Understanding the impacts of NPM and proposed solutions to the healthcare system reforms in Indonesia: the case of BPJS

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Abstract

This study critically evaluates the adoption of a universal healthcare system recently introduced by the Indonesian government in 2014. Our study is driven by the lack of critical analysis of social and political factors and unintended consequences of New Public Management, which is evident in the healthcare sector reforms in emerging economies. This study not only examines the impact of economic and political forces surrounding the introduction of a universal health insurance programme in the country but also offers insights into the critical challenges and undesirable outcomes of a fundamental reform of the healthcare sector in Indonesia. Through a systematic and detailed review of prior studies, legal sources and reports from government and media organizations about the implementation and progress of an UHC health insurance programme in Indonesia, the authors find that a more democratic political system that emerged in 1998 created the opportunity for politicians and international financial aid agencies to introduce a universal social security administration agency called Badan Penyelenggara Jaminan Sosial (BPJS). Despite the introduction of BPJS to expand the health services’ coverage, this effort faces critical challenges and unintended outcomes including: (1) increased financial deficits, (2) resistance from medical professionals and (3) politicians’ tendency to blame BPJS’s management for failing to pay healthcare services costs. We argue that the adoption of the insurance system was primarily motivated by politicians’ own interests and those of international agencies at the expense of a sustainable national healthcare system. This study contributes to the healthcare industry policy literature by showing that a poorly designed UHC system could and will undermine the core values of healthcare services. It will also threaten the sustainability of the medical profession in Indonesia. The authors offer several suggestions for devising better policies in this sector in the developing nations.

Keywords: Healthcare system reforms, Indonesia, New Public Management, policy, UHC

Introduction

Since 1990s, the rise of neoliberalism has greatly affected policy-making and outcomes of healthcare reforms worldwide, where the objective is to implement private sector business theory and practices through the so-called New Public Management (NPM) (Saltman and Duran, 2015; Lindlbauer et al., 2016; Mei and Kirkpatrick, 2019). Despite its popularity, the institutionalization of NPM in the health sector has produced unintended outcomes, which include more unequal access to health care where people with higher incomes have better outcomes than poor people (Rotarou and Sakellariou, 2017) and the lack of improvement in the quality of care, equity and efficiency (Homedes and Ugalde, 2005). Furthermore, the introduction of NPM in this sector has increased anxiety experienced by healthcare professionals, triggered conflict between clinical and non-clinical staff and driven the resistance from doctors and social activists (Pushkar, 2019). It is widely
criticized that the main beneficiaries of NPM reforms in the healthcare sector are not the citizens of these nations but transnational corporations, consultant firms, and the World Bank’s staff at the expense of taxpayers (Homedes and Ugalde, 2005). For this reason, a fundamental reorientation of international financial institutions such as the IMF and World Bank in reforming the health sector in developing nations is essential (Stubb and Kentikelenis, 2017). As Xu and Mills (2019, p. 4) suggest that the effectiveness of financial and service-delivery policy arrangements is facilitated or enabled by their institutional framework. Therefore, understanding the aspirations from different groups of stakeholders is important in understanding the process and impacts of a policy-making process in the health sector (Razavi et al., 2019).

In Indonesia, following the collapse of the Suharto regime in 1998, successive administrations implemented a more democratic political system and structural reforms in the public sector.¹ In the health sector, NPM reforms have been realized into several features (Maharani et al., 2015). These features including the adoption of decentralization in the management of public hospitals in Indonesia since 2001 and greater roles have been granted to local authorities to manage and fund local public hospital. Under decentralization, public hospitals have been encouraged to adopt corporatization to allow these hospitals to gain revenues from patient fee section. Since 2014, a more significant reform has been undertaken with the launch of a universal social security administration agency called Badan Penyelenggara Jaminan Sosial (henceforth BPJS) in 2014 (Suryanto and Boyle, 2017). However, there is a limited body of literature published on this topic. An early major study that explored the key challenges of healthcare reform in Indonesia was undertaken by Aspinall (2014). He argues that a democratic political system in a country always provides an opportunity for politicians to use UHC as an attractive political strategy to obtain public support. Given the nature of Indonesian’s democracy in that oligarchs still rule, there are predatory politics and authoritarianism; these realities seriously compromise the state’s capacity to implement these reforms successfully (Aspinall, 2014). Another study by Mboi (2015) found that despite post-Suharto governments showing a strong political commitment to developing better health services, these efforts have not been supported by an effective and efficient system put in place. Further studies by Rakmawati et al. (2019) find that after decentralization, the Indonesian health system at the district level still functions well below expectations.

Reflecting on the above studies, despite the impacts of NPM on the reforms on a nation’s healthcare system having been extensively identified, these analyses mainly focused on developed economies (Mei and Kirkpatrick, 2019). In addition, most prior studies on the health sector in Indonesia fail to consider the roles of international players in the policy-making and the implementation of reforms. In fact, the role of international agencies, such as the World Bank, IMF, and US International and Development Agency (USAID), and their ideologies is to influence policy-making and level of nationalized healthcare sector reforms in developing economies (Homedes and Ugalde, 2005; George, 2017). Under neoliberalism, people’s payment of debts to these institutions must be prioritized at the expense of education and healthcare services in developing nations. This situation has led to major problems in many African and South American countries and in Greece recently (Ramli, 2000; Marsa, 2009; Karanikolos and Kentikelenis, 2016; Stuckler et al., 2017; Pavolini et al., 2018). Walt (1994, p. 366) stated earlier that historically much healthcare policy has only been really interested in the technical features of policy content, rather than the processes of putting policy into effect. Thus, this study contributes to the healthcare policy literature by identifying the impacts of economic and political narratives concerning a universal health insurance programme in an emerging economy in the Southeast Asia, Indonesia.

Drawing from the discussion above this study raises the following research questions:

• How does NPM affect the nature and impacts of a new universal health coverage insurance system through BPJS in Indonesia?
• What are the structural problems that emerge in Indonesia through the institutionalization of BPJS?
• What strategic solutions can be offered to establish a better and more sustainable national healthcare system so that BPJS can achieve its objectives?

This study contributes to the academic literature on policy-making in the health sector at the global level by empirically showing the nature and institutional challenges of a fundamental reform of the healthcare sector in Indonesia. Beyond this, this article has important insights for government policy-makers and academics particularly in developing and emerging economies.

Key Messages

- The launch of an UHC insurance programme in Indonesia in 2014 was a milestone aimed to provide a national comprehensive healthcare system.
- There is a lack of deep understanding about real problems faced by Badan Penyelenggara Jaminan Sosial (BPJS) that will threaten its sustainability. The implementation of the UHC programme is purely driven by political motives and managed by New Public Management principles.
- The Indonesian government’s approach to implement the UHC health insurance programme should ensure efficiency in care provision and primarily focus on achieving a minimum basic set of treatments for all patients.
- Five solutions are offered including the need to transform the primary role of BPJS, automatic memberships for all citizens, simplification and refocus of BPJS’s coverage, the use the Tax Office to collect BPJS levies and allocation of more public budgets for BPJS operation.

1 As the result of its economic and political transformation following the collapse of Suharto’s regime in 1998, Indonesia’s position as a new democracy is improving. In the last 10 years, the economy’s growth per year has been 5% cent, which has effectively tripled the economy. Since 1999, Indonesia has been a member of G20, giving it a permanent and very visible role on the world stage.
Methods

To answer the research questions, this study employed a qualitative research approach to identify and analyse the experience of Indonesian government and people, by analysing what the implementation of BPJS has produced. To enhance the credibility and reliability of the validity of its findings, we follow that any qualitative study requires triangulation of data by examining information more than one source of information and utilizing it to build a coherent explanation of an observation. In addition, to enhance the quality of document sources used in this study, we adopted key principles as suggested that include (1) the authenticity of a primary or secondary document; (2) the credibility—about the accuracy of information contained in a document; and (3) the reliability of the producer of a document source. These principles were used to undertake a systematic and detailed review of prior studies, legal sources and government reports/documents, media reports and other relevant information on the implementation and progress of an UHC health insurance programme. This approach is common to prior studies examining the impacts of NPM on the health sector in many nations (Walt et al., 1999; George, 2017).

To collect and analyse the data, we carried out several procedures based on the suggestion as discussed above. First, we used document analysis to explore information around the political background, nature and impact of healthcare sector reforms in Indonesia with respect to the implementation of BPJS. Such information has already been published in medical, economic, political, management and public administration journals, research reports and publicly available Indonesian government reports. Our search strategy involved searching the PubMed database and other resources at the University of Canberra, e.g. ISI Web of Knowledge, Google Scholar and ProQuest. To scope the major issues, we used several keywords including ‘health sector reforms’, ‘health financing and insurance’, ‘universal health coverage systems’ and ‘Indonesia’. A total of 362 document sources were initially selected from published research papers, government laws, government reports and media reports. After we carefully analysed how a source is relevant to the research questions, then we finally used 57 documentary sources. The decision to use the reports issued by media was based on the reputation of a media organization, and in this case, all these organizations had been operating the reputation of a media organization, and in this case, all these organizations had been operating 20 years when this study was carried out. In addition, the reports from these media organizations have been used by prior studies relating to public sector reforms in Indonesia including the heath sector and higher education (Pisani et al., 2016).

Results and discussion

Country context and key drivers of healthcare policy changes

For Indonesia, post-Suharto governments led by Megawati Sukarnoputri (2001–04), Susilo Bambang Yudhoyono (2004–04) and Joko Widodo (2014 to now) altogether mobilized UHC principles as part of their political campaigns to gain political support and stay in power. However, as Aspinall reminds us, given that Indonesian’s democracy is still dominated by oligarchs, political allies and families who ruled with Suharto, the logic of political power is predation and authoritarianism (Aspinall, 2014). In addition, given public sector reforms undertaken in emerging economies (e.g. Indonesia and Greece) were the primary consequences of financial and economic crisis, the roles of international agencies in shaping these reforms cannot be ignored. However, transnational organizations, such as the World Bank, IMF, ADB, Inter-American Development Bank and USAID, in facilitating policy-making and the implementation of public sector reforms in developing countries also potentially bring unintended consequences (Pavolini et al., 2018).

Because their operation is primally motivated by neoliberalism and making a profit, it reduced government spending on education and health throughout Africa, South America, Indonesia and Greece (Ramli, 2002; Marsa, 2009; Karanikolos and Kentikelenis, 2016; Pavolini et al., 2018). In our view, both oligarchic politics and neoliberalism as promoted by international agencies should be subjected to intense examination to understand the nature and consequences of how BPJS operates in Indonesia. This is discussed in the next sections of this paper.

The launch of BPJS: an NPM-based health insurance system?

With the launch of BPJS in 2014, Indonesia made steady progress in which 165 million people became members of the BPJS; the total number of members increased to 220 million in 2019 as Table 1 depicts. Commentators believe that BPJS is the world’s biggest single-payer health system (Wiseman et al., 2018). BPJS is a social security agency for health, and its purpose is to manage citizens’ health insurance and other eligible residents in Indonesia. According to Article 2 of Law 21 (2011) about BPJS, the operation of the agency must uphold three principles: humanity, public benefits and social justice for all Indonesian citizens. These principles are also reflected in its missions (BPJS, 2017) as follows:

1. increasing the quality of fair services,
2. expanding insurance memberships to cover all the people of Indonesia,
3. maintaining the sustainability of the insurance programme,
4. strengthening the policies and implementation of the BPJS programme, and
5. strengthening the capacity and the organization governance of BPJS.

Table 1 Membership of BPJS

<table>
<thead>
<tr>
<th>Year</th>
<th>Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>133.4 million</td>
</tr>
<tr>
<td>2015</td>
<td>156.8 million</td>
</tr>
<tr>
<td>2016</td>
<td>171.9 million</td>
</tr>
<tr>
<td>2017</td>
<td>187.9 million</td>
</tr>
<tr>
<td>2018</td>
<td>200.3 million</td>
</tr>
<tr>
<td>2019</td>
<td>222.2 million</td>
</tr>
</tbody>
</table>

Source: BPJS (2018, 2019a,b).

2 UHC means that all members of the public have the right to receive health services without financial difficulties. This includes basic and quality health services. This includes disease prevention, care, rehabilitation and palliative care programmes. Progress towards UHC is important for achieving the overall welfare target of the community in line with the UN Millennium Goals. Good health is a prerequisite for children to learn and adults to work. UHS is also important to help people get out of poverty and provide a basis for long-term economic development.
Beyond these missions, the agency also manages the payments of healthcare services, such as hospitals and other healthcare services providers, collecting premiums from its members and managing contracts with healthcare providers. Nonetheless, some operational features seem to be very different from other countries, which ultimately affect how BPJS operates. Agustina et al. (2019, p. 76) state that the Ministry of Health determines the standard of care, treatment and referral to ensure that primary care providers’ services are standardized.

However, it is important to note that policy-making and the implementation process of a national health policy is a complicated process, multidimensional, including a fair amount of uncertainty (Pavolini et al., 2018). Thus, despite establishing BPJS to deliver UHC principles and in effect consolidate the power of the government, a strong influence wielded by NPM appears in BPJS (Antara News, 2011; BPJS, 2018). The first concerns the overuse of financial measures in planning and managing BPJS. It is argued that BPJS’s model is heavily influenced by neoliberal policies and practices. A leading social activist has asserted that the government has ceded its obligations and responsibilities to the people and given them to a private sector company. The state has in effect entrusted the fate of working people to third parties and market forces (RMOL, 2011). The leader of state-owned companies’ workers, Abdul Latief Algaff, stated in 2011 that the neoliberal agenda was put forward by the Ministry of Finance, the World Bank, IMF, ADB and the ILO in instituting the BPJS (Antara News, 2011).

Second, despite the BPJS five missions reflect UHC principles, the operation of the BPJS is dominated by NPM principles and even worse (BPJS, 2018). For example, Government Regulation No 86 (2013) stipulates that those who fail to pay their BPJS premiums will not have the right to access public services such as obtaining a driver’s licence, passport and school enrolment for their children. Despite this policy may enforce people to pay their BPJS premiums, it is against other human rights of a citizen as stated by a national parliamentary member.

The government must understand the constitutional mandate that education and health are the basic rights of the people. I think since Indonesia’s independence, this is the first time there have been sanctions banning such rights (Satu, 2019).

Third, based on its organizational structures, BPJS reflects private sector model in its operations. These include the delegation of powers and great influence of the management teams. Furthermore, the compositions of the board directors, operational performance, budgets and financial reports and audit practices of BPJS are in line with the financial reporting standards used in the private sector (BPJS, 2018). Finally, other key features of BPJS operations are in line with private sector healthcare providers’ practice of business-style reporting systems, such as balance sheets, cashflows, assets and liabilities information and deficit reports (BPJS, 2017).

The increase in the number of services provided

There is no doubt that the launch of BPJS increased the number of patients in the system dramatically. For example, there were 233 million services provided in 2018 compared with 223 million in 2017. Table 2 also indicates an increase from 92.3 million services in 2014 and 230 million services delivered in 2018. A study by Vidyattama et al. (2014) supports the contention that a universal health insurance system in Indonesia encouraged the public to use health services. Numbers rose by ~8% when they were sick, and country-wide, the rise was by ~5% (Vidyattama et al., 2014).

**Table 2 BPJS services**

<table>
<thead>
<tr>
<th>Year</th>
<th>Services provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>92.30 million</td>
</tr>
<tr>
<td>2015</td>
<td>144.70 million</td>
</tr>
<tr>
<td>2016</td>
<td>178.80 million</td>
</tr>
<tr>
<td>2017</td>
<td>223.40 million</td>
</tr>
<tr>
<td>2018</td>
<td>233.90 million</td>
</tr>
</tbody>
</table>

*Source: BPJS (2017) and Denk (2019).*

The Financial Times (2017) dramatically reported the government’s initiative:

> Douglas Ramage, who runs the Jakarta office of Bower Group Asia, a US investment advisory company, says the Indonesian government deserves praise for dramatically expanding access to healthcare.

However, the increase in the number of patients and services provided was not followed by better quality services. In fact, the BPJS services do not cover healthcare service costs that are pursued outside the BPJS structure. Nor does it apply to care being obtained abroad, cosmetic procedures, infertility treatments, orthodontics, medical issues from drug or alcohol abuse, self-inflicted injuries or due to dangerous activities, alternative medicine, experimental medicine, contraception, cosmetics, baby food and milk. Further to this, BPJS does to apply to medical care required for natural disasters, epidemics, special occurrences or state of emergency-type situations (BPJS, 2017).

**Structural challenges and unintended outcomes**

Despite BPJS having significantly increased the quantity of health services, real challenges remain and these challenges hamper the financial sustainability and viability of the nation’s healthcare system in the long term. We observe that the root of these challenges indicates the dominant role of politics and political forces, which fail to consider the technical operations of BPJS from both medical and economic or financial perspectives. This also shows that the establishment of BPJS did not lead to the government being prepared to increase public spending on the resources required for the rising number of patients, or the availability of healthcare professionals. This situation is indicated by several phenomena, which are explained in more detail below.

**The rising deficit and not enough government budget support**

The BPJS (2016) states that it has the responsibility to create and maintain a high-quality and sustainable health insurance programme. In fact, coupled with poor government spending in the healthcare sector, BPJS has experienced rising deficits every year. For example, the deficit in 2015 was Rp 5.7 trillion ($400 million). This figure jumped to Rp 9.7 trillion ($692 million) and Rp 9.8 trillion ($700 million) in 2016 and 2017, respectively. Table 3 summarizes the financial deficits of BPJS from 2014 to 2018.

Many commentators believe that the deficits are due to the lack of government support to spend on public health. It is important to note that the portion of health costs in the Indonesian government’s budget lags very much compared with other similarly developing countries. For example, 22 of the 36 countries categorized as low income (GDP per capita less than US$1025) allocated 11% of their annual budget to the healthcare sector (Eko, 2013). Even African
countries, such as Rwanda, Tanzania and Liberia, have allocated up to 15% of their national budget to health. In contrast, Indonesia only spent 3.90% of its GDP for public health (Table 4). On the other hand, Chile is able to allocate 16% of its budget to health care (Eko, 2013). This fact is ironic, given the lack of government support to back up BPJS is not primarily caused by the lack of resources. In fact, the debt of BPJS is comparatively small compared with other government debts, which are the consequence of neoliberal policies taken up by the government in the past decade (Ramlili, 2000). This fact supports what has been voiced by some critical scholars (see Marsa, 2009; Karianikolos and Kentikelenis, 2016; Pavolini et al., 2018) that under the logic of neoliberalism, the priority of government budgets is not to serve the basic needs of citizens; instead, it is to pay what is owed to international creditors and bankers. This explains why the Indonesian government only spent Rp 6.8 trillion ($485 million) and Rp 4 trillion ($285 million) in 2016 and 2017, respectively, to bail out the deficit incurred by BPJS. These figures were only 0.32 and 0.19% of total government spending in 2016 and 2017, respectively (Table 5).

As Table 5 presents, the allocation of Indonesian national budgets to pay its debts to international financial institutions is significant small compared with the annual government budgets to international creditors. This is not a specific phenomenon uniquely for Indonesia, a low level of government funding to the public health also occurs in Greek and Latin America nations (Ramlili, 2000; Marsa, 2009; Karianikolos and Kentikelenis, 2016; Pavolini et al., 2018).

### Resistance from doctors

As prior studies found in other countries, the adoption of neoliberalism that encourages the use of business principles in funding and operating public healthcare systems has created untended outcomes. These include resistance from medical professionals, for instance doctors, dentists and medical specialists. For Indonesia, there has been continued resistance from medical professionals since 2015 against BPJS policies. For example, in 2015, CNN Indonesia (2015) reported that doctors, who serve patients of the Social Security (BPJS) system, often complain about the rates being paid cheaply by the government for each participant. The director of the United Indonesia Doctors Movement, Muhammad Yadi Permana, said that the problem was one of the triggers that led to poor services. He also stressed that, under the BPJS model, doctors are paid Rp 2000 (USD$10 cent) per patient, which was cheaper than parking. Such a frustration continued in 2016, as hundreds of doctors who were the members of the United Indonesia Doctor (DIB) held a peaceful protest in front of the State Palace on 29 February 2015 (RMOL, 2016).

### Politics

They demanded that the government reform the BPJS system by setting more appropriate fees paid to healthcare and other medical professionals. One of the doctors’ banners read ‘BPJS Must Satisfy Patients and Doctors, Not Only Officials’, ‘We Are Doctors Fighting People’s Servants Not Servants of BPJS’ (RMOL, 2016). In addition, Liputan6 (2019) reported that 35 000 dentists throughout Indonesia who were members of the Indonesian Dental Association (PDGI) threatened to withdraw from their partnership with BPJS. The report stated that dentists claimed that they were being harmed by regulation number 59 issued by the Minister of Health. This concerned the standard rates for health services in the implementation of national health insurance programmes. They said if the government indeed did not know how to improve outcomes for dentists, then they would break our contracts with BPJS (Liputan6, 2019).

### Table 3 The BPJS deficits

<table>
<thead>
<tr>
<th>Year</th>
<th>Deficit (Rp)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>3.30 trillion</td>
</tr>
<tr>
<td>2015</td>
<td>5.70 trillion</td>
</tr>
<tr>
<td>2016</td>
<td>9.70 trillion</td>
</tr>
<tr>
<td>2017</td>
<td>9.80 trillion</td>
</tr>
<tr>
<td>2018</td>
<td>8.20 trillion</td>
</tr>
</tbody>
</table>

*Rp 1 trillion is equal to US$71 million (Bank Indonesia, 2019).

Source: Depkes (2017).

### Table 4 Indonesian health budget to GDP

<table>
<thead>
<tr>
<th>Year</th>
<th>Payment for loan (interests + principles) (A)</th>
<th>Total spending (B)</th>
<th>A/B (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>254.80 trillion</td>
<td>2039.50 trillion</td>
<td>12</td>
</tr>
<tr>
<td>2016</td>
<td>499.30 trillion</td>
<td>2095.70 trillion</td>
<td>24</td>
</tr>
<tr>
<td>2017</td>
<td>500.00 trillion</td>
<td>2080.50 trillion</td>
<td>24</td>
</tr>
<tr>
<td>2018</td>
<td>398.00 trillion</td>
<td>1894.70 trillion</td>
<td>21</td>
</tr>
<tr>
<td>2019</td>
<td>396.54 trillion</td>
<td>2461.10 trillion</td>
<td>16</td>
</tr>
</tbody>
</table>

Source: Knoema (2017).

*Predicted figure.

### Table 5 Annual Indonesian government spending (Rp)

<table>
<thead>
<tr>
<th>Year</th>
<th>Payment for loan (interests + principles) (A)</th>
<th>Total spending (B)</th>
<th>A/B (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
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<td>398.00 trillion</td>
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<td>21</td>
</tr>
<tr>
<td>2019</td>
<td>396.54 trillion</td>
<td>2461.10 trillion</td>
<td>16</td>
</tr>
</tbody>
</table>

Source: BPJS (2017, 2019a,b).

3 Bank Indonesia (2019).

4 Bank Indonesia (2019).
BPJS is the president’s responsibility, and monthly premiums are decided by the government via the Ministry of Health. The president’s statement has been criticized by a member of the House of Representatives, Sumarjati Arjoso. He said that the president should provide a solution, rather than stating that the BPJS deficit must be solved by the Ministry of Health and BPJS. He also stressed that BPJS is a public legal entity that is under the direct authority of the president (Solopos, 2018).

Conclusions
Drawing from the research questions, several conclusions can be made. We find that the policy-making of BPJS was primarily motivated by the interests of the political elite and international agencies without seriously considering key barriers to the effectiveness of the long-term universal healthcare system. Thus, NPM has shaped the nature of BPJS through its structure and the operation of BPJS. The institutionalization of BPJS faces several obstacles that include a low premium setting, the raise of deficits, resistance from medical professionals and politician tendency to blame the government-initiated insurance company of its failure to pay the costs of care to hospitals and drug companies. Our findings reframe prior studies in which the institutionalization of NPM can produce unintended outcomes, which include increasing: first, unequal access between people on high and low incomes (Rotarou and Sakellariou, 2017) and resistance from doctors and social activist in the UK (Pushkar, 2019). It also understandability, the difficulties inherent in institutionalizing of UHC insurance system in such a large (over a quarter of a billion population) and diverse (17,000 islands) country ranging from the dense population of Jakarta to the sparse population of Papua. Therefore, it is important for the government in achieving the BPJS objectives to ensure both efficiency in care provision and a focus on achieving a minimum basic set of treatments for all patients.

Finally, based on our analysis of the structural organizational arrangements, the core role of BPJS as the state agent for UHC and current problems it faces, we officer several suggestions to make the BPJS’s operations more sustainable and effective. There is no doubt that the BPJS is a potentially society-improving institution in the post-Suharto era in Indonesia. Drawing from Andrews et al.’s (2019) argument that countries adopting a comprehensive package of healthcare reforms and displaying a strong NPM reform trajectory do better than those adopting only a partial one; for Indonesia, this is important to consider. Pursuing unrealistic goals will lead to inevitable subsequent disillusionment and problems to what can be achieved realistically with a more modest agenda. It can also lead to a serious misallocation and wastage of resources (Cheng, 2015). Drawing from recent challenges faced by BPJS and the experience of other countries, such as Australia or the UK, to design a more sustainable national healthcare system, we offer the following recommendations.

Transforming the primary role of BPJS
The existing BPJS model shows that it is an institution that administers the national health insurance programme, comprising the management of memberships, collecting premiums, administering contracts with providers and paying providers. This is in contrast to the role played by the Medicare in Australia, which is the publicly funded universal healthcare system. Medicare is the primary funder of health care, funding primary health care for Australian citizens and permanent residents. Residents are entitled to a rebate for treatment from medical practitioners, eligible midwives, nurse practitioners and allied health professionals who have been issued a Medicare provider number and can also obtain free treatment in public hospitals. By transforming its role, this will reduce the current role of the BPJS as a public funded health system and its role as an insurance company could be taken over by the private sector.

Automatic memberships for all citizens
Under the current model, the members of BPJS are those who are formally enrolled in the system. This is a very complicated registration system, particularly for those with low literacy. We urge the government to simplify the registration process, so that every Indonesian citizen is automatically a member of the BPJS by registering the number of a citizen’s national ID card (Kartu Tanda Penduduk). There are some benefits of this model. BPJS can act as the state agent to facilitate: first, the right of all citizens to access health care easily in line with UHC principles and the BPJS and, second, all citizens and other related institutions can save time and costs so that the current system runs better in relation to an individual BPJS registration system. Beyond this, with the support of an integrated database system connected with the Tax Office and the National Population Registration Center, it will enhance the ability of BPJS to monitor its operations effectively. In addition, as a public funded health system, we propose that there is only type of BPJS membership. If someone wishes to be serviced by their own doctors/specialist or private hospitals, they should be able to pay out of their own pocket expenses or paid by their insurance company along with some form of payment made by BPJS.

Simplification and refocus of BPJS’s coverage
Despite any UHC programme being politically popular, policy-makers should consider how the system can be sustainable long into the future. It is important to reduce the likelihood of unintended outcomes such as the failure of BPJS to pay hospitals and other care providers due to the lack of proper funding. We believe if this problem continues it will undermine and basically wreck the healthcare system. For Indonesia and other governments with similar economic and demographic situations, the role of an institution, such as BPJS, should be to focus on providing public funds to pay the hospital and care-related costs on time and effectively. The basic idea of creating an UHC system is actually to get sick people access to proper primary healthcare services and if they are too poor, set up a system so that they do not have to pay for these services from their own pockets. This opens more opportunities for the private sector to get involved in health care without a state-dominated healthcare system.

Using the tax office to collect BPJS levies
As explained earlier, the BPJS deficits are due to its inability to force members to pay their premiums on time. We argue that this situation is partially caused by the fact that BPJS is a private sector company that legally cannot enforce people to pay BPJS levies. In 2018 alone, the levies of 40% of BPJS members were uncollected (Prastyani, 2019). This is exacerbated by the low level of the people’s financial literacy; therefore, most citizens are not involved with banks and/or online business platforms. This fact makes it difficult for BPJS to detect and force anyone to pay their insurance premiums (Tempo, 2017). To reduce the existing complicated roles of BPJS as an insurance company and a government health funder institution, the key role of BPJS must be on better managing of public health
funds, while the collection of BPJS levies should be done by the Tax Office.

In addition, given the allocation of public funds is relatively low compared with what other emerging countries spend, the Indonesian government should allocate more money to support BPJS’s operations. There are three benefits in using the Indonesian Tax Office to collect the BPJS levies and provide a larger and financed budget. First, by appointing the Tax Office to collect BPJS, potentially the collection of BPJS levies could be boosted given the role of the Tax Office to enforce the payment of taxes and other levies in Australia and elsewhere with a similar healthcare system. Second, this will reduce the current deficits of BPJS and it can then pay the appropriate fees to health professionals. Finally, this will also maintain the quality of services and ensure that the healthcare profession remains attractive and viable to doctors, nurses, dentists, etc., and well into the future.

Finally, this study has limitations. One of these limitations is that we did not classify the participants into different social or economic groups. We suggest that future studies should analytically classify the participant groups to identify whether, e.g. there are different opinions with respect to the NPM reforms in the healthcare sector. Another avenue for future research is to conduct a comparative study about the progress and impacts of NPMR reforms in Indonesia and other nations that have comprehensively undertaken reforms in the healthcare sector.

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References


