". Some countries such as Afghanistan, Bangladesh, Cambodia, Haiti, and India have experienced contracting-out of non-government health providers.⁷² Contracting for health service delivery offers potentially favorable issues including (a) ensuring a greater focus on the achievement of measurable results, (b) overcoming the constraints to let the government use the resources, (c) exploiting the private provider's greater flexibility and generally better moral to improve health care services, (d) increasing managerial autonomy, (e) encouraging competition to increase effectiveness and efficiency, and (f) allowing governments to focus more on other roles in governing health care.⁷³ Some difficulties may happen such as low feasibility at large scale, for instance country-level, more expensive health care cost, inequities-induced, and sustainability problems.

The type of services in contracting system varies across countries and much depends on the program. Some modes in general as follows:

- a. specific services for designated health conditions, such as managing diarrhoea, acute respiratory infection, and fever problems among children, and malnutrition in the whole population,
- b. packaged and specified primary health care, including maternal and child health, family planning services, and various combinations of primary health care services, and
- c. unspecified primary health care.⁷²

Contracting system is considered to provide positive results in improving the quality of care. Some studies in Romania, Bangladesh, and India reported that contracting resulted in increasing patient satisfaction, more provided emergency care and client-oriented care, and percentage of disease treatment interventions using standardized medical practice guidelines. In improving health outcomes, contracting system may result positive impact like in Madagaskar but may also result no benefits in larger scale as Bangladesh experience.⁷²

Currently, there is no contracting system between purchaser (PT Askes and MoH) and providers (hospitals) towards universal health coverage. If this measure would be applied in Indonesia, the government should consider some factors. First, the quality should be operationally defined, and contract should develop well-structured indicators associated with quality. Second, the quality indicators should be linked to the payment to providers despite the number of interventions incorporated to pay-for-performance features is small. Third, the quality indicators should be strongly associated with utilization of contracted services.⁷²

The initial proposed attempt to ensure quality in Indonesia comes from Jakarta government that requires all providers to be accredited. It remains dubious despite the accreditation is one of efforts to improve the quality. Improving the quality of care should be initiated from primary-level care instead of focusing merely on hospital-based care. There is no significant measure taken by the government yet to handle primary-level care. The concept of family doctors remains unclear since have been proposed in the beginning of 1980's resulting in poor preventive care and referral system. Even, if the government remains to require accreditation for all hospital, the government does not establish precise policy including what is the deadline and what is the penalty. Instead of demanding 'only' the accreditation, the central government should develop contracting system and should consider some factor explained before.

An alternative to promote quality of care is delivering health care professionals in teams with a mix of skills. This initial experiment is promising instead of merely depending on financial incentives.³⁸ Initiated by Gajah Mada University, followed by "Pencerah Nusantara" movement under the Indonesian Office for Millennium Development Goals Achievement, an idea to create a more appealing working environment is offered. The result has not been published whether this promising program results in a positive impact.

The attempts to improve quality have to deal with problems in an increasing number of health care professionals. While the government has attempted to increase doctor stock through encouraging the number of medical school, the government has had to deal with the graduated doctors' quality. There are five main organizations in maintaining the quality of physician in Indonesia.

- a. The General Directorate of Higher Education (DGHE) of the MoEC is responsible to issue or revoke permits in running medical schools.
- b. Medical schools produce the number of doctors.
- c. The IMA is a medical professional organization and is responsible to conduct the competency examination for doctors regularly.
- d. The KKI registers graduated general physician, sets the standard of competency for general physicians and authorizes the application of medical disciplines to be taught in medical school.
- e. The MKDKI is responsible to ensure ethical issues in medical practice, receives the complaint from people regarding ethical violation in medical practice, proceeds with the trial of ethics, and decides to revoke or not the licensing for practicing.

Licensing and accreditation of medical school are vague so that the quality of graduates is questionable, particularly those from newly medical school.⁴⁸ The IMA has sub-structure, named as the Academy of Medicine of Indonesia (Majelis Kolegium Kedokteran Indonesia, MKKI), of which the roles are to improve medical professional education. Using standardized competency, the IMA implements regular examination for all physicians as a requirement prior to practicing. This examination is an obligatory for fresh graduated physicians. In order to maintain the quality, the IMA requires all physicians to be reviewed once in 5 years. The review procedure includes calculating continuous medical education credits and practicing record credits. Physicians who fail to comply with the requirements have to follow examination of their competency like fresh graduated physicians.

This mechanism sounds good, but leaves a shocking fact that a number of failed is high. It reveals that poor quality of medical schools is an urgent issue. A wise policy of the DGHE to suspend permits of new medical school should be bundled together with the policy to strengthen accreditation methods for medical school and aid the existing shortcoming, particularly for public medical schools. Surprisingly, the IMA plans to launch contradicting policy which terminate national competency examination. This examination is essential to maintain the quality of doctors and ensure that doctors have minimum competency to practice. Terminating the national competency exam is considered as negative policy while the new policy of the internship is also criticized.

Since 2011, the MoH and the IMA have launched the internship policy. The fresh-graduated physicians are spread to rural public health care service before they are able to obtain individual license to practice. They are rolled to either Puskesmas or district/sub-district public hospital. However, this policy is widely criticized. Lacking of resources leaves the fresh graduated physicians

practice under minimal monitoring, in addition to those supervising in rural areas are considered as having inadequate competency to supervise. The MoH and the IMA should map and design appropriate facilities to be used in the internship program. Another problem is that the government fails to pay the physicians appropriately and regularly. The base payment for internship physicians is very low of Rp 1,250,000 (USD 136) per month, whereas they have to carry out a lot of work in public health care facilities. Regarding the payment problem, the MoH has to improve payment mechanism and increase the wage, if it is possible.

As explained in *Acceptability*, the MKDKI has played an important role to ensure the quality of medical practice. The number of 16% doctors whose licenses have been revoked shows that the MKDKI is sincere in enforcing the medical standard considering medical and ethical appropriateness.^{61,62} The remaining is how to take preventive measures in ensuring that physicians doing their practice complying with ethical issues thoroughly and medically appropriate according to the standard.

In addition to physician problems, the poor quality of nurses and midwives also has similar causes. The number of new schools grows rapidly without proper credentialing process. The reforms spearheaded by the professional organization are ongoing, but increased quality remains unclear. The causes that should be improved are lagging of pre-service training and short supply and poor quality of internship despite the high number of health school.³⁸ The authority to manage health schools for nurses and midwives is also unclear. The health schools are formally under the jurisdiction of the MoEC, but in reality the MoH controls 33 health schools. The MoH even works in accreditation procedures together with National Accreditation Board. This is not a common approach and the accreditation processes are not aligned with international standards of credibility, independence, and transparency. This condition is aggravated by the growth of health schools which are established with only a license from district head at district level. It results in poor educated and quality production of nurses and midwives.⁴⁸ New policies are required including providing more D3-level training institutions, internship programs, and qualified teachers, as well as restrict health school licensing.

7. Policy recommendations

Some recommendations are provided for the excellent movement toward universal health coverage and its attempts to fulfill the right to the highest attainable standard of health.

7.1 General recommendation

Some provinces/districts have been successful to attain universal health coverage through various local policy strategies. It is important for the central government to examine local experiences and

identify lesson learned to improve the national program. National program may not provide excellent access without local support. Decentralization creates many dependencies of the local development on their local capacities. The central government should assist to identify local governments with good, moderate, and poor capacities. Those local governments with moderate and poor capacities should be supervised to manage their resources appropriately. Setting national target in strengthening local capacity and local health system may be a promising solution instead of leaving local government to set own measures.

7.2 Improving coverage

There is no significant problem in the benefit package and proportion of cost sharing. Further government's work is how to attract employer and informal sectors to involve in national health insurance, particularly Jamsostek scheme. Expansion to informal workers is extremely challenging as many developing countries, such as Brazil, China, Mexico, and Thailand have faced. Reducing the level of premium contributions may be the alternative, in addition to developing collection mechanisms. The low monthly premium of Rp 40,000-50,000 (USD 4.3-5.4) may be attractive, but large promotion and persuasion is unquestionably needed. It is not only the government's task, but PT Askes as designated national health insurance has to take over appropriately. The socialization should ensure that all eligible people enroll to the program.

7.3 Increasing availability

- a. Firstly, the government has to improve health care professional database. The MoH, KKI, and IMA have to develop a better method in registering the health care professional. Currently, data are fragmented and incomplete. Registration of doctors in KKI should be checked regularly with the MoH and IMA data to ensure the validity and reliability. Updating database of health care professional regularly either in local and national level is required to portray the availability of health care professionals countrywide. Linking health care resources planning with overall civil service reforms is also imperative.³⁸
- b. Mandatory placement for fresh graduated general physicians would be effective to supply health care workers in rural and remote area. However, this mandatory placement should be considered as short-term policy. The fresh graduated doctors are mandated for six-month service before they can obtain a license to medical practice or apply for specialist training. The program should be also applied for fresh graduated specialists. The local government should combine this policy with financial and nonfinancial incentives in order to attract more health care workers working in rural and remote area. Alternative incentive scheme initiated by sending health care professionals in teams, explained in *Quality* section, should be evaluated for further feasibility. The local

government should also align the deployment policy with progressive overall local development including providing better infrastructure.

- c. Providing universal health coverage must be complemented by providing an adequate number of health care facilities and its equity countrywide. The MoH has to set national design and divide the clear authorities between central and local government to build health care facilities. It would need high sufficient fund so that advocating central government and the House of Representative to increase the proportion of the health budget within overall nation budget is a must. Pressure from social movement including health care workers is imperative.

7.4 Widening accessibility

- a. Preventing the leakages is also imperative. Active validation and requires the eligible beneficiaries to enroll may reduce potential of leakage. In addition, for the tax-revenue scheme, resource transfer from central to local government should be based on verified enrolment numbers instead of capitation and utilization basis. Actually, it would not be a big deal if the government really intends to raise tax-revenue for health care program. The proportion of health care budget should increase up to 5% in minimum.
- b. Eliminating illegal upfront payment and rejection from health care facilities needs joint efforts among the MoH, PHO, DHO, hospital association, and community. The MoH, PHO and DHO have to develop a mechanism of complaints, sign memorandum of understanding with hospitals, and construct adequate penalties for hospitals violating the memorandum. Hospital association has a role in maintaining hospital performance and conduct equal supervision. Community encourages the well-implemented program and monitors any potential violation in the grounds.

7.5 Making it more acceptable

- a. Discrimination, in particular for specific disease such as HIV/AIDS and tuberculosis, should be diminished by introducing this issue into whole health program. Currently, programs for specific disease are implemented in fragmented structure, courses, and budget which result in low effective and sustainable program. Introducing this specific program into whole attempts to strengthening the health system is required.
- b. Regarding service which should be respectful of medical ethics, the MKDKI altogether with the IMA should develop preventive measures instead of merely accommodate people's complaints of medical services. Actions to ensure services which respectful of medical ethics would be overlapping with concerns to improve the quality of services explained below.

7.6 Improving quality

- a. Licensing and periodical review are critical to improve the quality of health care professionals. The IMA should continue national examination for physicians. The Indonesian Midwifery Association (Ikatan Bidan Indonesia, IBI) and Indonesian National Nurse Association (Persatuan Perawat Nasional Indonesia, PPNI) should also take similar measure which is not in current practice. Periodical review is required for all health care professional prior to extend their license to practice. Following that measure, the government may limit the recruitment for new civil workers to those who have been certified and reviewed periodically according to national standard.
- b. Moratorium of new development of health and medical schools is imperative, unless with justified reasons. Following this action, the DGHE should accredit all health and medical schools and strengthen the regulation, such as limiting enrolment for those poor-accredited schools or programs. The KKI, the IBI, and the PPNI, in parallel, should establish competency and education standards. In particular for IBI and PPNI, regulatory body for competency and education standardization has not established yet and is urgently needed.
- c. In terms of provider payments method, performance-based payments may improve the quality. In addition, it aids to maintain efficiency and treats public and private sector similarly. However, it requires appropriate infrastructure and well-designed program. Piloting the project in an urban setting may be the alternative instead of implementing in the whole country.
- d. The MoH should consider contracting system which focus on either primary care services or specific diseases. As explained in *Quality* section, this measure is potential if the MoH develop good, measurable indicators and construct monitoring and evaluation systems. Otherwise, contract system would not result in positive impacts on overall health system.

8. Conclusions

During the movement toward universal health coverage, Indonesia has achieved some improvements in its attempts to fulfill the right to the highest attainable standard of health for its citizens. It has been clear that social movement has an important role. The government, despite being as a main policy actor, should be forced by pressure groups from community in order to ensure the implementation of universal health coverage. The pressure has resulted in some developed legal and policy instruments which have been successful to improve the three dimensions of coverage, availability, accessibility, and acceptability, whereas there has not been improvement in quality of health care services.

Decentralization policy has created a positive impact in terms of improving universal access to health care services. However, negative effect of unequal access among regions complicates the

process toward universal health coverage. Because of various capacities of local governments, some provinces have been successful to assist the central government in providing universal health coverage through their strong capacities while some provinces have failed to do so. Political circumstances, elite interests, and local resources are the main determinants of local government to provide universal health coverage for its population.

The movement to achieve universal health coverage and fulfill the rights to the highest standard of health still requires many years to be true. Some shortages are evident. Although the coverage has been improved, the proportion of uncovered people remains high and higher than the two benchmark countries, Thailand and Philippines. The availability of health care services has to deal with lacking of health care professional and its unequal distribution. The rural and remote areas are the most affected by availability problems. Despite the government has provided comprehensive benefit package, people in rural and remote area cannot access the package because of the unavailability of health care professionals and facilities. The accessibility has been improved in terms of the package, but physical and financial constraints have remained to be solved. While there has been a significant problem in acceptability, the quality of health care services is still poor. The policy to ensure the quality of health care services is very limited even raises negative effects. Some recommendations are provided regarding the current achievement and may, hopefully, improve the process.

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Annex

Annex 1. Benefit packages provided by existing health insurance scheme in Indonesia

Characteristics	Before 2014				2014	
	Askes	Jamsostek	Private health insurance	Jamkesmas	Beneficiaries	Non-beneficiaries
Participation	Compulsory, for active and retired civil servants, soldiers.	Compulsory, for employees; opt out for employers that could provide better benefit packages	Voluntary	Social health insurance, for poor	Social health insurance, for poor	Merged Askes and Jamsostek, compulsory
Participants	Personal and max. 3 family members	Personal and max. 3 family members	Personal	Personal	Personal and not-working-family members; more than 3 family members is allowed	Personal and not-working-family members; more than 3 family members is allowed
Financial management	PT Askes	Jamsostek Ltd	Private insurances	Ministry of Health	PT Askes	PT Askes
Primary care						
Primary (public) health centre	Yes	Yes	Yes	Yes	Yes	Yes
Private primary care	No	Yes, registration required	Yes	No	Yes, registration required	Yes, registration required

Secondary care						
Inpatient care	Public only	Public, class 2 Private, class 3	Public and private	Mostly public, class 3	Mostly public, class 3	Public and private
Outpatient care	Public only	Public and private	Public and private	Mostly public, class 3	Mostly public, class 3	Public and private
Maternity care						
Prenatal care	Yes	Yes, up to 3 children	Yes	Yes, up to 3 children	Yes	Yes
Normal delivery	Yes	Yes	Yes	Yes	Yes	Yes
High risk and complicated delivery			Yes, selective	Yes	Yes	Yes
Dental care	Basic, on PUSKESMAS	Basic, on PUSKESMAS	Basic	Basic, on PUSKESMAS	Basic, on PUSKESMAS	Basic, on PUSKESMAS
Prevention and health promotion						
Individual health education	Yes	Yes	Yes	Yes	Yes	Yes
Basic vaccination	Yes	Yes	Yes	Yes	Yes	Yes
Family planning	Yes	Yes	Yes	Yes	Yes	Yes
Health screening	Yes, selective	Yes, selective	Yes, selective	No	Yes, selective	Yes, selective
Rehabilitation care	Yes	Yes	Yes, selective	Yes	Yes	Yes
Intensive care	Yes	Yes, limited	Yes, selective	Yes	Yes	Yes
Accident	No	Yes, work accident	No	No	No	No
Hemodialysis	Yes	No	Depends on	No	No	Yes

			insurance package			
Limitation	Eyeglasses, hearing aid, mobility aid, dental prosthesis	Eyeglasses, eye prosthesis, dental prosthesis, hearing aid, mobility aid	Depends on insurance package	Eyeglasses, hearing aid, mobility aid	Supplementary medicines	
Exclusion	Mobility aid, circumcision without medical indication, fertility treatment, advance vaccination, cosmetic treatment, dental prosthesis, alternative medicine, check up.	Beyond designated providers, STD, general check up, advance vaccination, occupational diseases, fertility treatment, alternative medicine, home care, psychotherapy, cosmetic treatment.	Depends on insurance package	Cross-border care, circumcision without medical indication, fertility treatment, cosmetic treatment, dental prosthesis, alternative medicine, general check up.	Cross-border care, circumcision without medical indication, fertility treatment, cosmetic treatment, advance vaccination, drugs dependence and alcoholism treatment, suicide-associated treatment, dental prosthesis, alternative medicine, general check up, home care, psychotherapy.	
Source of funds	Member contribution 2% basic salary +government 2% basic salary; no limit	Single: 3% basic salary; members with dependents: 6% salary; limit to Rp 1 million	Depends on insurance package	Tax-based. "Premium" Rp 6,000/capita	Tax-based. "Premium" Rp 15,500/capita	Civil servants: member contribution 2% basic salary +government 3% basic salary; no limit. Formal employees: 5% basic salary;

						with dependents more than 4: plus 1% salary per members. Informal employees: Rp 40,000-50,000 per month
Financing body	Ministry of finance	Employers	Individuals	Ministry of Finance	Ministry of Finance	Ministry of Finance, Employers and Individuals
Cost sharing	Yes, if members want to upgrade class or branded drugs	No	Depends on benefit packages	No	No	Yes, if members want to upgrade class or branded drugs
