

Regulator and Payor Relation: Institutional Challenges in Achieving Universal Health Coverage in Indonesia

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ABSTRACT

Indonesia is currently struggling towards Universal Health Coverage (UHC) by the year 2019, but policy actors have difficulty in adjusting centralized health insurance management policies at the central level through Law No. 24/2011 on Social Security Provider (BPJS) and Presidential Regulation No. 12/2013 on Health Insurance, with a health service management policy whose authority more decentralized instead through Law No. 23/2014 on Local Governments and Government Regulation No. 18/2016 on Local Apparatuses. Objective: To determine the pattern of institutional relations relating to policies and regulations between the central and the local governments in the implementation of the health insurance program in Indonesia, which has been decentralized at the local level. Method: This study was an exploratory case study. Data were collected in-depth interviews and focus group discussions with 67 policymakers at the central and local levels. The data analyzed using transcripts and an open code matrix. Result: The role of the principal in the pattern of the relation of JKN policy implementation at the central and local levels tends to be weak and does not have complete control of the agent. Weak principal control requires stronger hierarchical control of the principal at the central level (central government) and greater incentives for the principal at the local level (BPJS Health). Meanwhile, principals and agents in terms of policy interpretation, share common interests. Principal control toward the agent is weak and causes asymmetrical information. Finally, in terms of policy application, the agent has more information so that the principal has a dependency on the agent. Conclusion: Implementation of JKN policy at the central level has a conflict of interest between the government as the principal and BPJS Health as the agent. The government has the goal to fulfill the quality of health services (quality control), while BPJS Health has the goal of optimizing health financing (cost control).

Keywords: *decentralization, health financing, national health insurance*

1. INTRODUCTION

The implementation of National Health Insurance (NHI) is carried out by *Badan Penyelenggara Jaminan Sosial (BPJS) Kesehatan* in a centralized manner, as mandated by Article 1 Paragraph (1) of the BPJS Law which states that BPJS is a legal entity formed to organize social security programs. According to Article 2 of the BPJS Law, the BPJS is tasked with organizing the National Social Security System (NSSS) based on humanitarian principles, benefits and social justice for all Indonesian people.

In this case, all forms of implementation of the NSSS are held nationally by BPJS, including health insurance in it. This is reinforced by Article 6 of the BPJS Law which states that BPJS organizes health insurance programs.

The problem that illustrates the complicated relationship between institutions at the central and regional levels is the problem of overlapping policies

and authorities. One of the most prominent and escalated to the public at this time is the issuance of BPJS Regulation Number 1 of 2018 concerning Emergency Assessment and Procedure for Replacement of Emergency Services Costs; The Health Services Assurance Director Regulation of *BPJS Kesehatan* Number 2/2018 concerning Guarantee of Cataract Services in the Health Insurance Program; The Health Services Assurance Director Regulation of *BPJS Kesehatan* Number 3 /2018 concerning the Guarantee of Maternity Services with Healthy Newborns in the Health Insurance Program; and The Health Services Assurance Director Regulation of *BPJS Kesehatan* Number 5/2018 concerning the Guarantee of Medical Rehabilitation Services in the Health Insurance Program. In its implementation, the three regulations caused polemics at the central level, where there was considerable rejection from other government institutions such as the Ministry of Health (MoH), the *Dewan Jaminan Sosial Nasional* (DJSN; National Social Security

Council), and stakeholder institutions such as professional organizations and health associations after the issuance of these regulations. The public debate that took place eventually led to conflicts of interest and conflicts of policy authority which ultimately had an impact on health services for the NHI program participants. Differences in understanding and the number of institutions that have slices of authority in the field of health services and health insurance certainly have an impact on the region, where regions must translate existing regulations into regional policies which ultimately affect the number of these actors will greatly influence health service policy as stated by Ham and Hawkins (2003) in Preker and Harding (2003: 86) that many different actors can influence the implementation of health service policies in the field. On the other hand, the implementation of Law No 23/2014 concerning the Regional Government also has an impact on increasing regional authority in managing health services. The implementation of regulations issued by the MoH is very dependent on the ability of the region it self to manage its health services.

On the other hand, the authority in administering health insurance is fully centralized in BPJS. In the end, the interaction between central and regional governments in the implementation of NHI becomes very intense, especially between BPJS as the operator of health insurance with the regional government as the health service operator (provider). In this case, the role of the MoH as a regulator at the central level is even further away in the field.

Referring to the context of the background description of the problem above, the research problem can be formulated as follows: The roles of each institution at the central level tend to be complicated and have their respective authority which intersects each other. On the other hand, although all program standards in terms of service to membership have been determined from the central level by the BPJS, the MoH and other institutions, the authority to develop health facilities most of them regulates by the regional government in the Health Law, Hospital Law, and Regional Government Laws. In this case, the relationship between institutions at the central and regional levels in the implementation of NHI is crucial. This requires a deeper understanding of the pattern of relations and authority between institutions at the central and regional levels, including the compatibility between existing regulations, both related to centralized health insurance authority and decentralized health service authority. It is essential to obtain the best policy recommendations in order to implement a centralized NHI program in synergy with decentralized health service policies in the regions. From all of this, the problem formulation is obtained, which is how the

pattern of institutional relations between the central and regional government in the implementation of the NHI program. The purpose of this study is analyzing the pattern of institutional relations relating to policies and regulations between the central and the local governments in the implementation of the health insurance program in Indonesia, which has been decentralized at the local level

2. METHOD

This research is an exploratory case study type. Data were collected in-depth interviews and focus group discussions with policymakers at the central and local levels. The unit of analysis in this study is institutions. The population used in this study is the regional and central government where the subjects to be studied include: BPJS, related with *Kementerian/Lembaga K/L* (MoH and Ministry of Domestic Affairs) and regional governments that are the object of research. The selected informants include, BPJS Leader (Supervisory Board/Director/Board of Directors/Deputy of Directors Board), General Secretary of the MoH, General Directorate of Health Ministry, Regional Leaders (Regents/ Mayors/Deputy of Regents /Deputy of Mayors /Regional Secretaries/*Asda Kesra*), Leaders / DPRD Member, Head of Health Office, BPJS Department Deputy, Head of Branch/KLOK Office and related staff, related academics or other related informants/informants. The numbers of informants used in this study were as many as 67 people who were collected sequentially. The data analyzed using transcripts and an open code matrix.

The method of sampling for interviews was chosen using purposive sampling with inclusion criteria. This study was submitted to the Ethics Committee Approval Ref: KE/FK/0810/EC/2018 of the Faculty of Medicine Gadjah Mada University to obtain ethical clearance. This research was carried out after ethical confirmation was obtained. The ethical principles applied in this study are Confidentiality, Anonymity and Informed Consent.

3. RESULTS AND DISCUSSION

The existence of health insurance is part of the mandate of the constitution, which aims to support the achievement of health development goals, improve the highest degree of public health. The 1945 Constitution Article 28 Paragraph (1) states that every person has the right to live and has the right to defend his life, furthermore Article 34 Paragraphs (2) and (3), the state develops a system to guarantees for all people and empowers people who are weak and incapable in accordance with human dignity. The state is responsible for providing adequate health care facilities and public service facilities.

Several laws were then regulated to further elaborate the constitutional mandate, including The Law No. 29/2004 concerning Medical Practice, The Law No. 35/2009 concerning Narcotics, The Law No. 36/2009 concerning Health, The Law No. 44/2009 concerning Hospital, The Law No. 52/2009 concerning Development of Population and Family, The Law No. 18/2014 concerning Mental Health, The Law No. 36/2014 concerning Health Workers, and The Law No. 38/2014 concerning Nursing.

Regulatory sources regulate the implementation of NHI. Those are regulations originating from the government as regulators, and the other from the BPJS as operators. Regulations from the government consist of the law, government regulations, presidential regulations, ministry regulations, and circulars letter. Regulations originating from BPJS is technically regulating the implementation of NHI. In the form of BPJS' Regulations, Directors Regulations, and Circular Letters. Both types of rules must be in line, especially the regulations issued by BPJS as operators must be in line with the regulations set by the government as regulators. In its implementation, there were several revisions to the regulations issued. This can be due to disharmony, ambiguity in interpretation, development of the situation or adjustment to the needs of the wider community.

Table 1. Several of Disharmonic Regulations

The Law		Disharmony
UU 24/2011: The BPJS is tasked with organizing the SJSN based on humanitarian principles, benefits and social justice for all Indonesian people.	UU 23/2014 The authority of the provincial government is a provincial-scale affair that covers the handling of the health sector	In the implementation of NHI, there are at least two things held, those are the implementation of health insurance, and the implementation of health services, both of which are related. In reality, it is difficult to standardize health insurance policies whose control by BPJS with health service management policies by the local government.
UU 36/2009: The government is responsible for the implementation of public health insurance through the NSSS for individual health efforts.	UU 24/2011: The BPJS is tasked with organizing the SJSN based on humanitarian principles, benefits and social justice for all Indonesian people. BPJS is a Public Legal Entity.	UU 36/2009 is the law of the National Health System, and the implementation of Health Insurance is the responsibility of the government. While according to UU24/2011, The implementation of the social security system is carried out by the Social Security Agency in the field of Health as a Public Legal Entity. The government does not regulate the Public Legal Entity itself and its position is not regulated in the National Health System.
UU 36/2009: the budget for health is at least 10% of the APBD	Perpres 32/2014 Capitation budgets for Puskesmas, managed by the local government SKPD	Two sources of funding in the FKTP have the potential to create overlapping use of the health fund budget, both

	Minister of Health Regulation No. 21 of 2016: The amount of payment allocation for health services and operational costs for health services is set every year by the decision of the head of the region at the suggestion of the SKPD head of the District or City Health Department.	sourced from the APBD and capitation funds provided by BPJS. In the end, the local government can shift its budget burden to capitation funding sources.
UU 40/2004 Government and private health facilities are not required to cooperate with BPJS	Perpres 12/2013 Government and local governments' health facilities must work together with BPJS. BPJS cannot stop the government health contract.	All health facilities should ideally work with BPJS, and BPJS can terminate cooperation if health facilities violate the contract.

In the implementation of the NHI, there are still disharmonic regulations, where the regulation is in contradiction with other regulations. For example, Article 36 Paragraph (2) of the Presidential Regulation Number 12 /2013 concerning Health Insurance and Article 23 Paragraph (1) of The Law of 40/2004 concerning the Social Security System are contradictory and give rise to norm conflicts. In Article 36 Paragraph (2) of the Presidential Regulation Number 12/2013, the article is forced because the health facilities owned by the government and regional governments are required to cooperate with BPJS. While in Article 23 Paragraph (1) of Law No. 40/2004 concerning the NSSS, the article is regulating because the government or private health facilities can cooperate with BPJS or may not cooperate with BPJS. It is this conflict of norms that can lead to conflict and legal uncertainty in the implementation of the provision of health insurance by government-owned, regional and private health facilities. To resolve the norm conflict, it can be resolved by itself through the principles of legislation. In the norm conflict in the two articles, the legal principle used is the *superior lex principle of legion derogate inferiori*. This principle applies higher laws and regulations to override lower laws and regulations. Then Article 23 Paragraph (1) of Law No. 40/2004 concerning the NSSS is declared to have ruled out Article 36 Paragraph (2) of the Presidential Regulation Number 12/2013 concerning Health Insurance.

Holistically, the current form of the relationship between the central and regional governments in the implementation of the JKN program can be described as follows. That relationship in the context of JKN implementation, the principal's role in the pattern of relations at the central level tends to be weak and does not have full control over agents, but conversely, in the pattern of relations at the regional level, the role of agents tends to be weak towards principals. That weak principal control requires stronger principal hierarchical control at

the central level. That the weak bargaining power of agents in the regions demands the strengthening of the role of agents in a hierarchical manner at the regional level (BPJS Health). That the factors that determine the success of the overall JKN program implementation in addition to the interpretation, organization, and policy application (context) factors are stronger hierarchical control factors for the government as the principal at the central level and stronger bargaining power in a hierarchical manner for BPJS Health as an agent at the regional level (mechanism).

Patterns of Relationships between Governments in Implementing JKN Policy				
Level of Relationship	Central Level		Regional Level	
Entitas	Central Government	BPJS	Local Government	
The Role	Principal	Agent	Principal	
Policy Interpretation	Weak	Strong	Strong	Strong
Policy Organization	Weak	Strong	Weak	Strong
Policy Application	Strong	Strong	Weak	Strong
Principal Relationship Pattern - Agent	<i>Traditional Model</i>		<i>Plato Republic Model</i>	

Implementation in the field, the role of agents, is carried out by BPJS Health as the only institution appointed by law to manage social security in the health sector. As described in the results of the study, BPJS Health as a public legal entity, acts as an agent appointed directly by the President of the Republic of Indonesia as the main principal. As a public legal entity, the hierarchical position of the BPJS Health is not explicitly regulated in government, especially in the case of a hierarchical coordination relationship through one of the Ministers as an assistant to the President as is generally the other Non-Ministry Government Institutions. In this case, it can be said that BPJS Health is of the view that the agent has a hierarchical privilege directly with the President so that his status with other related Principals under the President is equivalent to non-hierarchical. This causes no single principal institution related to JKN to control BPJS Health hierarchically.

The interesting thing is if the results of the two case studies are synthesized, where the Principals at the central level have a quality control perspective, while the Principals at the regional level have a cost perspective where the regions rely instead on capitation of the Health

BPJS to overcome the funding of regional health facilities. This condition illustrates that the devolution of authority (decentralization) from the central level to the regions in the field of health services cannot achieve the objectives of improving the quality of health services themselves. On the other hand, BPJS Health as a strategic purchaser agent that is expected to support in terms of centralized health financing, tends not to have a bargaining position when dealing with local governments that play a dual role both as principals who have authority over the development of health services in their region as well as acting as agents that provide health services through its health facilities.

Ideally, the dual role of the local government should make it easier for BPJS Health to control costs as well as quality control for health facilities that work together through direct support from local governments. The commitment of the region as the principal of the health service, as well as the health facilities agent tends to shift the burden of the health facility financing to the Health BPJS as the agent. This act results in the BPJS Health being burdened in its role as an agent towards the Regional Government, while the Regional Government has the potential to shift its budget allocation to other priorities.

4. CONCLUSION

In implementing the JKN program at the central level, there is a complicated role relationship at the principal level where there are many institutions that have the authority and responsibility related to JKN, some of which have a dominant role include the MoH (regulator in the health sector, PBI budget allocation holder); Ministry of Social Affairs (regulators in the area of poverty alleviation, related to PBI data); Ministry of Home Affairs (regulator, supervisor of population data, regional coach); Ministry of Finance (as the manager of the APBN); PMK Coordinating Ministry (coordinator in the field of people's welfare); Office of the Vice President of the Republic of Indonesia (Chair of the National Team for the Acceleration of Poverty Reduction) and the National Social Security Board (Public policy formulator). Each principal has interests that intersect with each other and have a significant impact on the success of the JKN program, but interestingly none of these institutions are given full authority to represent the President as the main principal of the implementation of the NHI program.

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