

PROMOTING NEW HEALTH INSURANCE SYSTEM IN INDONESIA; LESSON LEARNED FROM AUSTRALIA

Mendorong Sistem Jaminan Kesehatan Nasional Baru di Indonesia; Belajar dari Pengalaman Australia

Mahpud Sujai

Pusat Kebijakan APBN, Badan Kebijakan Fiskal, Kementerian Keuangan
Jln. Dr. Wahidin No. 1, Jakarta Pusat 10710, DKI Jakarta, Indonesia
Email: msujai@gmail.com

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ABSTRAK

Perubahan signifikan dari struktur perekonomian Indonesia telah menyebabkan kebutuhan masyarakat tidak hanya sekedar kebutuhan dasar seperti makanan dan pakaian, namun kesehatan dan pendidikan telah menjadi suatu keharusan bagi masyarakat. Mengantisipasi kondisi ini, pemerintah akan menerapkan sistem kesehatan yang baru pada tahun 2014 sebagaimana diamanatkan oleh undang-undang. Tulisan ini memiliki tujuan untuk mengeksplorasi beberapa aspek yang berpengaruh terhadap formulasi dan implementasi kebijakan, khususnya dalam merancang sistem asuransi kesehatan yang baru di Indonesia dan belajar dari pengalaman Australia. Metodologi yang digunakan dalam penulisan ini adalah penelitian primer seperti wawancara mendalam dengan beberapa ekonom kesehatan, peneliti pemerintah serta pengamatan terhadap organisasi yang mengelola sistem kesehatan di Australia dan penelitian sekunder dengan melakukan tinjauan pustaka sistem asuransi kesehatan, analisa benchmarking, membandingkan sistem asuransi kesehatan di Indonesia dan Australia dan menganalisa yang terbaik dan cocok untuk diterapkan di masa depan. Ada beberapa temuan menarik yang bisa direkomendasikan seperti reformasi kesehatan Australia dan hubungan antara sistem kesehatan publik dan swasta.

Kata Kunci : cakupan universal, pengeluaran kesehatan masyarakat, sistem asuransi kesehatan

ABSTRACT

Significant change of Indonesian economy has lead to the need of people more than just basic need such as food and clothes. Others such as health and education have become a must for Indonesian. Anticipating this condition, government will implement new universal coverage health system in 2014 as mandated by law. This paper has objectives to explore several aspects which contribute or influence to the policy formulation and implementation, particularly in designing new health insurance system in Indonesia and learning from Australian experience and best practice. Methodology used in this paper is both primary research such as in depth interview with some health economist, expert form universities, government researcher as well as observation to the organization that manage health system in Australia and secondary research by doing literature review of health insurance system, benchmarking, compare and contrast the health insurance system in Indonesia and Australia and analyze the best and suitable ones for implemented in the future. There are several interesting findings that can be recommended such as Australian health reform and relationship between public and private health system.

Keywords: health insurance system, public health expenditure, universal coverage

I. INTRODUCTION

Indonesian economy has increased rapidly. In 2000, the Indonesian GDP is only \$165 billion or number 27 in the world. In 2011, with a GDP of \$847 billion, Indonesia's rank has climbed up to number 16 in the world. Meanwhile some analysts have predicted that Indonesia could become the seventh largest economy in the world by 2030.

The successful story of the Indonesian economy followed by the increase of people welfare and reduces poverty and inequality. The poverty rate in Indonesia has declined sharply from 14 percent in 2009 to 11 percent in 2011 and will continue to decline to 8 percent in 2014 (Indonesian State Budget APBN 2009-2014). This number reflected by the increase sale of luxury goods such as cars, motorcycles, electronics and cell phones as well as cement for building houses and infrastructure.

The rapid rise of Indonesian economy has swift people's concern from basic needs such as foods and clothes to the more advance priorities such as health, education and social security. It will lead Indonesia to the welfare state such as other developed countries.

Indonesian government has anticipated this condition by promoting some breakthrough policies such as increasing minimum labor's wages and introducing social security system. In the end, such policies will increase the productivity of the economy. The most recent policy that government will implement is the National Social Security System or *Sistem Jaringan Sosial Nasional (SJSN)* which is mandated by the SJSN law No.40/2004 and the Social Security Administrative Bodies or *Badan Pengelola Jaminan Sosial (BPJS)* law No. 24/2011. This policy will radically change the social protection paradigm from the traditional one through the line ministries budget to the insurance based social protection.

The Indonesian Social Security System will be implemented gradually in two steps. First step is the Health Insurance System that will be implemented in 2014. The next step is the Employment Insurance Systems which are the rest of social insurance system that will be implemented in 2015. Indonesian government has already design the health insurance system for 2014 implementation. However, many loop holes and weaknesses still exist and need for improvement in the future.

The implementations of health insurance systems are vary. Each country has a different system depend on many concerns, such as the conditions of its people, health infrastructure or even GDP per capita. The advanced insurance system mostly implemented in the developed countries with more advanced life and health indicators. Australia as one of the developed country has implemented the health insurance system since 1950s under the National Health Act by the implementation of universal health coverage through subsidy, tax deductions and regulation of public health insurance. The result is Australia has become an advanced country in providing health services for all Australian.

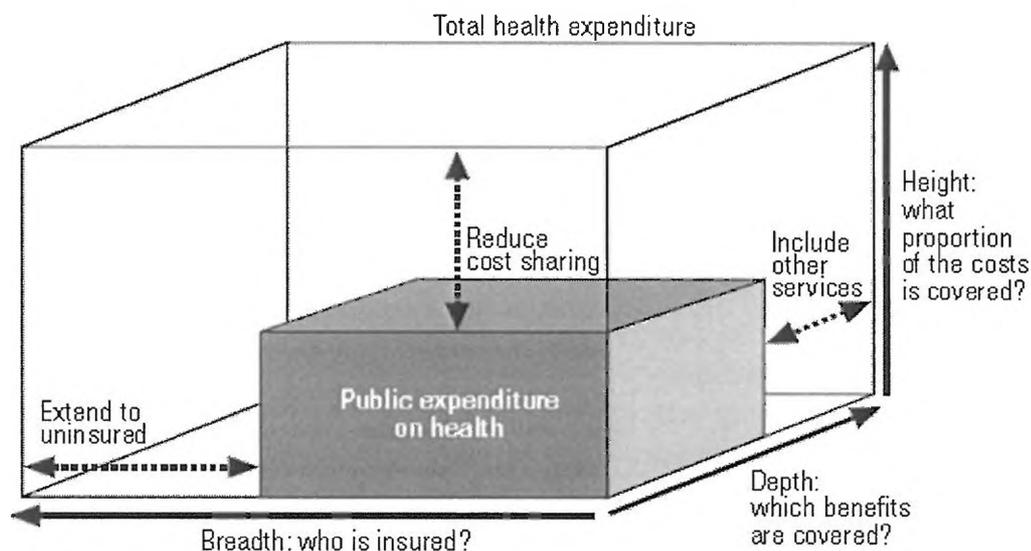
Therefore, this paper will focus on analysis of the Indonesian new health insurance system and elaborate lesson learned from Australian health insurance system.

II. LITERATURE REVIEW

Indonesia now is moving toward the universal health coverage system in its health system. Universal health coverage is a condition when every people can have a similar access to the healthcare services without any financial difficulties (WHO Report, 2010). According to the 2010 World Health Organization Report, there are three ways and conditions for a country to move towards universal health coverage, first by increasing total health expenditure both public expenditure and private expenditure. If the public expenditure increases, it will reduce cost sharing vise versa. Second, by extending health insurance to uninsured people, so it will significantly increase the number of membership in the insurance system. Increasing public health expenditure is the only possible way to extend beneficiaries especially poor people and informal worker. Third, by defining benefit that will be

covered by the insurance. Increasing public health expenditure can deepen the benefit cover include the other services not only the basic health service one (WHO Report, 2010).

In order to reform the health sector, Indonesian Government together with the parliament has produced new health law Number 36/2009 about Health. The introduction of new health law has made significant change in health sector reform in Indonesia. This law has reformed the health system in Indonesia from government based health serviced limited to limited number of people to the universal coverage system that cover all of Indonesian with health insurance.



Source: World Health Organization report, 2010

Figure 2.1. Moving forwards towards Universal Coverage.

One of the main challenges to achieve universal health coverage in the developing countries such as Indonesia is reaching out the poor and the informal sector. The problem occurs in the developing countries are the number of the poor people who cannot afford to buy private health insurance is still large and the number of people who are in the informal sector is also large. However, all countries regardless of income level can set out on the path to universal health coverage through a mix of different pre-payment and risk pooling mechanisms, using a combination of tax funding and social health insurance (Carrin and James, 2004).

While achieving universal health coverage in lesser developed countries may be more difficult, many countries that recently moved to universal coverage began the process when they were at an earlier stage of economic development (Anier, Ahmed, Ros and Ir, 2013; Mills, 2007). Generally, characteristics of the lesser developed countries are the tax income base is narrow and the revenue collection for social health insurance is constrained (Carrin, Waelkens, and Criel, 2005), as well as expenditures are spread over other economic priorities. Other characteristics are the formal employment sector such as government and private enterprises is low, poor people are relatively high and most of the population live in the rural area.

Indonesia is starting to move towards the universal coverage system by introducing law no 40/2004 about National Social Security System (SJSN) and law no 24/2011 about Social Security Acting Authority (BPJS). However, Indonesia is a developing countries and match with some criteria such as (i) Tax base income is still low with the tax ratio around 14 percent (ii) Revenue collection for social health expenditure is constrained, in case of Indonesia is almost none, (iii) The number of poverty is still

extensive which almost 30 millions of Indonesian are poor, (iv) Most of the people (more than 70 percent) live in rural area, (v) The informal sector is predominant in the economic structure of Indonesian economy.

Those criteria above will make the implementation of universal health coverage in Indonesia have some challenges and constraints. Government effort to implement the universal health coverage mandated in the law is a very ambitious program. It requires a strongly institutional, organizational and financing effort to success this program. However, government has committed to implement this new system next year with many constraints and obstacles will occur in the future.

III. METHODOLOGY

This paper has an objective to explore several aspects which contribute or influence to the policy formulation and implementation, particularly in designing new health insurance system in Indonesia. From this objective, the research question raised is how the new health insurance system in Indonesia changes radically the health services for all Indonesian in the future.

Other objective of this paper is to learn from the experience and best practice from other countries that have implemented universal health coverage for such a long time which in this case Australia. From this objective, the research question raised is how the Australian health insurance system works to benefits its people and what the best practice that can be learned for Indonesia.

Most of the methodology used in this paper is secondary research methodology by doing literature review of health insurance system, benchmarking, compare and contrast the health insurance system in Indonesia and Australia and analyze the best and suitable ones to be implemented in the future. In the other hand, primary research methodology also used to strengthen the analysis by doing in depth interview with some health economist, expert form universities, government researcher as well as observation to the organization that manage health system in Australia.

IV. ANALYSIS AND DISCUSSION

4.1. Health Insurance System in Indonesia and Australia

4.1.1. Health Insurance System in Indonesia

Health insurance system firstly introduced in Indonesia in 1968 when the government set up the new policy for government official and army healthcare by establishing Healthcare Management Fund Authority (Badan Penyelenggara Dana Pemeliharaan Kesehatan) as an embryo for National Health Insurance under the Ministry of Health. In order to made the service more professional, Government changed the agency into Government Corporation namely Perum Husada Bhakti in 1984. The corporation transformed again in 1992 to become PT. Askes with more flexibility in managing its fund and contribution. In 2005, Government gave more responsibility to PT.Askes for managing social health insurance for the poor (Askeskin).

The most significant reform is going underway after the law no 40/2004 and law no 24/2011 was introduced. PT. Askes will transform into National Health Insurance Agency (BPJS Kesehatan) which have responsibilities for health insurance for all Indonesian started in 2014. The insurance system will cover 86.4 million lowest income earners, 16.8 million government official with their family, 3.5 million army and police with their family as well as the rest of Indonesian who still do not covered by health insurance.

This reform is first step for Indonesia in implementing universal health coverage. There are some principles in managing this new health system. First, it is implemented simultaneously throughout

Indonesia with the principle of mutual aid so there will be cross subsidy within the system. Second, it refers to the principles of social health insurance whereas the poor and needed people will be covered under public health expenditure. Third, managed healthcare principle will be implemented in structural and hierarchical way. Fourth, program organized by non-profit principle. Fifth, ensure availability and equality in service for all participants and managed by accountable and transparent principle with the emphasis of prudence, efficiency and effectiveness (SJSN Law, 2004).

According to the law no 40/2004, there are two main institutional that involved in the implementation of universal health coverage system in Indonesia, which are National Social Security Council or *Dewan Jaminan Sosial Nasional* (DJSN) and Health-Social Security Acting Authority or *Badan Pengelola Jaminan Sosial Kesehatan* (BPJS Kesehatan). In the article 7, DJSN has duties and responsibilities to conduct a study and research regarding social security, to formulate policy for SJSN investment fund, to propose budget for social security to the government and to conduct monitoring and evaluation regarding social security implementation. In the other hand, article 10 law no 24/2011 stated that BPJS has duties to manage and conduct the implementation of social security, such as identifying membership, collecting premium, managing and investing social security fund, receiving contribution from member and government and allocating fund for the need of social security program.

Every Indonesian include foreigner who lives in Indonesia at least for 6 months are compulsory to become the member of health insurance system. There are 3 types of membership in the system. First, benefit member recipients who are the lowest income group selected by the government, and the government will pay the contribution for this member group. Second, members who are employed both in the government and private sector. These members are paid the premium by cost sharing contribution between employee and employer. Third, members who are neither benefit recipient group nor employed are obliged to become a social health insurance member and paid their premium to the BPJS.

The social health insurance reform underway in Indonesia will change dramatically healthcare system in several aspects which are membership aspect, benefit aspect, health facilities and infrastructure, financing and institutional aspect. In the membership aspect, currently less than 30 percent of Indonesian covered by health insurance. From approximately 240 million people, people who already covered by health insurance are 16.8 million government official include their families, 3.5 million army and police include their families, 4.4 million private employees covered by Jamsostek and 8.8 million private insurance member include 30 million poor people covered by Jamkesmas and 11.3 million people covered by Jamkesda program. In total, only approximately 74.8 million people out of 240 million Indonesian people who are covered by the health insurance. After the implementation of BPJS, all Indonesian are compulsory to have a health insurance, either through the BPJS system or through the private health insurance system.

Meanwhile, current condition of the benefit received by the members is un-standardize and un-comprehensive. The benefit is still partial and in the different level with each member. However, there are big excess claim in cost sharing, since people still choose whatever health service with their own consideration. In the future, the new system will try to standardize the benefit as needed by the member. In the other hand, there will be comprehensive action between health promotion, prevention, curative and rehabilitation in one system. This comprehensive approach will minimize cost sharing and optimize the utilization of the service.

The other important thing should be considered is the availability of health infrastructure as well as health workforce. Even though all Indonesian is covered by health insurance, it will not be effective if the health infrastructure and health workforce are limited. The limited health infrastructure and its workforce are obstacles for providing better health services. Current condition is un-standardize and

lack of health facilities especially in the regional level. The health work force faces similar condition. The ratio of doctors per population is far away behind even some comparative neighboring countries such as Thailand and Philippines. In the future, there should be a better quality and quantity of health facilities and health workforce. Especially when all Indonesian already covered by insurance, many Indonesians will significantly change their habit to go to the hospital. It should be anticipated with more health infrastructure and health workforce.

The financing aspect considers the premium which in current condition is still varies and un-standardize, not only in the amount but also in term of premium collection. The insurance financing also varies between health insurance service providers. Some are using capitation system and some other are using diagnosis related or reimbursement system. The current scheme is still using social assistance from government and private health insurance for some others. In the future, it will be more standard in the financing insurance as well as the insurance system where the poor using social insurance and non poor using premium collection system.

In the institutional aspect, currently the administrator is varies including public insurance company and government. Management scheme and organization capacity also varies and un-pattern as well as the operating procedures still different among each institutions. However, the new system will formed a new insurance authority (BPJS) which will administer the entire public insurance scheme besides the private insurance ones. There will be similar operating procedures and the capacity will be much bigger to handle several conditions.

4.1.2. Health Insurance System in Australia

Australia is one of the advanced countries in the health conditions, proved by a leading in almost every health indicators such as life expectancy, birth and death rates and infant mortality. Life expectancy in Australia is among the highest in the world which stays at 81.4 years on average in 2010. Meanwhile the death rate and birth rate stays at 6.5 and 12.8 respectively per 1,000 people, and the infant mortality rate is 5,0 per 1,000 live birth in 2010. Australia's health service also in a best indicator with the indicator of 1 doctor for 322 people on average and 1 hospital bed per 244 people. One of the reasons might be because of its good healthcare system including its health insurance system.

Health system is part of the social security system in Australia. Similar to other countries and international best practices, there are three parties who involved in the social security system which are government or public, employer and employee or individual. However, there are 5 parts of social security system commonly practices in Australia which are health system, age pension, work injury, unemployment and maternity. The Table 4.1 showed the resume of social security system in Australia.

Health insurance system firstly introduced by Federal Government of Australia in the year 1950s. Insurance health policy in Australia started in 1953 when the parliament endorsed the National Health Act which proposed universal health coverage through subsidy, tax deductions and regulation of private health insurance.

In the year 1984, the Australian government introduced a medicare system as the national universal health insurance program which continues to implement until now. Under the Medicare system, Australian Government provides the public health service for all Australian free of charge. However, Medicare is not a premium system such as implemented in the insurance business.

Medicare is funded partly through the tax levy at the rate of 1.5 percent on top of regular tax rate, mostly out of general revenue but with exceptions of low income earners. Besides that, there is an additional levy of 1 percent imposed for high income earners who do not have a private health insurance. This policy is an incentive for high income earners for using private health insurance and avoiding the public insurance ones.

Table 4.1. Social Security Scheme in Australia

Name of Insurance	Health	Age Pension	Work Injury	Unemployment	Maternity
Government/ Public/ Safety net program	Public service, Budget funded	Public service, budget funded	No	Budget funded, government assistance	No
Personal Contribution/ Employee/ Individual	Private health cover, optional but highly recommended with some incentives	5 percent of wages (super annuation)	Personal insurance, not compulsory	Insurance personal scheme/income lost protection	No
Employer	No (rare)	Compulsory, rate of 9%- 12% of wages	Compulsory Insurance premium	No	Allocating fund, minimum period after birth

Source: Analysis from various sources

The total federal government health expenditure for 2010-2011 financial year was AU\$55.9 billion, which consists of around AU\$17.6 billion are the cost of medicare and the rest or around AU\$38.3 are the cost of other general health expenditure. In the other hand, revenue raised by the medicare levy in the 2010-2011 financial year is around AU\$9 billion, which only partially offsets half of the total medicare cost (Australian Institute of Health and Welfare, 2011).

Medicare provides coverage for primary healthcare services, ambulatory health services and public hospital health services. However, 1.5 percent tax imposed allocated for medicare program is extensively not enough for providing public health, and it should be more funded with federal tax. Medicare does not cover all of health services, any additional services should be covers privately such as dental care, cosmetic surgery and other premium services. Medicare provides free public hospital treatment for public patients. It also subsidies the cost of medical treatment delivered in private hospital and doctors the community such as general practitioner and medical specialist through the medicare rebates, usually 85 percent of schedule fee for out of hospital or 75 percent of fee for in hospital.

4.2. Public and Private Health Expenditure in Australia

One of the main issues in the healthcare system in Australia is the proportion of health expenditure between public and private sector. Some countries are highly depend on public expenditure to finance their healthcare system, such as Japan and Scandinavian countries which public expenditure has a proportion of more than 80 percent of their health expenditure meanwhile only 20 percent are from the private sector.

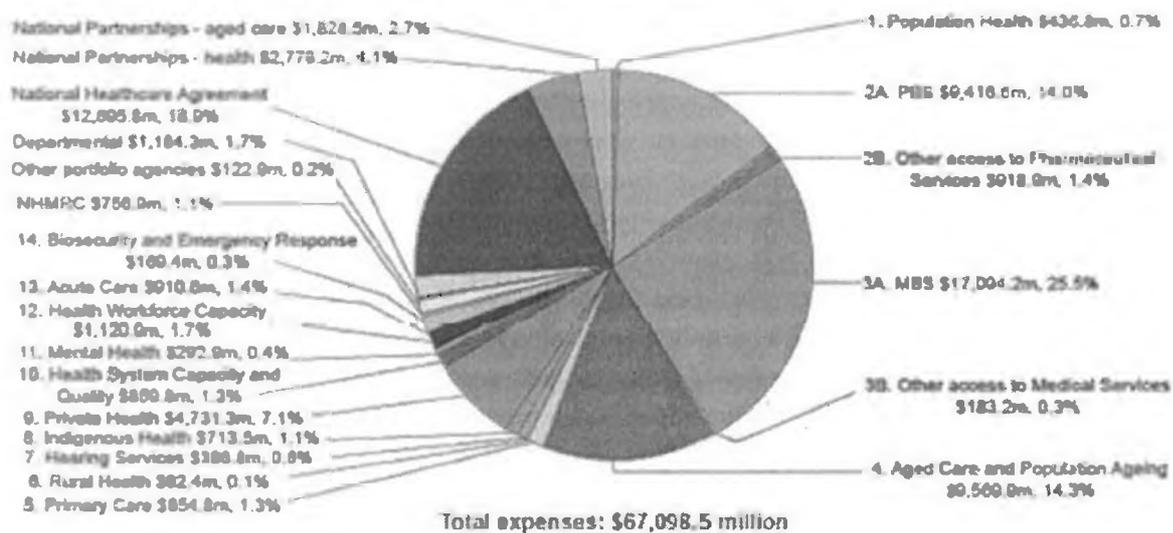
In the other hand, other countries highly depend on private sector to finance their healthcare service, such as United States whereas public sector only spends around 45 percent of their total health expenditure and private sector has a proportion of 65 percent from its health expenditure. However, Australia is in the moderate level, whereas public spending for healthcare service has a proportion at around 70 percent of its total health expenditure (OECD, 2011).

In case of Australia, from the total private health expenditure which takes around 30 percent from total health expenditure, only 25 percent are through private health insurance, meanwhile the rest or about 75 percent are from individual out of pocket or other source of funding such as from charity organization. In the other hand, commonwealth government expenditure takes percentage of around 50

percent of total public health expenditure. Meanwhile, the rest are states and territories public health expenditure.

There are many items incurred in the commonwealth health expenditure. However, only five significant expenditure applied from the total of the commonwealth health expenditure. The biggest proportion of the expenditure is for the medicare benefit scheme which takes around 25.5 percent of the total commonwealth expenditure, followed by National Healthcare agreement, which is the transfer fund from the commonwealth to the States Government, pharmaceutical benefit scheme and private health insurance rebate which takes proportion of 18.9 percent, 14 percent and 7.1 percent, respectively.

Portfolio of Health and Ageing programs: Commonwealth estimated expenses by outcome and major program, 2011-12



Source: Department of Health And Ageing Australia

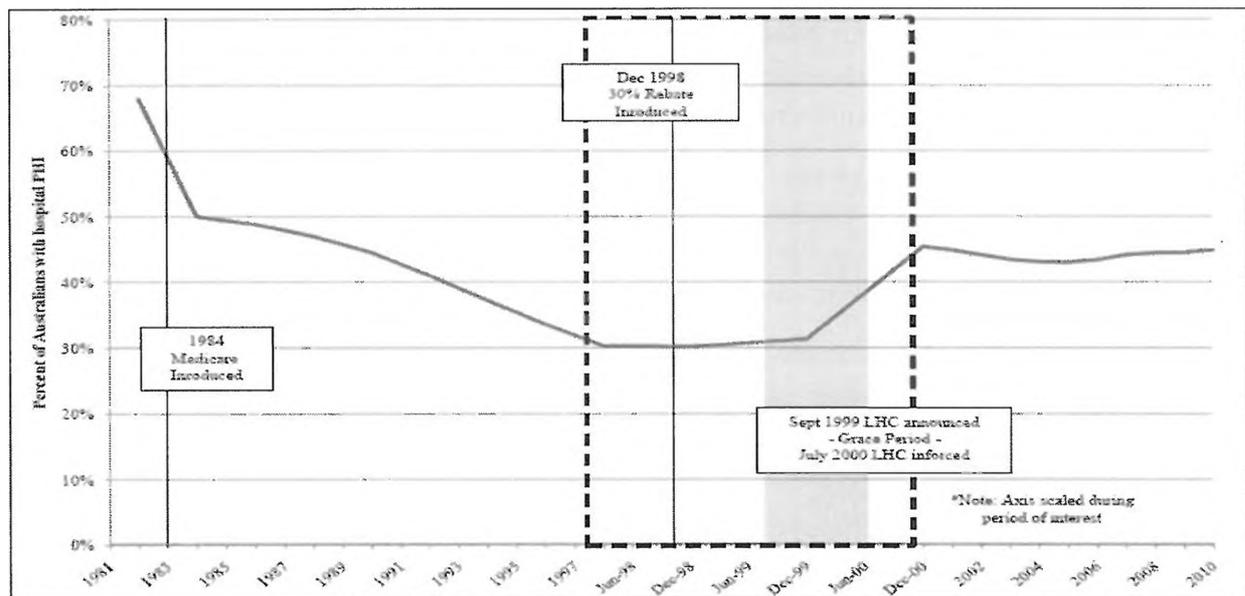
Figure 4.1. Proportion of Australian Health Expenditure.

Before the medicare introduced in 1984, the composition of health expenditure was dominated by private sector, including private health insurance in the private hospital by around 70 percent. However, the composition changed dramatically after medicare implementation. The private sector health spending including the use of private health insurance in private hospital declined significantly in only several years, from 70 percent in 1981 and 60 percent in 1983 to only 30 percent in 1997. In the other hand, public sector health spending including public sector hospital increased significantly form only less than 40 percent in 1983 to almost 70 percent in 1997.

In the financial year 2010-2011, total health expenditure in Australia was AU\$130 billion which is around 9.3 percent of GDP. Nearly 70 percent of total health expenditure in Australia or around AU\$90 billion is paid by the government. The proportion of health expenditure paid by the government is around 37 percent paid by the State Government, and the rest or around 63 percent paid by the Federal Government (Australian Institute of Health and Welfare, 2011).

In the other hand, the remainder 30 percent or around AU\$ 40 billion comes from private health expenditure. The proportion of private health expenditure consists of around 24 percent covered by private health insurance, around 59 percent comes from individual out of pocket and around 17 percent comes from other private sources such as charity organization (Australian Institute of Health and Welfare, 2011).

After medicare policy introduced in 1983, medicare becomes the largest source of funding for healthcare in Australia. It can be seen in the following figure.



Source: Australian Institute Of Health And Welfare

Figure 4.2. Proportion of Australian with Private Health Insurance.

The dramatic change of this composition has caused two main problems. First, the medicare system created disincentive for Australian people to participate in the private health system including private health insurance and private hospital. This policy made the private health sector become uninterested in enhancing their businesses. Secondly, the public health sector become too dominant, this situation caused the public hospital became over capacity and the government budget allocated for health expenditure rise significantly.

The Medicare introduction has made significant change in public health expenditure. Most of the public health expenditure spent through Medicare system. This reform has significantly increased government budget allocation for health sector. Prior to the above condition, in 1997, Australian government introduced private health insurance reform which had two main objectives. First objective is to encourage private funding especially through private health insurance to enhance private health insurance industry. Second objective is to relieve pressure in public health system and public expenditure.

The reform introduced by the Australian government mainly in promoting some incentives to encourage people to use the private health insurance and private hospital. Some of the incentives are:

- a. Lifetime health cover was introduced in 2000. This policy enabled insurance company to increase premiums up to 2 percent per annum for person who takes out private health insurance after age of 30. Meanwhile, people who take out private insurance after age of 40, will include 20 percent loading of their premium. This policy designed to encourage a young membership and keep individuals enrolled.
- b. Private health insurance rebate was introduced in December 1998. The government subsidized the premium cover payment up to 30 percent for both hospital and extra cover. This policy designed to promote private health insurance system membership by increasing affordability. This policy also has an objective to strengthen Australian private health insurance industry.

- c. Medical levy surcharge was introduced in 2008. This policy encourage people especially high income earners to take out the private health insurance, by surcharging 1 percent on top of 1.5 percent medicare levy for people who have annual income more than AU\$80,000 for singles and AU\$168,000 for couples but do not take out private health insurance. This policy has led to the high income earners are join the private health insurance, since the Medicare levy that should be paid is higher than the premium that they have to pay for private health insurance.

Even though the reform does not change the composition of public and private health expenditure, because government has to spend billions of dollars for private insurance premium rebate, however the reform has succeeded to make equilibrium in the proportion and prevent more increase in the public health expenditure as well as promoting the development of private health sector in the same way as public health sector.

Table 4.1. Composition of Public and Private Health Expenditure

Year	Government			Health Insurance funds	Non-Government		
	Federal Government	State/Territory and local	Total		Individuals	Other	Total
1992-93	43.6	23.4	66.9	11.4	15.8	4.9	33.1
1993-94	45.1	21.3	66.4	11.0	16.9	5.6	33.5
1994-95	44.8	21.6	66.3	10.7	17.1	5.9	33.7
1995-96	45.2	22.0	67.2	10.5	16.0	6.3	32.8
1996-97	43.7	22.9	66.7	10.4	16.7	6.3	33.3
1997-98	44.4	23.8	68.2	8.8	16.7	6.3	31.8
1998-99	43.3	23.7	67.0	8.0	17.3	7.8	33.0
1999-00	44.3	24.9	69.2	6.9	16.7	7.3	30.8
2000-01	44.4	23.3	67.7	7.1	19.0	7.2	32.3
2001-02	44.0	23.2	67.2	8.0	17.5	7.2	32.3
2002-03	43.6	24.4	68.0	8.0	16.7	7.3	32.0
2003-04	43.6	23.6	67.2	8.1	17.5	7.3	32.8
2004-05	43.8	24.0	67.7	7.7	17.4	7.1	32.3
2005-06	42.8	25.3	68.0	7.6	17.4	6.9	32.0
2006-07	42.0	25.3	67.3	7.6	17.4	7.2	32.2
2007-08	43.2	25.5	68.7	7.6	16.8	6.9	31.3
2008-09	43.2	26.5	69.7	7.3	16.8	5.7	30.3

Source: Australian institute of health and welfare

4.3. Challenges and Constraints for Indonesia

There are three main weaknesses and vulnerabilities that should be faced in implementing the new health insurance system in Indonesia. From the Australian experience, to implement new health insurance system it should be formulated the best design of the scheme, administration of the scheme and health insurance fund management.

4.3.1. Design of the scheme

In order to design the new health insurance scheme, there are several factors to be considered such as who the participant is, who the contributor is, how the contribution is and what the benefit is. All the factors affected must be put in balance, between the budgets funded and the allocation of the fund. It should also consider the expected cost unit of health service compare to the premium collected.

4.3.2. Administration of the scheme

The administration of the new scheme also has an important role in the successfulness of this program. Without proper administration, the new program will create new problem both in the system and the budget. The issue regarding the administration of the scheme is who the administrator is, how the regulation is, who the regulator is, how to collect the contribution, sanction and penalties for those who does not contribute and the accountability and prudent issues.

The new system will involve big numbers of people, premium and healthcare services. It should be well organized, accountable and reliable services. The system should consider the right mechanism of premium collection, investing fund, payment benefit and relation between insurance administrator (BPJS) and healthcare service provider such as hospitals and doctors. Since the government plays a very important role in this new scheme as a premium contributor for the poor and government employee as well as the stockholders of BPJS. As the biggest premium contributor, government should ensure the availability flow of fund in order to maintain the new system stay on track.

4.3.3. Management of the fund

In order to maximize the benefit for all stakeholders, especially the insurance member, management of fund is also one of the most important factors that should be considered. Several issues raise with management of fund, such as fund management, accountability, regulation, prudential aspect of fund investment, investment return, investment scheme and value of the investment benefit.

The other challenge is the availability of budget allocated for the health sector. Since universal health cover will be implemented, it must be a significant change in people's habit for health problems. People will easily go to the healthcare service, and there will be an increase in the healthcare service demand. The problem is the availability of health service supply as well as government ability to finance this program. Therefore the new insurance system should be followed by increasing budget allocation.

Nevertheless, government should find the way out to increase healthcare financing, either by increasing revenue or reallocation of budget from other sector. When government provide more services, there should be more revenue coming in.

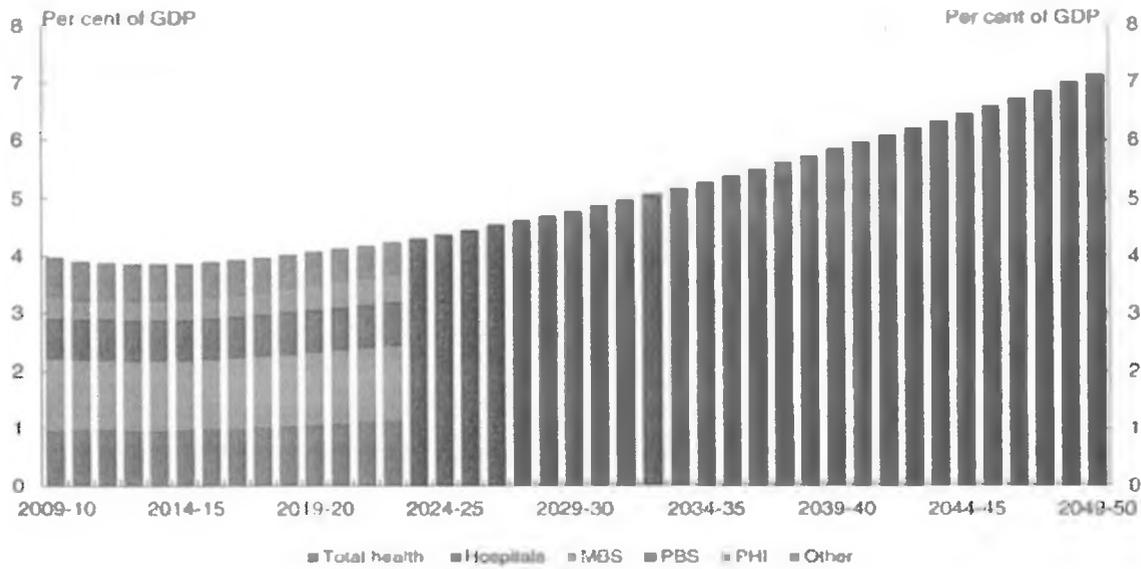
4.4. Lessons Learned

There are several lessons we can learn from Australia to achieve good health system for all Indonesian. First, Australia highly depends on public health system which is already sophisticated. Government allocates big amount of budget proportion compare to other expenditures. However, Australia tries to balance between public health expenditure and private health insurance. Some incentives are given to promote private health insurance industry. In case of Indonesia, we should also develop and promote our private health insurance system, in order to strengthen our health system and reduce the budget burden caused by the increase of public health expenditure.

The situation that faces Australia is almost similar to other developed countries such as Japan and Scandinavian Countries. Better health condition leads to increase the life expectancy with caused new problem which is aged care. More proportion elder people, more increase their health expenditure. In case of Australia, it health expenditure will increase almost double in the next 20 years.

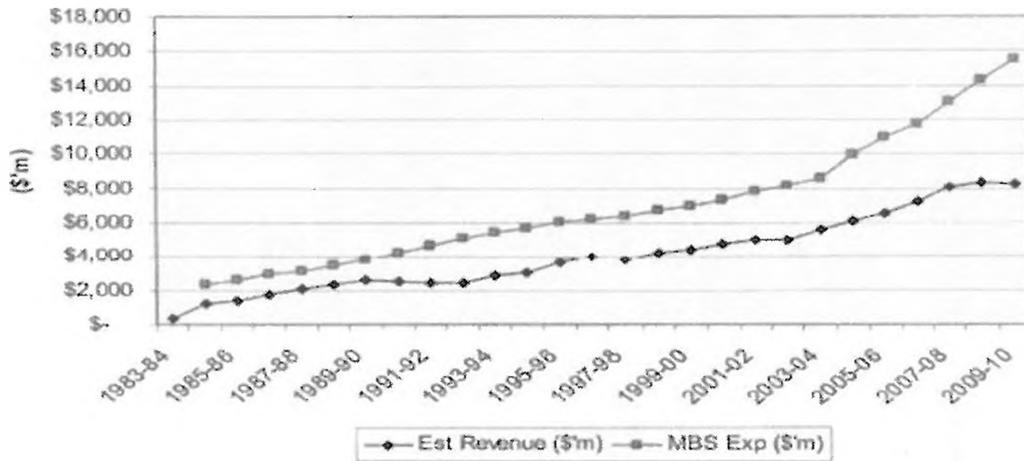
Second, there should be policy to link the government service provided in this case is health insurance cover, with the revenue that government should allocated for providing such services. It can be either earmarking some revenue for example from tobacco excise or finding other source of revenue. Even in Australia, when there is a medical levy scheme, public health expenditure is far higher than the revenue generates. In recent years as well as future projection, the medicare benefit scheme (MBS) expenditure is increase significantly compare to the medicare levy revenue gained. This is caused the gap between revenue and expenditure is much higher and caused more and more medicare scheme funded with the general revenue.

Third, government should also increase the budget allocation for health sector. Budget allocation especially use for increasing the capacity of health infrastructure such as hospitals, primary care service (puskesmas), health promotion and campaign as well as to provide more health workforce such as doctors, nurses and other workforce related to the health system.



Source: The Australian Treasury

Figure 4.3. Projection of Australian Health Expenditure.



Source: Department of Health and Ageing, Australia

Figure 4.4. Comparison between Medicare Levy Revenue and MBS Expenditure.

Fourth, government should allocate more resources on health promotion and campaign, since preventive action is better than curative action. We should campaign healthy living such as increasing health environment, sanitation, health promotion, sports and exercise in order to make Indonesian healthier. There should be a better cooperation and coordination between several government institutions related to the health system such as Ministry of Health, BPPOM, BKKBN etc. Fifth, it will be better if there is a subsidy for the pharmaceutical as well, especially for the generic drugs either in prescription base or in the hospital. It will reduce health cost for the people. In the end, the program will not be successful without the support from local government. There should be active participation from the local government both budget support and health workforce, because the health sector is one of the responsibilities that have already transferred from central government to the local government

mandated by Decentralization Law number 32 and 33 year 2004 and Government regulation number 38 year 2007.

V. CONCLUSION AND POLICY RECOMMENDATION

5.1. Conclusion

Indonesia will implement the new universal health insurance system in 2014 as mandated by law. BPJS will act as public insurance administrator which will run the public insurance scheme for all Indonesian. There are 3 important factors to make the new system run successfully, design of the scheme, administration of the scheme and management of fund. There are also several aspects to be considered to achieve maximum benefit for all members such as membership aspect, benefit, availability of health facilities and health workforce, financing as well as institutional aspect.

Australia has developed the universal coverage system since 1950's and currently all of Australian were covered by health insurance either public or private insurance. Public health plays the most important role in Australia, since 70 percent of the health expenditure is public expenditure. In order to enhance the role of private health insurance as well as balancing the public health expenditure, Australian Government has reformed its health system especially in providing more incentives for private health insurance to be more developed. Government should anticipate the implementation of this new system in term of budget consequences. It must be an increase in health sector budget, consequently government should finance this program either by increasing revenue or allocating from budget for other sector.

5.2. Policy Recommendation

Indonesia must develop and promote private health insurance system as well as public insurance, in order to strengthen our healthcare system and reduce the budget burden caused by the increase of public health expenditure. Government must increase the budget allocation for health sector which is still very low compare to other comparative countries. Budget allocation especially use for increasing the capacity of health infrastructure such as hospitals, primary care service (puskesmas) as well as to provide more health workforce such as doctors, nurses and other workforce related to the health system.

Government should allocate more resources on health promotion and healthy living campaign such as increasing health environment, sanitation, health promotion, immunization, sports and exercise in order to make Indonesian healthier. It will make less people come to the hospital and reduce budget burden for health expenditure. There should be a better cooperation and coordination between several government institutions related to the health system such as Ministry of Health, BPPOM, BKKBN etc. It will be better if there is a subsidy for the pharmaceutical as well, especially for the generic drugs either in prescription base or in the hospital. It will reduce health cost for the people.

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