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EVALUATION OF UNIVERSAL HEALTH COVERAGE POLICY : A COMPARISON STUDY BETWEEN INDONESIA AND THAILAND

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Bilamana di kemudian hari ditemukan ketidaksesuaian dengan pernyataan ini, maka saya bersedia dituntut dan diproses sesuai dengan ketentuan yang berlaku dan mengembalikan seluruh biaya penelitian yang sudah diterima ke kas negara.

Demikian pernyataan ini dibuat dengan sesungguhnya dan dengan sebenar-benarnya.

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EXECUTIVE SUMMARY

This research basically is an evaluation study on UHC both Indonesia and Thailand. The Universal Health Coverage (UHC) Policy is an important health policy issue among ASEAN Countries, including Indonesia and Thailand. Thailand has been implemented UHC for almost twelve years, and on the other hand, Indonesia has just in the beginning step of UHC. Even though both of them started UHC at the different year, but both of countries can have lesson learn by evaluating their implementation either their preparation for UHC. The facts shown, UHC brings benefit for the people, but still there are UHC off-track in both countries, despite nominal comprehensive coverage for the poor, patients had difficulty accessing certain services, poor quality and unequal distribution of government health facilities.

The long term goal of this research is to have a sustainable research collaboration with Thammasat University to produce international publication base on research, reference book and to fill the MoU between UniversitasMuhammadiyah Yogyakarta and Thammasat University Thailand. The short term goal of this research is to response to the problems related to UHC both in Indonesia and Thailand. This research in particular will try to address the evaluation of two things, first, how do the distinctive model of UHC implementation both in Indonesia and Thailand. Second is how do the distinctive results of UHC impact both in Indonesia and Thailand.

The analytical approach of this study is derived from a mix methods between quantitative and qualitative research methods. In this mix methods, the quantitative approach will use more on descriptive quantitative parameter such as table of frequency and the average of dispersion by conducting survey. While in qualitative will use the interview guide and focus discussion group to explore the information that have not been covered by survey. The survey and FGD wil be conducted both in Indonesia and Thailand with the certain respondents and and key informen. Finally, this research will also performing the procedures of triangulation to mean convergence among researchers (agreement between field notes of one investigator and observations of another) and convergence among theories.

In order to achieve through the goal of this study, the policy model is utilized. It is considered the most effective way to help analyze, reformulate, implement, control, and provide feedback on the UHC in Indonesia and Thailand. To serve this goal, the scope of this research project has 5 phases of study:The 1st phase of the study will provide a comparative analysis of the similarities and differences in the UHC of Indonesia and Thailand. The second phase will explore the extent and policy related regarding gaps and problems of UHC by utilizing the result of first phase. The third phase will evaluate policy in order to fill these gaps by decreasing or eliminating obstacles to the UHC system of Indonesia and Thailand. The fourth phase will design draft of policies and strategy for improvement of UHC implementation regarding each urgent issue and over all in Indonesia and Thailand. The fifth phase will result improving of implementation model of UHC policy regarding as comparative analysis of policy in Indonesia and Thailand.

Keywords: *Policy Evaluation – Health Services – Social Security*

FOREWORD

Assalamu'alaikum wr.wb.

Gratitude to Allah s.w.t. for His invaluable blessing for us so the final report of the research entitled Evaluation Of Universal Health Coverage Policy :A Comparison Study Between Indonesia And Thailandhas been finished.

The objectives of the research is to evaluate the UHC policy in Indonesia and the comparsion to Thailand. The result for the first year reearch shows that the evaluation of UHC in the two countries results in varies remarks, but most of the results have higher remarks in Thailand. The second year research will focus on the identifying the factors which affect the implementation of UHC in the two countries.

We would thank for Higher Education Ministry of Indonesia who fully support the research. In addition, We also appreciate and thank to the Dean as well as staffs of Political Science at Thammasat University Thailand,as a research partner, for his kindness to support the international collaborative research.

Finally, we wish that the research will give both academic and practical contribution in the future.

Wasalamu'alaikumwr.wb.

Yogyakarta, November 10, 2015

Principal Researcher,

Dr. Dyah Mutiarin

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CHAPTER 1

INTRODUCTION

1.1. Background and Significance

Universal Health Coverage (UHC) in ASEAN countries has been a crucial issue of how a country provides health care policy for their citizens at large. The access to quality health service, provision of heath services, benefit to health scheme, and institutional design are amongst the features of UHC in its implementation (Lagomarsino, 2012; Simmonds and Hort, 2013). Indonesia and Thailand as developing countries in ASEAN experience UHC with the same rationality face the same problems in healthcare. The problem of inequality and poor quality still remains as the basic problem for both UHC in Indonesia and Thailand (Prakongsai et al. 2009; Limwatananon et al. 2009; Pitayarangsarit, 2012; Harimurti et al.2013; Road Map toward National Health Insurance, UC 2012-2019; Simmonds and Hort, 2013).

Indonesia initiated UHC in January 2014 and committed to achieving universal coverage by 2019. UHC in Indonesia known as National Health Coverage/ Jaminan Kesehatan Nasional (JKN).The policy framework is based on Law No. 40/2004 on the National Social Security System, and Law No.24/2011 on the Social Security Agency (BPJS). Those two laws followed by Road Map toward National Health Insurance—Universal Coverage 2012-2019 (Peta Jalan Jaminan Kesehatan Nasional 2012-2019). Base on this road map, health insurance for the poor and for the near poor (Jamkesmas) has been expanded to reach 76.4 million people (32 per cent of the population). The table below show the numbers of people and type of insurance in Indonesia by 2012.

Table 1.1.Numbers of people and type of health insurance in Indonesia by 2012.

Type of Health Insurance	People
Participants of Health Insurance for Civil Servants / (Askes PNS)	17,274,520
Military and Police/ TNI/Polri	2,200,000
Jamkesmas Participants (Ministry of Health)HealthInsurance for the Poor	76,400,000
JPK Jamsostek Participants /Peserta JPK Jamsostek (WorkforceSocialSecurity) - Private employees and employers	5,600,000
Jamkesda/PJKMU Participants - regional health insurance for the poor/ PesertaJamkesda (yang dijaminPemda)	31,866,390
Corporate Insurance (Self-Insured)/Jaminan Perusahaan	15,351,532
Commercial Health Insurance Participants/ Peserta Askes Komersial	2,856,539
Total	**151,548,981**

Source: Republic of Indonesia 2012. Roadmap toward National Health Insurance, 2012-2019.

As shown at Table 1.1., the biggest number of participants is from Participants of Health Insurance for Civil Servants (Askes PNS) and the smallest is from military and police/ TNI/Polri. The scheme is funded by the central government from general tax revenue. Beneficiaries particularly the poor are not responsible for premium payments nor are they charged a copayment at the time of visit, but for the formal workers and informal workers are subject to pay the premium in certain amount. This financial health system will burden the state budget at large.

Simmonds and Hort (2013) state that there were potential inequalities in implementing universal health coverage in Indonesia. Indonesia experience Poor quality and unequal distribution of government health facilities have been issues in implementing UHC.While in Thailand, the UHC has been implemented since 2002. UHC in Thailand known as Universal Coverage (UC) Thai government passed the National Health Security Act in 2002. UHC become one of the most important social tools for health systems reform in Thailand. The new Universal Coverage Scheme (UCS), combined the already existing Medical Welfare Scheme and the Voluntary Health Card Scheme.(Jurjus, 2013).

However there are also some challenges of UHC implementation in Thailand. The UCS covers 75% of the Thai population, provides a comprehensive (and growing)

package of services and deepening financial risk protection, and relies on general tax as its source of funding. In its first 10 years the scheme was adequately funded, aided greatly by GDP growth and strong political commitment.

Table 1.2.Characteristics OfThailand's Three Public Health InsuranceSchemes After Achieving Universal Coverage In 2002

Scheme	Population coverage		Financing sources	Benefits package	Purchasing relation	Access to service	Per capita expen-diture 2010
Social Security Scheme (SSS)	Private sector employees, excluding dependants	16%	Payroll tax financed, tri-partite contribution 1.5% of sal-ary, equally by employer, employee and govern-ment	Comprehensive: outpatient, inpatient, accident and emergency, high-cost care, with very minimal exclusion list; excludes prevention and health promotion	Contract model: inclusive capitation for outpatient and inpatient services	Registered public and private competing contrac-tors	US$ 71
Civil Ser-vant Medi-cal Benefit Scheme (CSMBS)	Govern-ment em-ployees plus dependants (parents, spouse and up to two children age <20)	9%	General tax, non-contributory scheme	Comprehensive: slightly higher than SSS and UCS	Reimburse-ment model: fee for service, direct disbursement to public providers for outpatients; conventional DRG for inpatients	Free choice of public providers, no registration required	US$ 367
Universal Coverage Scheme (UCS)	The rest of population not covered by SSS and CSMBS	75%	General tax	Comprehensive: similar to SSS, including prevention and health promotion for the whole population	Contract model: capitation for outpatients and global budget plus DRG for inpatients	Registered contractor provider, notably within the district health system	US$ 79

Source: Health Insurance System Research Office, 2012

In other hand, the path ahead for universal health coverage in Thailand should remain focused on equity, evidence, efficiency and good governance (Health Insurance System Research Office/HISRO, 2012). The study by HISRO (2012) stated that for ambulatory care in health centre, district hospitals, and provincial hospitals were pro poor while university hospitals seem to pro rich. This result can be implied that district health centre, district hospitals, and provincial hospitals performed well in terms of pro poor utilization. This might be due to the geographical proximity to rural population who are vastly poor. This pattern was consistent before and after UHC implementation meant that pro poor utilization was maintained. However, the pro rich pattern of university and private hospital might be explained that main customers of these hospitals are CSMBS and SSS patients who are better off than UC scheme patients. This pattern was similar in hospitalization of inpatients (Thammatach - aree, 2011).

This research generally is an evaluation study on UHC both Indonesia and Thailand. Under the MoU between Universitas Muhammadiyah Yogyakarta and Thammasat University since 2012, this research, beside a form of networking with foreign partner university, is also a milestone for 2014 and 2015. The milestone follow the activities stated in the MoU such as collaboration post graduate studies, collaboration in exchange of student, conducting joint research, exchange of staff member, joint scientific meeting, and exchange of academic information. This research has been started with a background study by the students of both from Universitas Muhammadiyah Yogyakarta and also from Thammasat University on the Background Study on Public Health Services in 2013. Below is the research roadmap on Public Health Policy of the two parties.

Table 1.3. Collaboration Research Project of UniversitasMuhammadiyah Yogyakarta and also from Thammasat University.

Year	Milestone	Output
2012	Preliminary Research Meeting on Public Health Policy at Thammasat University	Baseline data of Public Health Policy in Indonesia and Thailand
2013	Back Ground Study on Public Health Services in Indonesia and Thailand	Draft Paper on Public Health Services in Indonesia and Thailand
2014	Evaluation of Universal Health Coverage Policy : A Comparison Study Between Indonesia And Thailand	Article for International Publication. Article for International Seminar.
2015	Evaluation of Universal Health Coverage Policy : A Comparison Study Between Indonesia And Thailand	Article for International Publication. Article for International Seminar.
2016	Enhancing Health Coverage Policy for Modeling Advance Health Services : A Comparison Study Between Indonesia And Thailand	Article for International Publication. Article for International Seminar. Reference Book.

In relation with the research roadmap of Universitas Muhammadiyah Yogyakarta and also from Thammasat University, and to response the implementation of both UHC schemes in Indonesia and Thailand, this research is an important

contribution for the issues related of UHC in Indonesia as well as in Thailand.

With this background, despite nominal comprehensive coverage for the poor, patients had difficulty accessing certain services, poor quality and unequal distribution of government health facilities. The research will try to address the evaluation of two things, first, how do the distinctive model of UHC implementation both in Indonesia and Thailand. Second is how do the distinctive results of UHC impact both in Indonesia and Thailand.

To understand and cope with issues of UHC in Indonesia and Thailand, both teams are counterparts to each other and put each counterpart as host research location.

CHAPTER 2

LITERATURE REVIEW

2.1. Universal Health Care

In line with decentralization in health sector, the role of state has shifted from being an implementer of health service delivery, to a regulator creating enabling environment.Health service supply -including National Health Insurance- is shaped in part by government policies and actions, specifically the resources that a country has available and how a government prioritizes the health sector within its development program (Shah, 2005). Further Shah also stated, governments have choices about how to best allocate their resources within the health sector—between different types of health services, between different modes of financing and delivery, and between different levels of care—all of which have implications for improving the health of the poor.

WHO stated that Universal health coverage is the single most powerful concept that public health has to offer, attests to the increasing worldwide attention given to universal coverage—even for less affluent countries—as a way to reduce financial impoverishment caused by health spending and increase access to key health services (Lagomarsino et all , 2012, 933). In his recent study Lagomarsino et all (2012) observed nine low-income and lower-middle-income countries in Africa and Asia that have implemented national health insurance reforms designed to move towards universal health coverage.

In past decades, high-income countries pursuing universal health coverage have relied on various approaches. On the other hand, lower-income countries wishing to pursue coverage reforms have to make key decisions about how to generate resources, pool risk, and provide services (Lagomarsino et all, 2012, 933).

In their recent study, some developing countries are attempting to move towards universal coverage. The nine countries are five at intermediate stages of reform (Ghana, Indonesia, the Philippines, Rwanda, and Vietnam) and four at earlier stages (India, Kenya, Mali, and Nigeria). These nine countries has launched ambitious national health insurance initiatives designed to move towards universal coverage, or have implemented incremental improvements to existing national insurance programs. The nine developing countries are creating hybrid systems, which isshown on below table.

Table 2.1. Main National Level Schemes of UHC

	Year of reform	Revenue generation (sources of revenue ordered by proportion of contribtuion)	Risk pooling		Service delivery		
			Single	Multiple	Primarily public	Mixed	Primarily private
Intermediate-stage reform countries							
Ghana (NHIS)[25]	2003	Value-added tax, investment income, formal-sector payroll contributions, household premiums	×			×	
Indonesia* (BPJS)[26]	2004	General government revenues, formal-sector payroll contributions		×		×	
Philippines (PhilHealth)[27]	1995	General government revenues, formal-sector payroll contributions, household premiums	×			×	
Rwanda (Mutuelles)[28]	2000	Donor funding, general government revenues, household premiums, formal-sector payroll contributions		×	×		
Vietnam (VSS)[29]	2002	General government revenues, formal-sector payroll contributions	×		×		
Early-stage reform countries							
India* (RSBY)[30]	2008	General government revenues		×			×
Kenya* (NHIF)[31]	2002	Formal-sector payroll contributions, household premiums		×		×	
Mali* (Mutuelles)[32]	2009	General government revenues, household premiums		×	×		
Nigeria* (NHIS)[33]	2009	Formal-sector payroll contributions, general government revenues, household premiums, donor funding		×		×	

For purposes of this table, we focus on the main national-level schemes. NHIS=National Health Insurance Scheme. BPJS=*Badan Penyelenggara Jaminan Sosial* (social security administrative body). PhilHealth=Philippine Health Insurance Corporation scheme. Mutuelles=community-based health-insurance schemes. VSS=Vietnam Social Security. RSBY=*Rashtriya Swasthya Bima Yojna* (national health insurance programme). NHIF=National Hospital Insurance Fund. *Countries that are working to expand existing pools to include new populations, or are merging existing pools to create one pool.

Table 1: **Structure of health financing reforms in nine developing countries**

Source :Lagomarsino et all, 2012.

This study found that each of the nine countries has had strongly rising incomes, with per-head income increasing by between 15% and 82% between 2000 and 2010 (data from World Bank world development indicators database), which the evidence suggests ought to lead to demands for improved access to care and reductions in household out-of-pocket health-carecosts (Lagomarsino et all, 2012, 935).

Regarding the health policy, at least there are three demands that must be

satisfactorily answered by the stakeholders, namely: 1.) good understanding about the politic process that affects the policy, 2.) the necessity to create a participative policy formulation system, 3.) that the result of the policy formulation must be able to answer the real problem in the society.

Further, the decentralization policy in health sector has been fueled by new efforts at democratization through promoting accountability and introducing competition and cost consciousness in the health sector. The state's new role has shifted from being an implementer of health service delivery, to a regulator creating enabling environment (World Bank on Social Accountability: Strengthening the Demand Side of Governance and Service Delivery"!, 2006) . World Bank in 2004 developed framework modified to illustrate the accountability mechanisms in a decentralized setting. This conceptual differentiation is important as it captures the re-positioning of actors, mandates and authorities in the decentralized service delivery system. The so-called *intermediate route of accountability* refers to client *voice* and the *compact* mechanisms relating clients to public officials and service institutions at the sub-national government level.

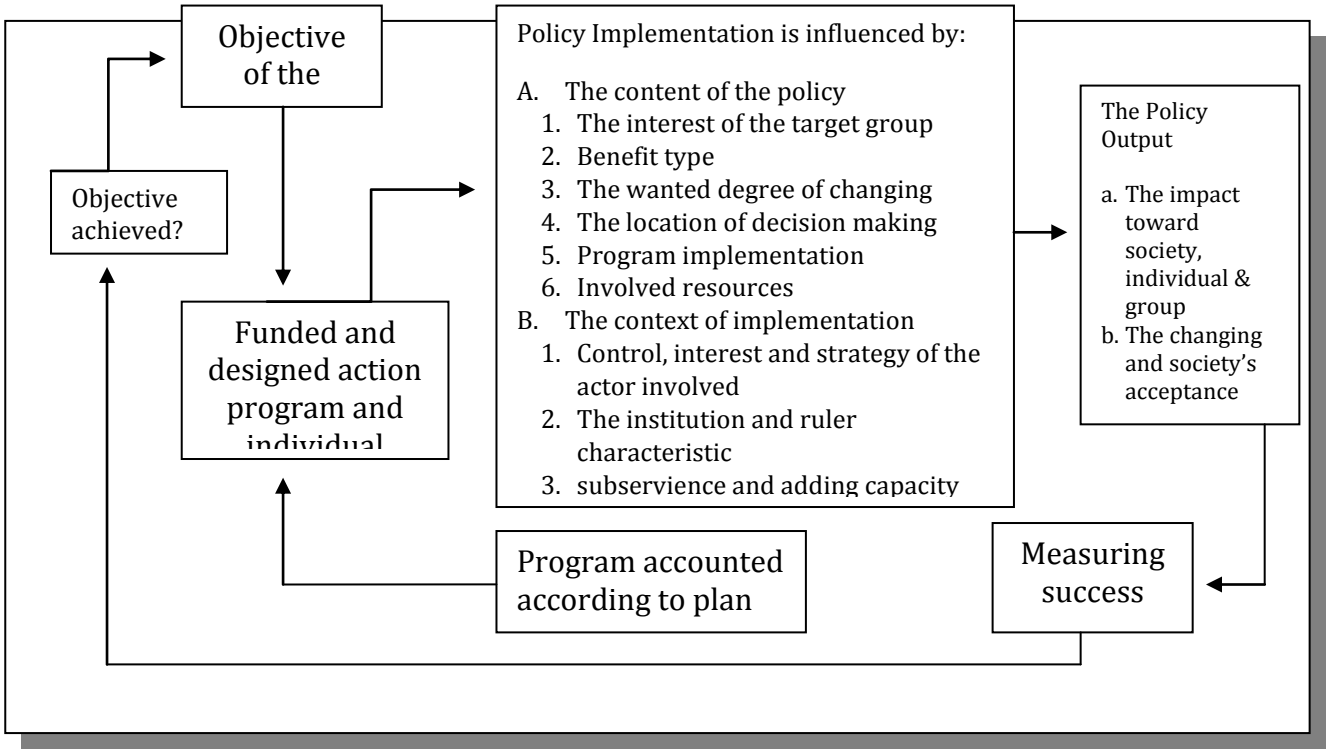
2.2. Evaluation of Health Policy

Public policy particularly in health sector does not only deal with individual or segmented interests, but it deals more with common objectives, public interests, or citizens at large. The proposed course of action that constitutes policy is then implemented through subsequent decisions and actions.

Reviewing health sector policy could not be separated from the nature of public policy itself. Grindle (1980 p. 11) says that the activities of implementation is strongly influenced by a number of factors (a) the content of policy (b) the context of policy implementation. Factors of policy content (content of policy) covers; (1)

affected interests 2) type of benefit, (3) the desired extent changes, (4) location of decision making, (5) implementer programs and (6) affiliated resources. Whereas in the context of implementation the factors that influence are: (1) power, interests and strategies of the actors involved, (2) character-institutional characteristics in the regime, and (3) compliance and responsiveness.

Figure 2.1. Policy Framework (Grindle, 1980)



The output from the inputs conversion is on the priority scale and furthermore chosen based on the urgency to become a public policy that has to be solved by the government into output that one of it is policy which implementation's aim is to solve previous issues to achieve the goal and target that has been set before.

More than that, because public policy is a series of evaluation, a more comprehensive understanding framework is needed to explain how they set up an evaluation and make improvement.

Evaluations are undertaken for a variety of reasons:

1. To judge the worth of on going programs and to estimate the usefulness of attempts to improve them: to identify planning and policy purposes, to test innovative ideas on how to deal with human and community problems.
2. To increase the effectiveness of program management and administration: to assess the appropriateness of program changes, to identify ways to improve the delivery of interventions ,
3. Tomeet various accountability requirements: impact accountability, efficiency accountability, coverage accountability, servicedelivery accountability, fiscal accountability, legal accountability

Palmier, divides policy evaluation into four categories:

1. Planning and need Evolutions.

   Includes assessment of the target population, the need now and in the future as well as existing resources.

2. Process evaluations

   Evaluation of the implementation of the action, executing media programs and information systems.

3. Impact evaluations

   Evaluate impact of policies, whether expected or not, and the expansion of the program.

4. Efficiency evaluations

   Evaluation of efficiency policies, which can be seen from the comparison with the cost advantage (Leslie, 1987: 52)

With the aim to provide an assessment of the implementation program, in this assessment did not evaluate the overall phase of the policy but only one stage of its implementation (implementation evaluation).

Evaluation of the implementation according to Ripley is including the

following:

1. Evaluation is reviewed to evaluate their processes
2. Implemented by adding questions to be answered in the perspective of what happened other than in compliance perspective.
3. Done with the evaluating aspects of the policy impacts that occur in the short term. (RJ Heru, 1997: 35)

Evaluation of the program performance consist of:

1. The relevance and the strategy of the program at large.

   The focus will be on assessing to which extent the program is adressing the major problematic situation.
2. The effectiveness of the program.

   It focus to which extent the program has been able to achieve its expected outputs and targets
3. The efficiency of the program.

   It analyse to which extent the program has used its resources in an optimal way.
4. The impact of the program.

   Impacts are changes at a higher level that are beyond the direct control of the program. It focus on changes in behavior within the groups and individuals with which the program had direct interaction.
5. The sustainability of the program.

   It is to understand to which extent the program has already produced some impacts or is expected to do so in the future, given the constraining environment and influencing factors.

To know the results of a health sector policy on national social insurance, evaluations are undertaken to measure:

1. The existing policy framework and strategic plans for the UHC.
2. National health insurance budget distribution
3. Identify implementation systems and priorities, targets and standards of UHC .
4. The equity impacts of national social insurance policy.

CHAPTER 3

OBJECTIVES AND BENEFITS OF THE RESEARCH

3.1. Objectives

1. The research will try to address the evaluation of how do the distinctive model of UHC implementation both in Indonesia and Thailand.
2. The research will try to address the evaluation of how do the distinctive results of UHC impact both in Indonesia and Thailand.

3.2. Benefits

3.2.1. Theoretical Benefit

a. Giving new perspectives of thought contribution related to the field of policy evaluation, especially using international comparison approach.
b. Enriching the present references of policy evaluation field of study.

3.2.2. Practical Benefits

a. Contribute to solve the current issues related to UHC policy implementation in the two countries, by advising the policy makers which is based on the practical issues research findings.
b. To improve the consciousness of the stakeholders related to the rights, duties and procedures of UHC scheme, so that their involvement to succeed the policy implementation is increasing in future.

CHAPTER 4

RESEARCH METHODOLOGY

4.1. Phase of Research

In order to achieve through the goal of this study, the policy model is utilized. To serve this goal, the scope of this research project has 5 phases of study:

Phase 1: The 1st phase of the study will provide a comparative analysis of the similarities and differences in the UHC of Indonesia and Thailand.

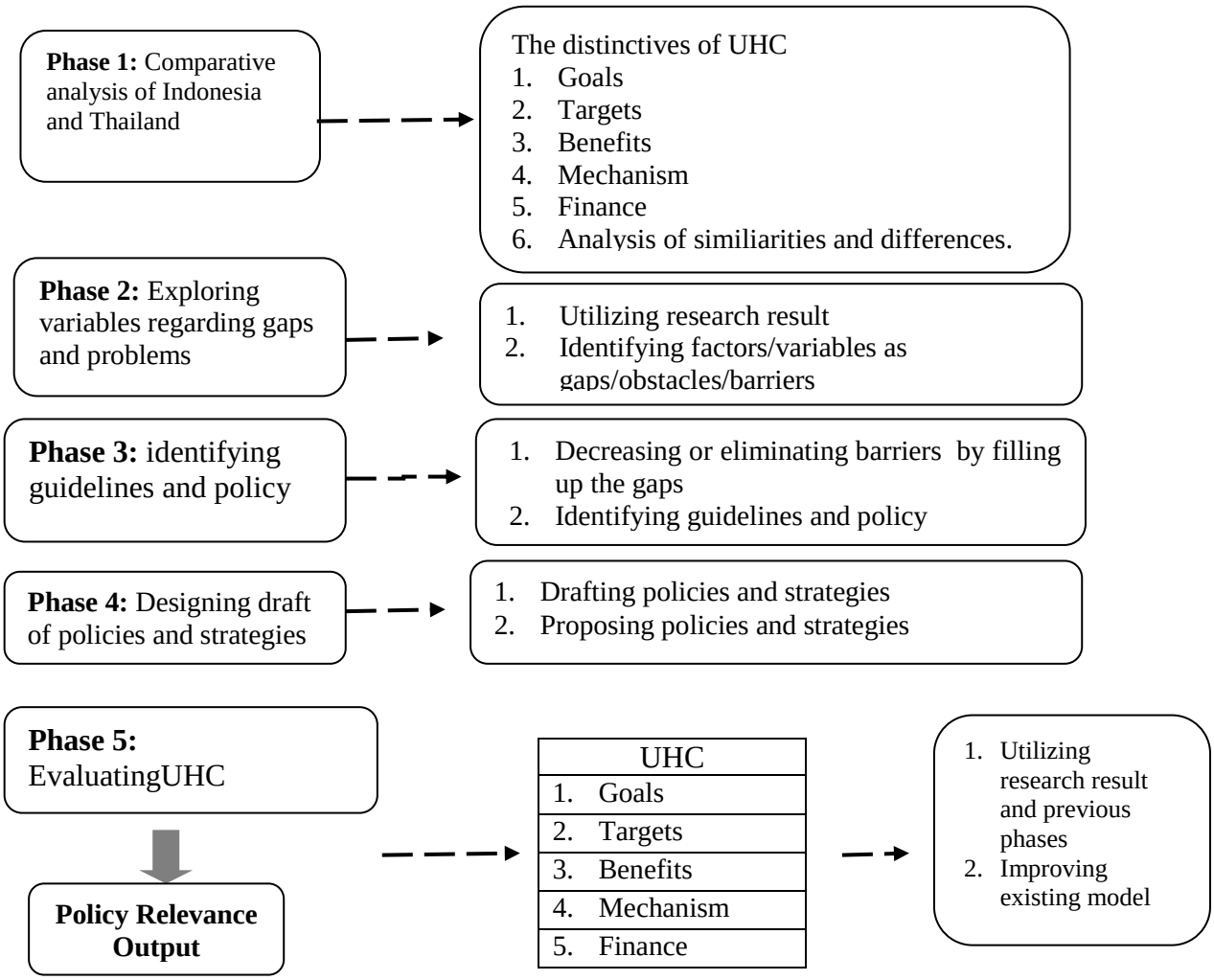
Phase 2: The second phase will explore the extent and policy related regarding gaps and problems of UHC by utilizing the result of first phase.

Phase 3: The third phase will evaluate policy in order to fill these gaps by decreasing or eliminating obstacles to the UHCsystem of Indonesia and Thailand.

Phase 4: The fourth phase will design draft of policies and strategy for improvement of UHC system regarding each urgent issue and over all in Indonesia and Thailand.

Phase 5: The fifth phase will result improving of implementation model of UHC policy regarding as comparative analysis of policy in Indonesia and Thailand.

Figure 4.1. Conceptual and Evaluation Framework



This evaluation is based on the policy evaluation of health insurance in the selected areas. The followings are the steps that are taken in this study:

1. Most of the data in this study will be quantitative and qualitative in nature. This implies that the analytical approach of this study is derived from a mix methods between quantitative and qualitative research methods. It is known earlier as multi-method, integrated, hybrid, combined, and mixed methodology research (Creswell and Plano Clark 2007: 6 in Driscoll, et.al. 2007). Mix methods generally described as methods to expand the scope or breadth of research to offset the weaknesses of either approach alone (Blake 1989; Greene, Caracelli,

and Graham 1989, Rossman and Wilson 1991 in Driscoll, et.al. 2007). Mix methods also refer to the use of two or more methods in a research project yielding both qualitative and quantitative data (e.g. Cresswell& Plano Clark, 2007; Greene, 2007; Teddlie&Tashakkori, 2009 in Driscoll, et.al. 2007). Mixed methods research has been complementing the existing traditions of quantitative and qualitative movements (Tashakkori &Teddlie, 2003, Teddlie &Tashakkori, 2009 in Driscoll, et.al. 2007). The term *quantitizing* has been coined to describe the process of transforming coded qualitative data into quantitative data and *qualitizing*to describe the process of converting quantitative data to qualitative data (Tashakkori &Teddlie 1998: 126 in Driscoll, et.al. 2007). In this mix methods, the quantitative approach will use more on descriptive quantitative parameter such as table of frequency and the average of dispersion by conducting survey. While in qualitative, literature on methodology suggest that in qualitative research tradition, *confidence* or credibility is acquired by performing the procedures of triangulation (Denzin, 1970). Triangulation has also come to mean convergence among researchers (agreement between field notes of one investigator and observations of another) and convergence among theories. The instruments for qualitative approach will use interview guide and Focus Discussion Group.

2. Data using in this research will be primary data and secondary data. Primary data will be collected through conducting survey to distribute the questioners.. There are considerable constraints to obtain data from the primary sources, and in this way, secondary data sourcesare particularly important. Secondary data consist of all evidence in the forms of documents and records.

Table 4.1. List of Secondary Data

Data	Source	
	Indonesia	**Thailand**
Report of UHC	BPJS	NHSO
Statistics of UHC	General Hospitals	General Hospitals
Financial Report of UHC	BPJS, Ministry of Finance	NHSO, Ministry of Finance
Health Indices	Ministry of Health	Ministry of Health

3. Literature Review. This study will be undertaken by comparing relevant literature and research.There have been many studies, reports and journals on UHC, and there are still some other ongoing studies in UHC as health insurance in Indonesia and Thailand. Aside from the necessity that such studies will be important references, they can be a good materials for enhancing the quality of this study.
4. Observation of the practices of UHC, of recipient groups whenrecieve the programmes as form of the health insurance system. Given the time limit for report, observation was carried out by taking samples from the selected areas.

Tabel 4.2.List of Observation

Name of object	Location	
	Indonesia	**Thailand**
Process of participants UHC Registration	BPJS	NHSO
Process of UHC Service delivery	General Hospitals	General Hospitals
Process of complain handling in UHC	BPJS, General Hospitals	NHSO, General Hospitals

5. Indepth interviews and questionnaires distribution to the key informants from government health agencies. These are carried out along with the observation.

Table 4.3. List of Interviewed

Indonesia	Numbers	Thailand	Numbers
Management of BPJS	3	Management of NHSO	3
Management of General Hospital	4	Management of General Hospital	4
Management of Ministry of Health	1	Management of Ministry of Health	1
Management of Ministry of Finance	1	Management of Ministry of Finance	1
JKN Participants	5	UC Participants	5
Management of Private Hospitals	2	Management of Private Hospitals	2
Management of Provincial Health Office	2	Management of Provincial Health Office	2
Management of NGO of Health Sector Watch	2	Management of NGO of Health Sector Watch	2
Total	20	Total	20

The technique sampling in this research will use Nonprobability Sampling with Quota Sampling procedure. Response rate which is expected is minimal at 60 percent. Sampling will base on Slovin formula: N = n/N(d)2 + 1 , whereas n = sample; N = population; d = precision value 95% atau sig. = 0,05. (Arikunto, 2005).

Table 4.4.Population and Sampling

Category	Area Base	Representative of Area base (Population)	Percentage	Number of Sample	Sample of each Category
Pregnant Women	20 groups from UHC Providers	401	20,36%	332	67
Elderly	20 groups from UHC Providers	1260	63,99%	332	213
Disable	20 groups from UHC Providers	177	8,99%	332	30
Vulnerable	20 groups from UHC Providers	131	6,66%	332	22
Total		1.969	100%		332

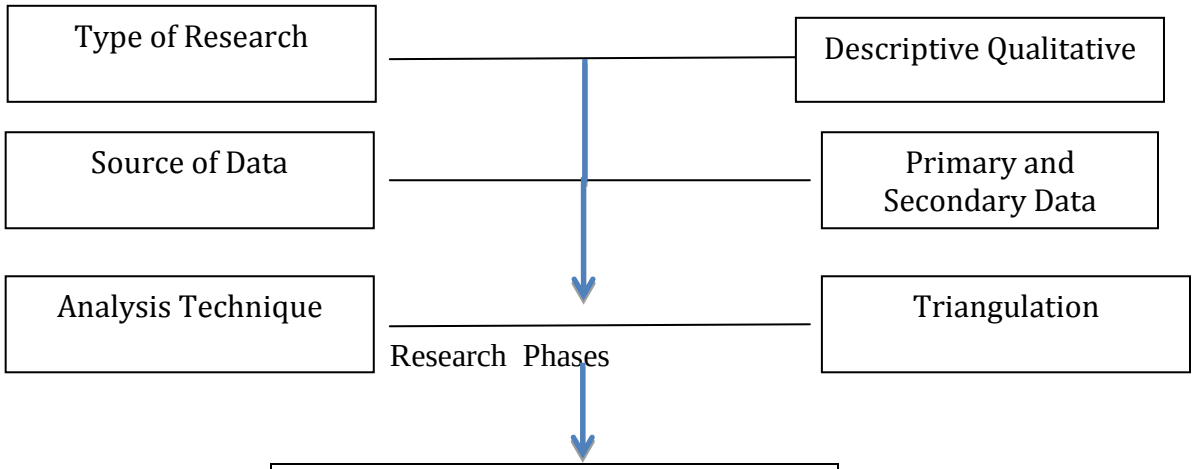
6. Information gathering through the Focused Group Discussions (FGD) of government agencies who provide UHC that are monitoring and that involve to set up policy insurance mechanism particularly in health sector.

Table 4.5. List of FGD participants

Indonesia	**Numbers**	**Thailand**	**Numbers**
Management of BPJS	3	Management of NHSO	3
Management of General Hospital	4	Management of General Hospital	4
Management of Ministry of Health	1	Management of Ministry of Health	1
Management of Ministry of Finance	1	Management of Ministry of Finance	1
JKN Participants	5	UC Participants	5
Management of Private Hospitals	2	Management of Private Hospitals	2
Management of Provincial Health Office	2	Management of Provincial Health Office	2
Management of NGO of Health Sector Watch	2	Management of NGO of Health Sector Watch	2
Total	20	Total	20

Intense discussions among the UHC implementer and the health care units will be conducted within small groups, e.g. 5 to 20 participants, with pre-determined topics or issues. The size of the groups is kept small to ensure that all of its members actively participate in the discussions.

4.2. Research Frame Work



Activity
Research instrument preparation
Baseline Data Gathering
Primary Data Gathering
Secondary data Gathering
Preliminary Report
Data analysis
Intermediary Report
Final Report
Submitting Seminar Paper
Seminar Paper Publication
Submitting Publication Paper
Paper Publication and Book Publication

Research Output :

- International Call paper,
-International journal,
- Reference Book of Policy Implementation,
- Intelectual Property Rights

CHAPTER 5

RESULTS

5.1. Description of UHC in Indonesia and Thailand

5.1.1. Profile of UHC in Indonesia

5.1.1.1. Legal Framework of National Health Insurance/JKN in Indonesia

On January 1st 2014 The Government of Indonesia (GOI) has taken significant steps towards universal health coverage through the development of an integrated national health scheme. The program known as National Health Insurance /JaminanKesehatan Nasional /JKN.It is an attempt to unified previous various social health insurance under a single social security agency. Report from Bappenas in 2014 (Bappenas, 2014) shows that JKN is the forerunner in the development of social assistance for health. Before JKN, the government had sought to pioneer some form of social assistance for health, such as social health insurance for civil servants (PNS), pensioners and veterans, as well as health insurance (JPK) safety net for employees of state-owned and private companies, as well as health insurance for military and police personnel.

JKN is in line with Law Number 40 of 2004 on National Social Security System (Sistem Jaminan Sosial Nasional/SJSN). Following Law No. 40/2004, the Government of Indonesia enacted Law No. 24/2011 on Social Security Administrative Body (Badan Penyelenggara Jaminan Sosial/BPJS).The establishment of Law on Social Security Administrative Body is an implementation of Law Number 40 Year 2004 on National Social Security System, in order to provide legal certainty for the establishment of BPJS to administer the Social Security programs throughout Indonesia. This Law is the implementation of Article 5 sub article (1) and Article 52 of

Law Number 40 Year 2004 on National Social Security System which mandates the establishment of Social Security Administrative Bodies and institutional transformation of PT Askes (Persero), PT Jamsostek (Persero), PT TASPEN (Persero), and PT ASABRI (Persero) into Social Security Administrative Body. The transformation shall be followed by the transfer of participants, programs, assets and liabilities, employees, and the rights and obligations. With this Law two (2) BPJS are established, namely BPJS Health and BPJS Employment. BPJS Health shall administer a health program and BPJS Employment shall administer a work accident, old-age, pension and death programs.

Bappenas (2015) identified the operations of social health insurance-related legislations consist of: nine (9) Governmental Regulations and eight (8) Presidential Regulations, as follows:

a. The Nine (9) Government Regulations (PP) include:
    1) Government Regulation No.101/2012 on Recipients of Health Insurance Premium Assistance;
    2) Government Regulation No. 82/2013 on the Initial Capital for BPJS;
    3) Government Regulation No. 84/2013 on Revision in Regulation No. 14/1993 on Labor Social Security;
    4) Government Regulation No. 85/2013 on Interagency Relation;
    5) Government Regulation No. 86/2013 on Method of Administrative Penalty for Employers other than State Organizer;
    6) Government Regulation No. 87/2013 on Management of Health Security Assets;
    7) Government Regulation No. 88/2013 on Method of Administrative Penalty for Supervising Board and BPJS' Board of Director,
    8) Government Regulation No. 89/2013 on Revocation of Regulation No.

69/1991 on the Health of Civil Servants, Recipients of Pension Fund, Veterans, former Veterans and their families;

9) Government Regulation No. 90/2013 on Revocation of Regulation No. 28/2003 on Subsidy and Governmental Allocation in the Establishment of Health Insurance for Civil Servants and Recipients of Pension Funds.

b. The Eight (8) Presidential Regulation are as follows:

1) Presidential Regulation No. 12/2013 on Health Insurance;
2) Presidential Regulation No. 105/2013 on Health Service for Ministers and Certain State Officials;
3) Presidential Regulation No. 106/2013 on Health Insurance for Chairs of State Institutions,
4) Presidential Regulation No. 107/2013 on Special Health Service on the Operational Activity of Ministry Of Defense, Indonesian National Armed Forces and Indonesian National Police;
5) Presidential Regulation No. 108/2013 on Phasing Social Security Program Membership;
6) Presidential Regulation No. 109/2013 on the Form and Content of BPJS' Financial Reporting and Statements;
7) Presidential Regulation No. 110/2013 on Salary or Wage and Other Additional Benefits and Incentives for Members of Supervisory Board and Members Board of Directors of Social Security Organizing Agency (BPJS);
8) Presidential Regulation No. 111/2013 on Revision of Presidential Regulation No.12/2013 on Health Insurance.

The Ministry of Health (MOH) also administered regulation related to social health insurance implementation. Related regulations to the health insurance program

produced by the MOH include: two (2) Health Ministry Regulation (*PeraturanMenteriKesehatan*) and a (1) MOH Decree (KeputusanMenteriKesehatan) Number 328 on the Drug Formulary. The two MOH Regulations are: (1) MOH Regulation No. 71/2013 on "Healthcare Services in the Health Insurance Program" and (2) MOH Regulation No. 69/2013 on "Standard of Healthcare Tariff at Primary and Referral Healthcare Facilities in the Implementation of Health Insurance Program."

5.1.1.2. JKN Objectives

National Health Insurance (JKN) is the government's commitment to providing health insurance to all Indonesians. National Health insurance is to ensure all participants receive health care for their basic needs (article 19 paragraph 2 in SJSN Law). The entire population needs to have access to health-care services that are proactive, preventive, curative and rehabilitative, as well as the necessary medication and medical supplies. In line with article 19, the ideal benefits package would be comprehensive and would guarantee health services according to an individual's medical needs for all forms of illness. The JKN aims to provide:

a. Personal health services;
b. Health promotion,
c. Preventive health,
d. Curative health,
e. Rehabilitative medicine services,
f. Medical consumable materials in accordance with the necessary medical indications

5.1.1.3. JKN Principles

In accordance with Law Number 40 of 2004 on SJSN, National Health Insurance is managed through the principles of:

1. Mutual cooperation ("Gotong royong"). With everyone paying their installments, the spirit of "gotong royong" supports the idea of the healthy helping the sick and the rich helping the poor.
2. Non-profit. BPJS is not permitted to make a profit. Public funds are collected in a trust to be used for the benefit of participants.
3. Openness, diligence-caution, accountability, efficiency and effectiveness. Management principles under the management of funds from participants and the results of developments.
4. Portability. This ensures that even if participants move house or change employment, as long as they remain in the Republic of Indonesia they maintain their rights as JKN participants.
5. Mandatory participation. All participants are protected. Applications adapt to the financial capabilities of people and the government, as well as the feasibility of program implementation.
6. Funding body. Payments by participants to the organizing body are entrusted in funds that are well managed and for the benefit of participants.
7. Funds managed by in social assistance funds are to be used entirely for program development and for the greater interests of participants.

5.1.1.4. Requirement to be JKN's Participant

According to Law of The Republic of Indonesia Number 24 Year 2011 on The Implementing Agency of Social Security, Article 14 Anyone, and followed by Regulation of President of the Republic of Indonesia no. 12 Year 2013 concerning Health Care Benefits, states that participants of National healthcare are:

a. PBI Health Care Benefits
b. Non PBI Health Care Benefits.

Participants of PBI Health Care Benefits include poor people and low inc ome people. Participants Non PBI Health Care Benefits are Participant who are not classified as poor and low income people and they consist of :

a. Salaried Employee and their family members;

b. Non Salaried Employee and their family members;

c. Non Employee and their family members.

Figure 5.1. BPJS Members Criteria

Source: Wihartini, PBJS Kesehatan, 2014

Recipient Contribution Health Insurance (PBI): the poor and people are not able to, with the determination of the participants in accordance with the law and regulation.

1. Non Receiving Aid Health Insurance Fee (Non-PBI), consisting of:

   Recipients Wage Workers and members of their families

   a) Civil Servants;

   b) Members of the military;

   c) Members of the National Police;

   d) State officials;

   e) Non Government Employees Civil Service;

   f) Private Employees; and

   g) Workers who do not include the letters a to f are receiving wages.

Including foreigners working in Indonesia for a minimum of 6 (six) months.

Non Receiving Wage Workers and members of their families

a) Workers outside the employment relationship or an independent worker;
b) Workers who did not include a letter that is not the recipient Wages. Including foreigners working in Indonesia for minimum of 6 (six) months.

Non-workers and family members

a) Investors;
b) Employer;
c) Pension Recipients, consisting of:
   - Civil Servants who stopped the pension rights;
   - Members of TNI and Police officers stopped the pension rights;
   - State officials who stopped the pension rights;
   - The widow, widower or orphan pension recipients who receive pension rights;
   - Recipient other retirement; and
   - Widows, widowers, orphans or from other pension recipients who receive pension rights.
d) `Veterans;
e) Pioneer Independence;
f) The widow, widower, or orphans of veterans or Pioneer Independence; and
g) Not Workers who do not include the letters a to e are unable to pay dues.

2. Family members that remains :

   Receiver Wage Workers:

   a) The nuclear family, including wife / husband and children are legitimate (biological children, stepchildren and / or adopted children), a maximum of 5 (five) people.
   b) Children biological, stepchild of a legal marriage, and adopted children are legitimate, with criteria:
      i. Not or have never been married or do not have their own income;
      ii. Not the age of 21 (twenty one) years old or has not been aged 25 (twenty five) years of formal education is still continuing.
   c) Non Receiving Wage Workers and Non-Workers: Participants can include family members who want (unlimited).
   d) Participants can include additional family members, including children 4 and so on, father, mother and in-laws.
   e) Participants can include additional family members, which include other relatives such as siblings / in-laws, household assistant, etc.

5.1.1.5. Targeted People

In the road map of JKN it was agreed that universal health coverage would be achieved by 2019 when all residents will have health insurance and receive the same medical benefits.

Figure 5.2. Phasing of Membership

Source: Wihartini, PBJS Kesehatan, 2014

The targets are:

1. As of 1 January 2014, BPJS Kesehatan has managed almost 125 million health insurance participants as shown in the table above. These participants will come from the Social Health Insurance for Civil Servants scheme (hereafter referred to as Askes), the Jamkesmas scheme (public health insurance), the Social Security Programme for Employees (hereafter referred to as Jamsostek), the national armed forces, the national police and parts of the Regional Health Insurance scheme (hereafter referred to as Jamkesda).
2. All those under the Jamkesda scheme will become members of BPJS Kesehatan no later than the end of 2016.
3. Employers will register their workers and their families in stages over the 2014–2019 period.
4. Self-employed workers earning an income will register as members of BPJS over the 2014–2019 period.
5. By 2019, no workers will be left undocumented with BPJS Kesehatan.
6. 257,5 millions (all Indonesian people) covered by BPJS Kesehatan. Universal health coverage will be achieved by the end of 2019 (TPN2K, 2015)

Figure 5.3. Health Insurance Participants

HEALTH INSURANCE PARTICIPATION 30 JUNE 2014	
TYPE OF PARTICIPANT	**TOTAL PARTICIPANTS**
Premium Assistance Beneficiaries (PBI)	86,000,000
Non Premium Assistance Beneficiaries:	
a. Paid Workers	23,761,627
b. Unpaid Workers	3,565,240
c. Non-Workers	4,922,121
Jamkesda	5,904,052
Total	124,553,040

Source: BPJS Kesehatan (30 June 2014)

5.1.1.6. Benefits of JKN

National Health Care Benefit is a benefit in a form of healthcare protection so thatwhich is given to every individual who has paid a premium or have the premium covered by the government.Healthcare services benefits consist of : Benefits of the National Health Insurance (JKN) Health Social Security Institution include:

- Primary health care, namely non-specialist health services include:
  1. Administration of service
  2. Promotive and preventive services
  3. Examination, treatment and medical consultation
  4. Non-specialist medical measures, both operative and non-operative
  5. Care drugs and consumable medical materials
  6. Blood transfusions as needed medical
  7. Investigations Laboratory diagnosis of first level
  8. Hospitalization first level as indicated
  9. Advanced level referral health services, the health services include:
- Outpatient, include:
  1. Administration services

2. Examination, treatment and specialist consultation by a specialist and sub-specialist doctor.
3. Medical treatment in accordance with a medical specialist, medical indications
4. Drugs and medical consumable materials
5. Medical device implants
6. Advanced diagnostic support services in accordance with the medical indications
7. Medical Rehabilitation
8. Blood Services
9. Forensic medicine services
10. Service bodies in health facilities

- Inpatient, which include:
  1. Non-intensive inpatient treatment
  2. Inpatient care in intensive care
  3. Other health services specified by the Minister

The benefit package has been unified, creating greater equity, at least on paper. However, different people have different levels of hotel coverage with PBI having less quality hoteling than others. This should be phased out. Special privileges for civil servants are creeping back into the package, sometimes in secret.

The Benefits Package still requires expansion and integration on certain dimensions. One example is the Primary Health Care Services Package. The PHC package has been defined in law, including medical services, medicines, routine lab, investment, training, and certification. The BPJS covers maternal and neonatal health (absorbing Jampersal), vaccines provided by the government (no syringes, needles,

etc.), treatment of communicable diseases, medicines. Outside of capitation payment are drugs for Puskesmas and home visits, and the latter may be an issue for providers in remote areas, as well as some outpatient specialty services.

Figure 5.4. Type of Benefits

TYPE OF BENEFIT	JAMKESMAS	JAMKESDA	ASKES	JAMSOSTEK
Basic Outpatient Services (RJTP)	Covered	Covered	Covered	Covered
Advanced outpatient services (RJTL)	Covered	Covered	Covered	Covered
Basic inpatient services (RITP)	Covered	Covered	Covered	Covered
Advanced inpatient services (RITL)	Covered	Covered	Covered	Covered max. 60 days p.a. per disability
Catastrophic benefits (hemodialysis, heart operations and similar)	Covered	Covered, except where access to equipment or experts is unavailable	Covered	Not covered
Special benefits	Spectacles, hearing aids, walking aids etc	Spectacles, hearing aids, walking aids etc	Spectacles, hearing aids, walking aids etc	Spectacles, hearing aids, walking aids etc
Exceptions	Services not delivered according to established procedure, infertility, cosmetic, natural disasters, social services, dental prosthetics	Services not delivered according to established procedure, infertility, cosmetic, natural disasters, social services, dental prosthetics	Services not delivered according to established procedure, infertility, cosmetic	Services not delivered according to established procedure, infertility, cosmetic, cancer therapy, hemodialysis etc
Thalassaemia benefit	Covered, including non-participants	Information unclear, not explicit, no information re. exceptions	Covered	Not covered as it comes under congenital abnormalities

Source: TNP2K (2010)
Note: Jamkesmas = Public Health Insurance; Jamkesda = Regional Health Insurance; Askes = Social Health Insurance for Civil Servants and Military; Jamsostek = Health Care Social Security Programme for Employees

5.1.1.7. Organization of JKN under BPJS Health

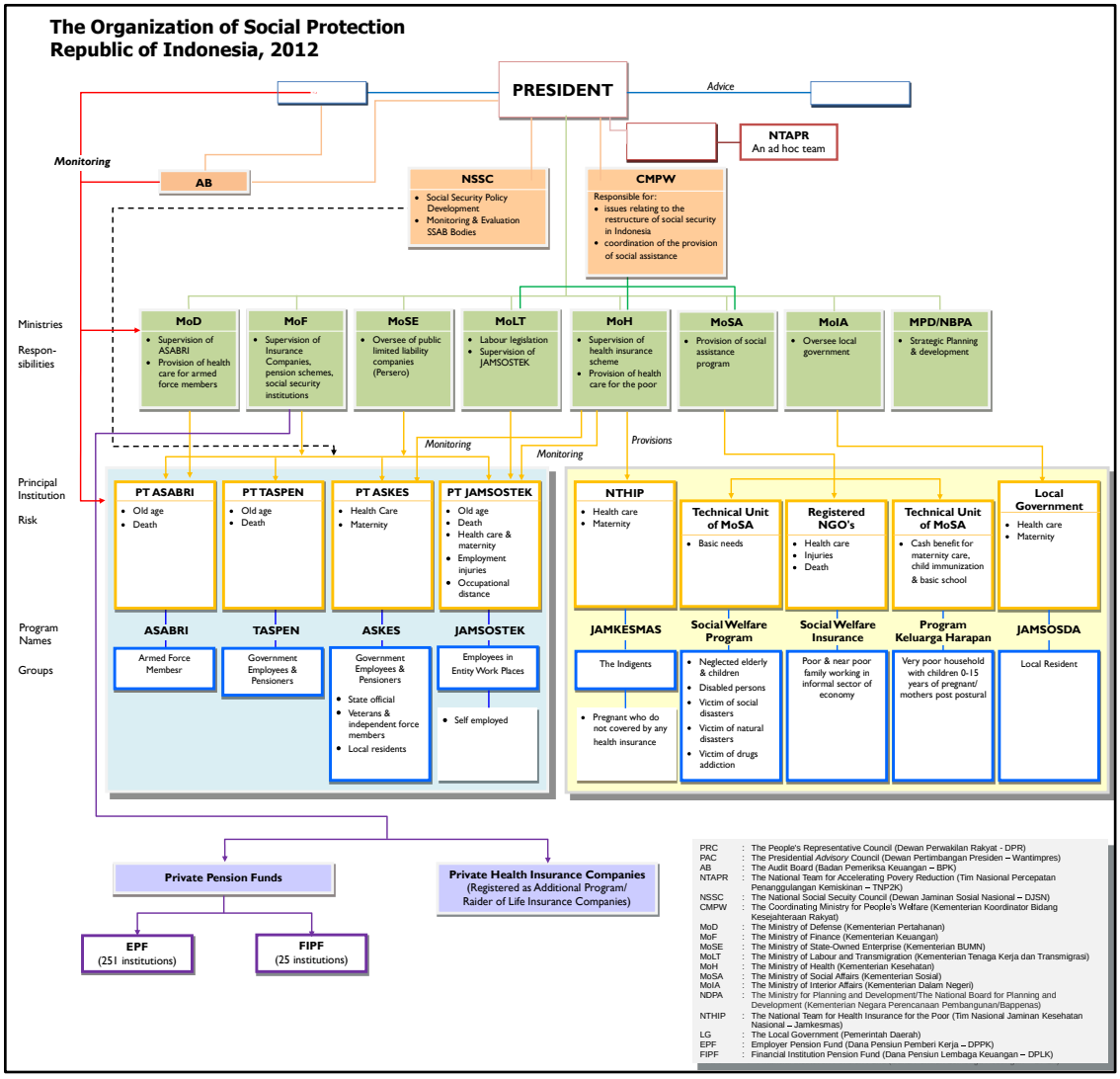
There are many institution linked to JKN under BPJS Health such as :

1. The People's Representative Council (Dewan Perwakilan Rakyat - DPR)
2. The Presidential *Advisory* Council (Dewan Pertimbangan Presiden – Wantimpres)
3. The Audit Board (BadanPemeriksaKeuangan – BPK)
4. The National Team for Accelerating Povery Reduction (Tim Nasional Percepatan Penanggulangan Kemiskinan – TNP2K)

5. The National Social Secuity Council (Dewan Jaminan Sosial Nasional – DJSN)
6. The Coordinating Ministry for People's Welfare (Kementerian Koordinator Bidang Kesejahteraan Rakyat)
7. The Ministry of Defense (Kementerian Pertahanan)
8. The Ministry of Finance (Kementerian Keuangan)
9. The Ministry of State-Owned Enterprise (Kementerian BUMN)
10. The Ministry of Labour and Transmigration (Kementerian Tenaga Kerja dan Transmigrasi)
11. The Ministry of Health (Kementerian Kesehatan)
12. The Ministry of Social Affairs (Kementerian Sosial)
13. The Ministry of Interior Affairs (Kementerian DalamNegeri)
14. The Ministry for Planning and Development /The National Board for Planning and Development (Kementerian Negara Perencanaan Pembangunan /Bappenas)
15. The National Team for Health Insurance for the Poor (Tim Nasional Jaminan Kesehatan Nasional – Jamkesmas)
16. The Local Government (Pemerintah Daerah)
17. Employer Pension Fund (Dana Pensiun Pemberi Kerja – DPPK)
18. Financial Institution Pension Fund (Dana Pensiun Lembaga Keuangan – DPLK)

All the relations of organization can be seen in the figure below:

Figure 5.5. The Social Protection Organization in Indonesia



Source: http://www.jamsosindonesia.com/

Based on Presidential Decree No. 160 / M Year 2013 dated December 31, 2013 on the Appointment of Commissioners and Board of Directors of PT Askes (Persero) to the Board of Trustees and Directors of Health Social Security Institution and Decision of the Board of Directors of Health Social Security Institution Number 1 In 2014, the Board of Directors commencing Health BPJS dated January 1, 2014 are as follows:

1. Fachmi Idris (President Director)

2. Purnawarman Basundoro (Director of Legal, Communication and Inter-Institutional Relations)
3. Tono Rustiano (Director of Planning, Development and Risk Management)
4. Fajriadinur (Director of Services)
5. Sri EndangTidarwati W (Director of Membership and Marketing)
6. TaufikHidayat (Director of Human Resources and General Affairs)
7. Dada Setiabudi (Director of Information Technology)
8. Riduan (Director of Finance and Investment)

5.1.2. UHC in Thailand

5.1.2.1 Legal Framework of UC in Thailand

In Thailand, UHC known as Universal Coverage (UC). Thailand's National Health Care has long been struggling by an authoritative medical doctor, SanguanNitayarumphong, and his small number of team in drafting the bill in 1997 before it gained attentions from the infamous rising and leading politician like Thaksin Shinawatra. Taking advantages of this new idea that would help him gain more votes from the people of Thailand, Thaksin Shinawatra grasped this opportunity to win the general election in 2001. Led by Think Tank team of SanguanNitayarumphong, Thai Rak Thai Party's bill proposal was passed into law by both the lower house and the senate in 2002 (Nitayarumphong, 2006).

Based on the National Health Security Act 2002, there are 9 Chapters and Transitory Provision, 70 sections in all. The Act begins with the definitions of terms and continues with 9 chapters, including the Right to Health service (section 5-12), National Health Security Board (section 13-23), National Health Security Office (section 24-37), National Health Security Fund (section 38-43), Health Care Unit and Standard of Health service (section 44-47), Standard and Quality Control Board

(section 48-53), Officials (section 54-56), Health Care Unit Standard Control (section 57-62), Penalties (section 63-64), and Transitory Provision (section 65-70).

Section 5 of the Act clearly states that the rights of all Thai citizens to be entitled to a health service with such standards and efficiency as prescribed in the Act. In addition, the details of the rights to health service are laid in various sections in the bill, such as section 6, 7, 41, 47, and 59 as follows:

1) The right to select a personal Health care unit or to change personal Health care unit to the personal convenience and necessity (section 6)
2) The right to receive health service at such other health facility as prescribed by the Board in case of reasonableness, accident, or emergency illness (section 7)
3) The right to complaint and request for investigation of being overcharged fees for service exceeding the rate as prescribed by the Board, being charged fees for service by a Health care unit without authority, or cannot be reimbursed for damage or injury caused by the Health service provided by the Health care unit within 32 a period deemed appropriate (section 59)
4) The right to request for reimbursement for any damage or injury caused by any service provided by the Health care unit and the wrongdoer (section 41)
5) The right to participate in the development of the nation national health security system policy and the Fund management (section 47)

5.1.2.2. UC's Objectives

A long continuous fight the Universal Coverage Services to get equal health services to every citizen strategically aim to achieve the following objective:

1) to focus on health promotion and prevention as well as curative care;

2) to emphasize the role of primary health care and the rational use of effective and efficient integrated services;
3) to foster proper referrals to hospitals;
4) to ensure that subsidies on public health spending are pro-poor, at the same time ensuring that all citizens are protected against the financial risks of obtaining health care.

5.1.2.3. UC's Principles

In order to achieve the goals specified above, the National Health Security Act 2002 was generated through along process of research and development based on nine various principles as follows:

1) Easy accessibility: people from all walk of life would be able to get access to health care and be part of the scheme, taking their responsibilities of their health, being the owner of the policy, monitoring the program, and partly responsible for the cost for the health care at reasonable price.
2) Entitled rights to health coverage and mechanism to the health coverage protection
3) Standard and quality health service units
4) Promoting the utilization of primary care units prior to be sent to the second tier health care unit
5) Supporting and promoting cooperation among all primary care units in network operation
6) Promoting long-term cost management of universal health care coverage to become independent from relying on unnecessary health care benefits
7) Standardization of all core health care benefits, reduce health care redundant benefits from different funds

8) Efficient health care management employing full stream information technology
9) One single health care fund

5.1.2.4. Requirement to be UHC's participant

As stipulated in the Section 5 of the National Health Security Act 2002, it is said that all Thai citizens shall be entitled to a Health service with such standards and efficiency. The Board shall have beneficiaries jointly pay cost sharing as prescribed by the Board to the Health care unit per visit, except such persons as prescribed by the Board who shall be entitled to Health service without joint payment.

All the people have to do is to go to health care units as specified by their rights to choose the primary service unit at their convenience, which can be changed to the one nearby in case they have moved to different place to live as they see appropriate. In case where severe treatment is required as confirmed by the family doctor, the patients shall be transferred to nearby hospital where there are specialized doctors and medical facilities available. Also in case of emergency, the patients will be sent to other hospitals where all facilities and doctors are at services. Medical expenses and costs will be charged and paid by different funds depending on their eligibilities. For instant, civil servants will be paid by the Civil Servants Health Service Fund; those in private sector will be covered by Social Security Fund, etc.

5.1.2.5.Targeted people

Thailand has one of the most complex health care systems in Asia. Prior to Reform, there were about six different health benefits schemes, targeting different groupws of people with different benefit packages. The first one is the low income and public welfare schemes for free of charge at designated public facilities. The second

one is for those workin for the government, called Civil Servant Medical Benefit Scheme (CSMBS). It provides health care benefits to both the government officers, their parents, and their dependents. The third one is the Social Security Scheme (SSS) for those working in the private sector with no copayment. It is a compulsary health insurance with limited choice of health care to a contractual public or privatehospital. The fourth one is the Workmen's Compensation Scheme (WCS). It is also a compulsary insurance scheme related to work with copayments when the total charge is higher than the set ceiling. Last, but not least, is the voluntary Health Card (HC) scheme, provided by the Ministry of Public Health (MPOH) for the access to only MOPH facilities with referral networks and no copayment.

The National Health Service Reform had been officially initiated since 2001 under the "30 Baht Health Care Project." It was first implemented as a pilot project in 6 province in April 2001, namely Patumthani, Samutsakorn, Nakornsawan, Yasothorn, Payao, and Yala. About 1.39 millions of citizens (37.37% of populations in 6 provinces) were covered in this scheme. Two months later, it was expanded to cover 15 more provinces, accounted for 4.9 million or 35% of population in these provinces. Later, in October of 2001, the project had also been implemented in all other provinces in Thailand and 13 areas of Bangkok because Bangkok Administration was more complicated and so required better preparation of project management. It was not very long that the 30 Baht project had fully covered every areas of Thailand in April, 2002. So, it was a gradual and continuous process of policy implementation.

After the National Health Security Bill was passed in 2002, the government initiated the reform as promise during political election campaign. The National Health Security Office (NHSO) was setup to manage the Universal Health Care Coverage in Thailand as stipulated in the 2002 National Security Act. Two governing Boards, namely The National Health Security Board and the Health Service Standard and

Quality Control Board, were also appointed to set the national health care policy and to monitor and control the quality of services up to the international standard accordingly. The details of the boards' authorities will be elaborated later in this report.

As a results of the reform, at present the health care system in Thailand had been cut down to three major schemes, including Civil Servant Medical Benefit Scheme (CSMBS), Social Security Scheme (SSS), and the National Health Security Scheme (NHSS). The 30 Baht project had been transformed to be NHSS. Each scheme targets different groups of Thai populations with different benefit packages. The one in focus of this study is the last one since it covers about 47 million 75% of population, while 8%, 15.8% are in the CSMBS and SSS respectively.

As stated above the National Health Security Coverage will target all Thai citizens who are not currently gain benefits from any other health service funds. It is estimated approximately around 2.3 to 5 million people in Thailand.

5.1.2.6. Benefits

Section 3 of this Act also states that "Health service expenses" refers to any expenses born by a Health Service provided by a Health Care Unit (HCU). The Board has responsibilities to appoint subcommittee to develop benefits scheme, including public health services, types and scope of public health service. The benefits are as follows:

1) Prevention and promotion services including medical and public health service for supporting people living more longer age and deceasing patient and disable rate.
2) Diagnosis and investigation services for checking mistakes which occur in medical service.

3) Ante-natal care including checking and supporting infant care services as the model of Department of health, Ministry of Public Health and/or World Health Organization (WHO).
4) Therapeutic items or services including medical treatment service until the end such as kidney treatment in particular.
5) Drugs, biological, supplies, appliances, and equipment including anti HIV virus was contained in national core medicine index.
6) Delivery including just first 2 children.
7) Bed and board in the service unit including food and general patient room.
8) newborn care
9) ambulance or transportation for patient
10) Transportation for a disabled person
11) Physical and mental rehabilitation including efficiency of medical service until the end.
12) Other expenses necessary for the Health service as prescribed by the Board.

Table 5.1. Benefit Package And Financing Characteristics Of The Health Benefit Schemes

Scheme characteristics	Low income and public welfare	CSMBS	SSS	WCS	Health Card	Private insurance
Benefit package						
Ambulance services	Only designated public hospitals	Public only	Public and private	Public and private	Public (MOPH)	Public and private
Inpatient services	Public only	Public and private	Public and private	Public and private	Public (MOPH)	Public and private
Choice of provider	Referral line	Free	Contrafcrual basis	Free	Referral line	Free
Cash benefitws	No	No	Yes	Yes	No	Usually no
Inclusive conditions	All	All	Non-work related illness, injuries, except 15 conditions	Work-related illness and injuries	All	As stated in the contracts
Maternity benefit	Yes	Yes	Yes	No	Yes	Varies
Annual physical	No	Yes	no	No	Possible	Varies

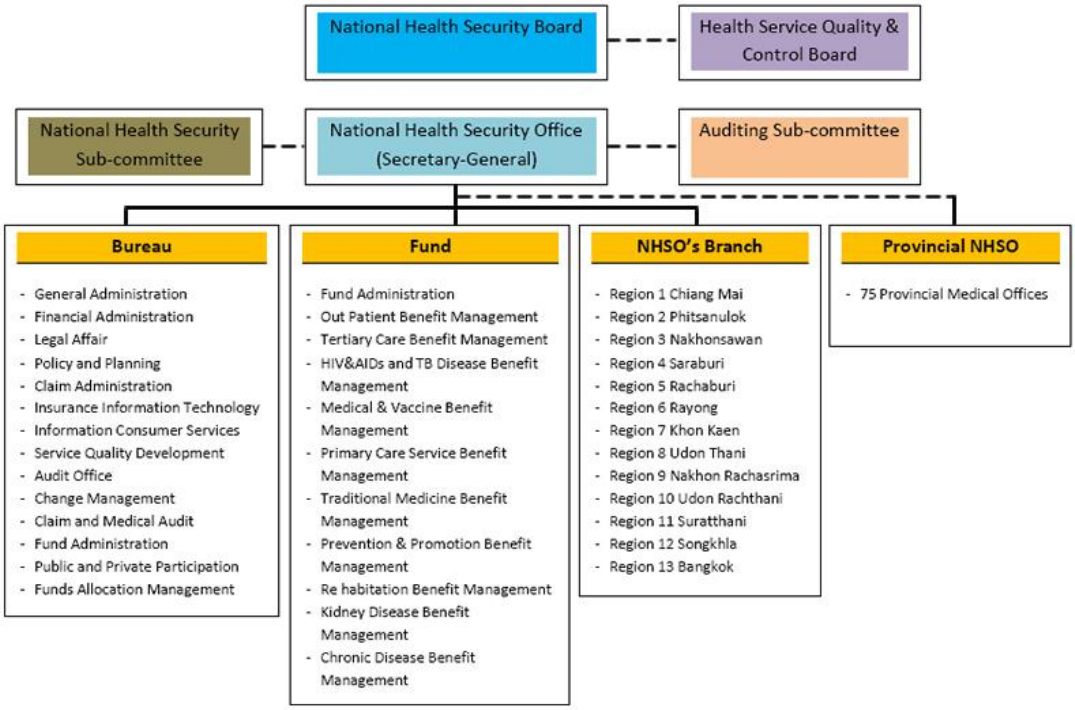
checkup						
Promotion & prevention	Very limited	Yes	Health education and immunisation	No	Possible	Varies
Services not covered	Private bed, specia nurse, eye glasses	Spediaql nurse	Private bed, special nurse	No	Private bed	Varies
Financing						
Source of fund	General tax	General tax	Tripartite contributions, 1.5% of payroll	Employer, 0.2-2% of payroll with experience rating	Household purchase 500 baht plus tax subsidy 500 baht	Premium
Financing body	MOPH	Ministry of finance3	Ministry of Labour	Ministry of Labour	MOPH	Competitive companies
Payment mechanism	Global budget	Fee-for-service reimburse	Prospective capitation	Fee-for-service reimburse	Limited fee-for-service	Fee-for-service reimburse
Copayment	No	Yes, for IP at private hospital	Maternity and emergency services	Yes, if exceed the ceiling of 30,000 baht	No	Almost none

Source: Pannarunothat and Tangcharoensathien, 1993; Supachutikul, 1996; and Tangcharoensathien and Supachutikul, 1997 cited in Nitayarumphong and Mills, 2005, p. 265.

5.1.2.7. Organizations

Based on theNational Health Security Act 2002, Thailand national health scheme is organized and managed by two closed related Boards: the National Health Security Board and the Health Service Standard and Quality Control Board under the National Health Security Office (NHSO), an autonomous organization (see figure 1 below).

Figure 5.6. Organization Chart of the National Health Security Office (NHSO)



Source: 2002 National Health Security Office. 2002. National Health Security Office's Structure. Access on May 31, 2015 from http://www.nhso.go.th/eng/Site/ContentItems.aspx?type=Mg%3d%3d.

The NHSO is led by the Secretary-General, with the assistance of the National Health Sub-committee and the Auditing Sub-committee. The duties of the NHSO are to manage and ensure the attainment of universal coverage for all.

In this design, the policy making and system development is assigned to the National Health Security Board who will develop the national health policy framework on benefit packages, heath care service standard, criteria and no-fault compensation and regulations frameworks for contracting providers. Under Section 13 of the 2002 Act, the Ministry of Public Health is appointed as the Chair of the National Health Security Board. Serving on the National Health Security Board also include a number of experts in medical sciences and public health, Thai traditional medicine, alternative medicine, finance, law and social sciences, administrators, high ranking government officials, representatives from health professional bodies, municipalities, local administration organizations and non-profit organizations working on children, youth,

women, elderly and other vulnerable groups are also included as the Committee members. from public and private organizations, namely Ministry of Defense, Ministry of Finance, Ministry of Commerce, Ministry of Interior, Ministry of Labor, Ministry of Public Health and Ministry of Education, and the director of the Bureau of the Budget. All board members are appointed by the Cabinet.

As the Health Service Standard and Quality Control Board, the members include the heads of many health care institutes such as the Department of Medical Services, the Food and Drug Administration Office, the Hospital Development Accreditation Institute and the Medical Registration Division; representatives from professional bodies, private hospitals, health care professionals, Royal Colleges as well as municipalities and local administration organizations; representatives from non-profit organizations working on children, youth, women, elderly and other vulnerable groups are elected as members; six qualified experts in tropical family medicine, mental health and Thai traditional medicine appointed by the Minister of Public Health. The Board's main responsibilities are to control, monitor, develop standard and quality of health care providers, and providecomments on standard fees for treatments, regulate no-fault liability payment, support public access to UC information and give response to consumer complaints.

To ensure the integrity and good governance of the policy and implementation, an audit sub-committee, acting as internal auditors, is appointed by National Health Security Board. Its main task is to closely inspect into the system whether internal operation, especially financial management, complies with the laws and regulations. The National Health Security Board will be regularly reported by the audit sub-committee on a quarterly and annual basis.

Taking a closer look at the inside operation of the NHSO, it is found that the NHSO is divided into the headquarter office and the regional offices. Located in

Bangkok, the central unit has 15 bureaus, responsible for policy and planning, system support as well as monitoring and evaluation. The regional offices are located in different provinces around the country--3 in the North, 3 in the East, 4 in the Northeastern, 2 in the South, and 1 in Bangkok-- responsible for administering and monitoring the fund management at the regional level to ensure that health security implementation is responding to the local health needs. There are also 75 medical offices in almost every province in Thailand in providing health services to the people.

5.2. Universal Health Care Membership And Finance

5.2.1. Indonesia's JKN Finance

JKN as the unified social insurance program that pool contributions from three broad categories of people: (i) the poor and near-poor whose fixed premium contributions will be paid for entirely by the central government (the group that was previously covered under Jamkesmas); (ii) those employed in the formal sector, both public and private, whose salary- based contributions will be paid for by employers and employees (this group includes those that were previously covered under AskeskinandJamsostek); and (iii) those who are non-poor and work in the informal sector who are expected to pay a fixed premium contribution upon enrollment in the program (this group would include most of those who are currently uncovered). The JKN was conceived to provide better health coverage for all Indonesians, by extending insurance to the entire population, including large swathes of the population previously not covered by any public insurance schemes (The Economist Intelligent Unit, 2015).

There are two kinds of JKN contribution:

1. Contribution for people below the poverty line (PBI) which is paid by central and local government.
2. Contributions of members paying their own premium

a. Workers in formal employment premium is shared by employees and employer calculated as a percentage of salary/wage.
b. Self and non employed pay nominal/ flat rate and determined by Presidential Decree.Contributions/ premiums are pooled and create the major source of funding for the scheme.

The tariff for a particular kind of health service over a fixed period is calculated by dividing the total number of claims for that service by the total usage of health services. As with usage, adjustments are also needed in calculating the tariff for the health-care service. It is also necessary to keep in mind that inflation in the health sector is usually higher than general inflation.

Table 5.2. The Tariff for Health Care Services in Indonesia

MEMBER	PREMIUM	MONTHLY MEMBERSHIP FEE (IDR)	COVERAGE
SUBSIDIZED MEMBER	NOMINAL (per member)	19,225-	Class 3 IP care
CIVIL SERVANT/ARMY/POLICE/ RETIRED	5% (per household)	2% from employee 3% from employer	Class 1& 2 IP care
OTHER WORKERS WHO RECEIVE MONTHLY SALARY/WAGE	4.5 % (per household) And 5% (per household)	Until 30 June 2015: 0.5% from employee 4% from employer Start 1 July2015: 1% from employee 4% from employer	Class 1& 2 IP care
NON WAGE EARNERS/ INDEPENDENT MEMBERS (Informal Sector)	NOMINAL (per member)	1. 25,500,- 2. 42,500,- 3. 59,500,-	Class 3 IP care Class 2 IP care Class 1 IP care

Source: MOH, 2014

Further regulation on assessment of emergency condition and procedure f or emergency services expense reimbursement shall be regulated under BPJS Healthcare Regulation.

There are 3 levels of Health care providers:

1. Primary health care providers: Public Health Service, Private clinic, Private Doctor
2. Secondary and tertiary health care providers: Hospitals both public hospitals and private hospitals

The Payment methods consist of

1. Primary health care providers: capitation
2. Secondary and tertiary health care providers: Ina-CBG's (Indonesian - Case Based Groups)

A single payer model places great responsibility on the purchaser to develop a payment system that is precise and fair. Indonesia boldly implemented a new prospective case-based payment system for Jamkesmas a few years ago called INA CBGs (for Indonesia Case-Based Groups). Using the Indonesian Case-Based groups payment model in implementing JKN, payments made to advanced level facilities were reformed through Ministry of Health regulation No. 69 2013 on the standard tariff for health services. These reforms were applied to level I and advanced level health-care service facilities under regulation No. 71 2013 on JKN health services. When Jamkesmas was first launched (2009–2010), payment of claims was based on the Indonesian Diagnoses-related Group (INA-DRG) but this was developed into the Indonesian case-based groups (hereafter referred to as INA-CBG) and has been used since 2011. As of 2014, it is not only used for patients who are PBIs but also for non-beneficiaries.The INA-CBG payment model is the amount of the claim that BPJS Kesehatan pay advanced health-care facilities for their services, according to the diagnosed illnesses (Kumorortomo, 2015).

In order to assess the effectiveness of Indonesian health finance policy to cover health services for the population, it is important to consider how has been the performance of the BPJS in integrating various health schemes in the country. As a

health scheme specifically targeted for the poor and near-poor, the Jamkesnas is now managed by the BPJS. With the official estimates indicate that there are 76.4 million poor and near-poor beneficiaries of the 252.8 million total population in 2014, the BPJS is managing formerly Jamkesmas to cover almost one third of the population. With the funding of about a quarter of the central government budget on health, the BPJS handling on Jamkesmas target is likely determine the Indonesian government intention to attain a universal coverage. As a health scheme specifically targeted for the poor and near-poor, the Jamkesnas is now managed by the BPJS. Jamkesnas program was started in 2005 as Askeskin, literary means health insurance for the poor. In 2007, the Askeskin that was originally based on households was renamed Jamkesmas to be based on individuals and expanded to also cover the near-poor. With the official estimates indicate that there are 76.4 million poor and near-poor beneficiaries of the 252.8 million total population in 2014, the BPJS is managing formerly Jamkesmas to cover almost one third of the population (Kumorotomo, 2015).

With the funding of about a quarter of the central government budget on health, the BPJS handling on Jamkesmas target is likely determine the Indonesian government intention to attain a universal coverage. It is therefore important to analyze the whole institutional arrangement for health policy in Indonesia as administrative efficiency is also a key factor determining the quality and the coverage of health services in the country.

Figure 5.7. Health Financing and Provision in Indonesia

Source: Adapted from Soewondo et al, 2011; BPJS, 2014.

Based on the estimate that the government finance is targeted to cover 86.4 million with the PBI premium of Rp 19,225 per person per month, the central government's contribution to BPJS would equal to Rp 19.9 trillion. Since the government budget in 2014 was only Rp 44.9 trillion, it implies that almost half of the overall government health budget would be used to finance the BPJS. Then, the consequence is straightforward: the share for financing other areas of spending such as salaries and operating costs for centrally-financed hospitals, investments in improving supply and much-needed preventive and promotive interventions would have to be shrunk. The 2015 budget is allocating Rp 47.8 trillion. (Kumorotomo, 2015).

The government is to be lauded for this bold move to such a powerful payment system to encourage greater technical efficiency. The hospital INA CBG system for all covered is of particular concern. It was developed outside of Indonesia, and based on United States clinical practice patterns and cost structures. In future years, the CBGs need to reflect local cost structures and clinical practice patterns. This will require development of a cadre of local experts who are not part of the hospital sector (as they are now), but can objectively and empirically assess and refine the software groupers that generate tariffs.

As Indonesia implements the new BPJS reforms, the issue of fiscal space for UHC has become paramount. The unified social insurance program will pool contributions from three broad categories of people: (i) *the poor and near-poor* whose fixed premium contributions will be paid for entirely by the central government; (ii) *those employed in the formal sector*, both public and private, whose salary-based contributions will be paid for by employers and employees; and (iii) *those who are non-poor and work in the informal sector* who will be expected to pay a fixed premium

contribution upon enrollment in the program. The central government outlays to finance the premiums of 86.4 million poor and near-poor in 2014 are expected to be IDR 19.9 trillion (~0.2% of GDP), up from 6 trillion allocated for financing Jamkesmas in 2011 (~0.1% of GDP).In addition to demand-side financing from the central government, additional supply-side financing from the central, provincial, and district governments will be needed to meet rising utilization rates as coverage expands. Indonesia's public spending on health was only around 0.9% of GDP in 2011, one of the lowest in the world (The Economist, Intelligent Unit, 2015).

5.2.2. Thailand UC's Finance

As shown in Table 5.2. below, the number of people register for the UC rights has increased every year from approximately 47 million, accounted for 70.14 % of population in 2011 to almost 49 million or 73.13% in 2015. It is going to be increased in the future and expected that all Thai citizens will be covered by either UC rights or other health security rights. Both numbers of male and female populations are quite close in registering for their rights to UC, with a slightly less female are unregistered as compared to male.

Table 5.3. Number of populations in Thailand covered by UC rights and other rights categorized by Gender from year 2008-2015

Year	Male			Female			Total (Male+Female)	*All rights (Male+Female)*
	Right to Health Insurance	Other rights	Unregistered	Right to Health Insurance	Other rights	Unregistered		
2008 - 2011	23,422,049	7,393,214	986,147	23,985,757	7,988,039	780,938	47,407,806	15,381,253
2012	24,036,268	69,816	478,312	24,434,417	99,983	373,359	49,492,155	*49,492,155*
2013	24,036,331	82,381	391,948	24,426,267	116,431	310,144	49,363,502	*49,363,502*
2014	23,942,134	120,229	161,680	24,234,990	146,027	153,425	48,758,485	*48,758,485*
2015	23,913,234	131,823	162,712	24,248,025	164,921	151,742	48,772,457	*48,772,457*

Source: compiling from EIS-NHSO, Health insurance information service center, 2015, online

In accordingly, from Table 2, the percentage of Thai populations entitled to Universal Health Coverage has been quite steady at approximately 73% from year 2011 to present. In year 2012, the number of people with UC scheme slightly increased by 1 %, but the years after has dropped to 73% and steady onward is because they have been covered by Social Security Scheme, the rights for those who work in private sector. The implication is that they have found jobs and have to co-pay for the social security rights with the government and their employees.

Table 5.4. Different Health Coverage Schemes of Thai People from 2011 to present

Health Coverage Schemes	2011	2012	2013	2014	2015
Universal coverage	73.44%	74.22%	73.87%	73.33%	73.36%
CMSBS & state enterprise	15.51%	7.76%	7.57%	7.34%	7.34%
Social security	7.67%	15.90%	16.37%	16.79%	16.85%
Other rights and statuses	0.42%	0.28%	0.33%	0.43%	0.45%
Unregistered	0.74%	1.31%	1.07%	0.49%	0.48%
Pending status	2.04%				
Thai citizens in foreign countries	0.02%				
Foreigners	0.16%				
Local Administration			0.15%	0.88%	0.91%
Unidentified rights and statuses		0.52%	0.63%	0.74%	0.61%
Total number of populations	64,754,314	65,503,955	65,903,942	65,884,703	65,836,240
Total (rights)	100.00%	100.00%	100.00%	100.00%	100.00%

Source: compiling from EIS-NHSO, Health insurance information service center, 2015, online

Concerning the Primary Care Units in Thailand, the services have been divided into 13 regional offices and one special group disperses to different part of the country (See Table 5.3). There are about 1,167 main service units in total, mostly in Bangkok, Chiangmai, and Saraburi provinces, respectively. Within each area, there are a total number of 11,342PCU, mostly located in Chiangmai (1,264 units), Nakhornratchasima

(1,064 units), and Ratchaburi (1,006 units), and etc. The PCUs have different capacities in number of medical doctors, nurses, personnel, and medical equipments and facilities to handle patients ranging from less than 10,000 people, the smallest PCU, to the biggest PCU, able to handle more than 50,000 cases. In comparison, most of PCUs, accounted for 90%, can provide services to less than 10,000 people. Interestingly, Bangkok has the less number of small PCUs, but with more of larger size of PCUs and able to provide the most services to large proportion of population. It is a tradition, norms, or belief that most Thai people would go straight to the General Hospital for minor sickness instead of going to visit "family doctors" in the PCU in their close vicinity or communities. This behavior has caused difficulties in capitation coverage financial management. Large facilities will not be able to handle overcrowded patients coming more than they received funding from the government based on the number of registered populations in the area; while small units will have not many registered patients.

Table 5.5. Numbers of Primary Care Unit in Thailand in year 2013 *

NHSO	Main Service Units		Total Primary Care Units (Places)	Proportion of Population to Primary Care Units (people)	Primary Care Unit <= 10,000 people	Primary Care Unit <10000 <= 30,000 people	Primary Care Unit > 30,000 <= 50,000 people	Primary Care Unit > 50,000 people
	Places	%						
Region 1 Chiangmai	116	9.94%	1,264	3,205	1237	23	4	-
Region 2 Pitsanulok	54	4.63%	709	3,688	685	24	-	-
Region 3 Nakhornsawan	52	4.46%	649	3,475	635	14	-	-
Region 4 Saraburi	102	8.74%	944	3,535	898	45	1	-
Region 5 Ratchaburi	76	6.51%	1,006	3,888	970	33	2	1
Region 6 Rayong	84	7.20%	886	4,360	819	62	3	2
Region 7 Khonkhaen	71	6.08%	907	4,202	886	21	-	-
Region 8 Udonthani	88	7.54%	971	4,479	939	31	1	-
Region 9 Nakhornratchasima	98	8.40%	1,064	4,797	1017	47	-	-

Region 10 Ubonratchathani	77	6.60%	928	3,658	916	12	-	-
Region 11 Suratthani	85	7.28%	820	4,545	780	37	2	-
Region 12 Songkla	83	7.11%	923	4,299	881	37	4	1
Region 13 Bangkok	179	15.34%	269	14,415	108	135	13	9
14. Special group	2	0.17%	2	37,686	-	1	-	1
Total	1,167	100.00%	11,342	4286.73	10,771	522	30	14

Source: EIS-NHSO, Health insurance information service center, 2015, online

* There is no data in other previous years available on website.

In general, there are two different approaches to finance universal health care in most developed and developing countries around the world: 1) the compulsory or social insurance, widely known as Bismarck Model and 2) the taxation method, known as the Beveridge Model (Nitayarumphong and Mills, 2005)

The Bismarck Model is considered as an insurance based system, such as a social insurance system, depending on the ability to pay and accessibility to services at time of needs independent from the government. Initiated in Germany with tight regulation framework for the contributions to health funds, it is applied to countries like Japan, Korea, and Taiwan because it creates less political conflict and a more centralized means of fund management. Furthermore, it gives more choices to the people.

The Beveridge Model is funded by tax or government revenue. The United Kingdom and Canada are the good example of countries using this model. No other countries in Asia and Latin America has applied this model to cover health care at full range.

Learning from reform experiences in different countries in Asia and Latin America, there is no "one best way" or "one size fits all." It all depends on the economic, political and social status of each individual country.

Another aspect of financial management to be considered is to decide whether to have a single fund or multiple funds of the money collected from the people. Various countries in Asia have adopted the multiple funds approach to health care such as Japan, Korea, and Chile; while Taiwan use the single way to manage funds. The only issue arises from multiple funds is the inefficiency of administrative cost. A single taxed-based health system would be easier to manage and Korea has been trying to merge or combine different funds into a single fund system.

In Thailand, the money used to support the National Universal Health Care Coverage comes mostly from the government. Based on the pilot implementation of capitation contract model in Banpaeo Hospital in January 2001 and Social Health Insurance early on in April 1991, the research concluded that the capitation contract model would be more suitable for increase of health care costs in the future in designing Universal Coverage Scheme. The general tax financed would be the best possible way for fund management in comparison to the fee for service reimbursement model of the CSMBS. Considering the upscale of UC scheme in the future, the copayment was contemplated to be politically and technically infeasible (Tangcharoensathien and others, n.d.). Section 38 of the 2002 Act has set up a "National Health Security Fund" (NHSF) under the National Health Security Office (NHSO) with main authorities in providing and supporting health care costs and public health services to service units. There are at least 8 different sources of funding to ensure that all citizens can get access to cheap and quality health care services at reasonable and affordable price as follows:-

1. Government annual allocation
2. Local government administration
3. Fees from services as specified by the Act
4. Fine collected by the Act

5. Donations to the National Health Service Fund
6. Interests from the savings and asset of the Fund
7. Other income or asset derived from related activities of the Fund
8. Other sources as allowed by the law, e.g. Dental Fund, Subdistrict Administrative Organization Fund, Medicine Fund, Kidney Fund, etc.

With the government's attempt to help all Thai citizens to have health security coverage, the number of registered population for UC scheme will be increased every year and as a consequence the cost of health care using tax-based compulsory finance will rise respectively. As seen in Table 5.4, the money allocated for UC scheme has increased from 56,091 million baht in 2003 to 154,258 million baht, about three times when it was first started. As previously elaborated, as more people (about 73% of population) joined the UC scheme, it is the government's obligation to provide health care benefits as it promised during the election campaign in 2002. Though, looking at the figure seem to be alarming, but this money is only accounted for 1.1% or 1.2% of the Annual National Gross Domestic Products (DGP), and only about 6% of the National Budget allocated each year. However, a closer look at the UC coverage from the data provided by NHSO, the amount of health coverage per person per year has increased more than 100% from year 2002 to 2014, from 1202.40 Baht to 2895.09 Baht, due to the expansion of the coverage and the benefits package to include minor care to chronic diseases. The success story of Thailand should be given credits to all those behind the reform and a continuous developments of new ideas and the efficiency of funds management.

Table 5.6. UC Annual Budget Allocation Year 2002-2014

List	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
GDP (Million Baht)	**5,450,643**	**5,799,700**	**6,476,100**	**7,195,000**	**7,786,200**	**8,399,000**	**9,232,200**	**8,712,500**	**10,000,900**	**10,650,960**	**11,572,300**	**12,295,000**	**13,242,000**
Annual allocated budget of Thailand	**1,022,300**	**999,900**	**1,163,500**	**1,250,000**	**1,360,000**	**1,566,200**	**1,660,000**	**1,951,700**	**1,700,000**	**2,070,000**	**2,380,000**	**2,400,000**	**2,525,000**
UC budget (include personnel salary)		**56,091**	**61,212**	**67,583**	**82,023**	**91,369**	**101,984**	**108,065**	**117,969**	**129,281**	**140,609**	**141,540**	**154,258**
- UC as % in GDP					1.1%	1.1%	1.1%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
- UC as % overall budget					6.0%	5.8%	6.1%	5.5%	6.9%	6.2%	5.9%	5.9%	6.1%
UC budget details													
1. UC targeted population (million)	45.00	46.00	46.82	47.00	47.75	46.07	46.48	47.026	47.2397	47.997	48.333	48.445	48.852
2. Capitation (Baht/head/year)	1,202.40	1,202.40	1,308.50	1,396.30	1,659.20	1,899.69	2,100.00	2,202.00	2,401.33	2,546.48	2,755.60	2,755.60	2,895.09

Source: NHSO, Policy and Planning, Funds Information 2002-2014

5.3. THE IMPLEMENTATION OF UHC

5.3.1. Respondents Profile

Based on the questionnaires collected in both countries (table 6.1.) there are shown that slightly more male (51.20 percent) than female respondents (48.30 percent) in Thailand. While in Indonesia, the samples shown more female (53.30 percent) than male respondents (46.70 percent). About half of the respondents accounted for married both in Indonesia and Thailand. Most of the respondents received six year of basic education and for high school. It is very interesting to find out that about 33.70% who come to receive UC services from Banpheo Hospital are unemployed or freelancers (18.50 percent), business owners (16.60 percent), or homemakers/housewives (14.60 percent), respectively. And lastly, more than 50% have their monthly earnings more or

less 10,000 Baht.[1]On the contrary, in Indonesia most of the respondents are non-PBI or participants who are catogorized as poor people and low income people.

Table 5.7. Geographical Background Of Samplings

	THAILAND		INDONESIA	
Sampling properties	Frequency	Percentage	Frequency	Percentage
1. Gender				
Male	105	51.20	140	46.70
Female	99	48.30	160	53.30
N/A	1	0.50	0	0
2. Age				
60 - 65	46	22.40	114	38.00
66 - 70	58	28.30	90	30.00
71 - 75	53	25.90	51	17.00
76 - 80	32	15.60	45	15.00
81 - 85	13	6.30	0	0
86 - 90	2	1.00	0	0
91 - 95	0	0.00	0	0
95 +	0	0.00	0	0
N/A	1	0.50	0	0
3. Residency				
Bangkok (Thailand)	167	81.50		
Yogyakarta (Indonesia			225	75.00
Other provinces	22	10.70	75	25.00
N/A	16	7.80	0	0
4. Marital Status				
Single	27	13.20	33	11.00
Married	111	54.10	198	66.00
Divorce/widow/separated	66	32.20	69	23.00
N/A	1	0.50	0	0
5. Educational level				
Primary	74	36.10	119	39.70
High school	41	20.00	106	35.30
Vocational	21	10.20	22	7.30
Undergraduate	55	26.80	53	17.60
Graduate +	7	3.45	0	0
N/A	7	3.45	0	0
6. Occupation				
Civil servants/public enterprise	4	2.00	0	
Business owners	34	16.60	70	23.3
Employees	11	5.40	41	13.7
Farmers /agricultural	1	0.50	14	4.7
Retire officials	13	6.30	30	10

[1]The conversion rate is about 33.00 baht per one US dollar.

	THAILAND		INDONESIA	
Sampling properties	Frequency	Percentage	Frequency	Percentage
Homemakers/housewives	30	14.60	45	15
Freelance	38	18.50	0	0
Unemployed	69	33.70	0	0
Others	5	2.40	65	21,6
7. Income per month (Baht equivalent to Rupiah)				
Less than 2,000	48	23.40	98	32.7
2,000 – 5,000	24	11.70	82	27.3
5,000 – 10,000	46	22.45	75	25
10,000 -20,000	47	22.95	30	10
20,000-50,000	32	15.60	15	5
More than 50,000	5	2.40	0	0
N/A	3	1.50	0	0

Source: Primary data

5.3.2. UHC Implementation

The perception of respondents on implementation both UC and JKN are varies. It has 5 parameters in the measuremenet such as: 1.Standart of Procedures of public hospital, 2. Communication between agencies of UHC Healthcare, 3. Medical human resources readiness, 4. Convenient Facilities and infrastructure, and 5. Medicinesufficiency.Overall, the perception of the respondents show better perception in Thailand rather than in Indonesia. In Indonesia the result in Standart of Procedures of public hospital parameter show 4.10 that is lower than Thailand with a remark of 4.68. In term of Communication between agencies of UHC Healthcare, it is found that Thailand is 4.56, while Indonesia only 3.77.

Another parameters of Medical human resources readiness, Convenient Facilities and infrastructure, and Medicine sufficiency also shown the higher result in Thailand.

Table 5.8. Parameters of Implementation UHC

Implementation	Thailand	Opinion	Indonesia	Opinion
1.Standart of Procedures of public hospital	4.68	Highly Satisfied	4.10	Very Satisfied
2. Communication between agencies of UHC Healthcare	4.56	Highly Satisfied	3.77	Very Satisfied
3. Medical human resources readiness	4.46	Highly Satisfied	4.18	Very Satisfied
4. Convenient Facilities and infrastructure	4.35	Highly Satisfied	4.20	Very Satisfied
5. Medicine sufficiency	4.46	Highly Satisfied	4.10	Very Satisfied

Source: Primary data

The higher result of Thailand in implementing UC can be understood that Thailand has been implemented UC for 13 years and has more health care units and sufficient of health resources such as doctors, nurses, medicine, and administration staff to organize UC. It can be traced from the numbers of Primary Care Units (PCU) in Thailand, the services have been divided into 13 regional offices and one special group disperses to different parts of the country. There are about 1,167 main service units in total, mostly in Bangkok, Chiangmai, and Saraburi provinces, respectively. Within each area, there are a total number of 11,342PCU, mostly located in Chiangmai (1,264 units), Nakhornratchasima (1,064 units), and Ratchaburi (1,006 units), and etc. It is a tradition, norms, or belief that most Thai people would go straight to the General Hospital for minor sickness instead of going to visit "family doctors" in the PCU in their close vicinity or communities. This behavior has caused difficulties in capitation coverage financial management. Large facilities will not be able to handle overcrowded patients coming more than they received funding from the government based on the number of registered populations in the area; while small units will not have many registered patients.

Table 5.9. Numbers of Primary Care Unit in Thailand in year 2013 *

NHSO	Main Service Units	Total Primary Care Units (Places)	Proportion of Population to Primary Care Units (people)	Primary Care Unit <= 10,000	Primary Care Unit <10000	Primary Care Unit > 30,000 <=	Primary Care Unit > 50,000 people

	Places	%			people	<= 30,000 people	50,000 people	
Region 1 Chiangmai	116	9.94%	1,264	3,205	1237	23	4	-
Region 2 Pitsanulok	54	4.63%	709	3,688	685	24	-	-
Region 3 Nakhornsawan	52	4.46%	649	3,475	635	14	-	-
Region 4 Saraburi	102	8.74%	944	3,535	898	45	1	-
Region 5 Ratchaburi	76	6.51%	1,006	3,888	970	33	2	1
Region 6 Rayong	84	7.20%	886	4,360	819	62	3	2
Region 7 Khonkhaen	71	6.08%	907	4,202	886	21	-	-
Region 8 Udonthani	88	7.54%	971	4,479	939	31	1	-
Region 9 Nakhornratchasima	98	8.40%	1,064	4,797	1017	47	-	-
Region 10 Ubonratchathani	77	6.60%	928	3,658	916	12	-	-
Region 11 Suratthani	85	7.28%	820	4,545	780	37	2	-
Region 12 Songkla	83	7.11%	923	4,299	881	37	4	1
Region 13 Bangkok	179	15.34 %	269	14,415	108	135	13	9
14. Special group	2	0.17%	2	37,686	-	1	-	1
Total	1,167	100.00 %	11,342	4286.73	10,771	522	30	14

Source: EIS-NHSO, Health insurance information service center, 2015, online
** There is no data in other previous years available on website.*

The PCUs have different capacities in number of medical doctors, nurses, personnel, and medical equipments and facilities to handle patients ranging from less than 10,000 people, the smallest PCU, to the biggest PCU, able to handle more than 50,000 cases. In comparison, most of PCUs, accounted for 90 percent, can provide services to less than 10,000 people. Interestingly, Bangkok has the least number of small PCUs, but with more of larger size of PCUs and able to provide the most services to large proportion of population.

5.3.3. Quality of Services

Thoroughly, the respondents' perception toward the quality of UHC service in Indonesia shows that about 79.67 percent of the respondents consider that there has been similarity and equality of JKN services for all participants. Only about 15.66 percent still thought that there has not been similarity and equality of BPJS services in giving the health services for BPJS patients. The empirical fact in field shows there are treatment differences between PBI BPJS participants and Non PBI participants. The Non PBI BPJS patients were given prioritiesfor services as served compared to PBI participants. Besides, the PBI patients will be delayed when they will arrange the room in hospital because they will be offered Second or First Class as the Third Class rooms are no longer available.

In contrary, in Thailand, the informants' opinion concerning the quality of services in seven different aspects told different stories. It was found that in all they were highly satisfied with services at Banphaeo Hospital. This came to no surprise since this hospital, the Sukhumvit Branch of best practice hospital, was formerly a small and old private hospital equipped with small number of in-patients beds before Banphaeo Hospital took over. However, what is more important is the quality of medical treatment with respectable and responsible doctors, staff and personnel who are willing to give health care services without regard whether they are rich or poor, and especially with pride in their professions. The findings in this research have confirmed that Banphaeo Hospital is successful in its ability to maintain the standard and quality services to people from all walks of life to get access to at the costs that they can afford with no burden on their family and love ones. Considering the kind, eyes and kidney related disease, and numbers of medical attention or visits, every one or two months, they need from the hospital, it would costs them a fortune if they have to pay their own medical bills because most of them are retired. Their monthly income

would not be enough to cover their cost of every day livings, not to mention the cost of regular heath care. The UC scheme is the only answer to their needs.

Table 5.10. Parameters on Quality Service of UHC

Service quality	Thailand	Opinion	Indonesia	Opinion
1. Equal treatment	4.62	Highly Satisfied	4.12	Very Satisfied
2.On-time services	**4.32**	Highly Satisfied	4.03	Very Satisfied
3. Sufficient services	4.15	Very satisfied	3.99	Very Satisfied
4. Continuous care services	4.67	Highly Satisfied	4.17	Very Satisfied
5. Service improvements	4.17	Very satisfied	4.15	Very satisfied
6. Safety	4.27	Highly	3.99	Very Satisfied
7. Customers Care(medical personnel)	4.53	Highly Satisfied	4.12	Very Satisfied

Source: Primary Data

In Indonesian Case, there are two kind of membership, those are subsidized member (Peserta Berbayar Iuran/PBI)and Non Subsidized (Non-PBI) participants. In order to analyze the perception of difference of subsidized member (Peserta Berbayar Iuran/PBI and Non-PBI participants on services, the Analysis of Variants (ANOVA) was conducted. It is seen from the dimensions that shape the influence difference, there are three dimensions: membership, services and finance dimensions. In order to discover whether there were influence differences then those dimensions were tested one by one.

After Analysis of Variants (ANOVA) was tested using one way ANOVA for the PBI and Non-PBI participants, either using one by one test based on the dimension or overall dimensions, it can be concluded as following:

1. There is significant influence difference on PBI and Non-PBI participants related to the membership, services and finance dimensions.

2. There is significant influence difference on PBI and Non-PBI participants when it is measured overall.

The influence difference which is explained previously can be summarized in the following table:

Tabel 5.11. The Difference of UHC Policy Implementation's Influence on PBI and Non-PBI Participants

Indicators	PBI Participants	Non-PBI Participants	ANOVA
The fulfilment of membership	The participants were not helped by the National Health Security program and had not fulfilled natural right of health because the registration process was too complicated and too many requirements to fulfil. They tended to agree with the scheme of Regional Health insurance (Jamkesda) and Community Health Insurance (Jamkesmas).	The participants felt being helped and that National Helath Security operated by BPJS for Health had fulfilled their basic rights of health.	Fh=100 Ft 5%=3,94 So, Fh>Ft (100>3,94) Then, alternative hypothesis is accepted It means that there is difference influence
Service guaranteed	When the participants were sick they felt secure and satisfied. They also felt that health services provided by National Health Security were good enough. It was supported by medicine provision that already used Case Based Groups (INA CBGs) system.	When the participants were sick they felt insecure and dissatisfied with health services provided by National Health Security organized by BPJS for Health. It was because they do not agree with health services for medicine provision used Case Based Groups (INA CBGs) system. The basic reason was that when they were sick and the medicine needed was not in INA CBGs'lists, then they had to find the medicine in other drug stores which means that they had to spend some more money.	Fh=100 Ft 5%=3,94 So, Fh>Ft (100>3,94) Then, alternative hypothesis is accepted It means that there is influence difference

Finance availability	The participants felt that when they were sick they did not need to think about their health expense since it had been guaranteed by government and the expense was sufficient.	The participants felt that when they were sick they needed to think about their health expense since theystill have to pay the dues every month in which the dues are varied depend on the service class they have chosen. However, the finance from the National Health Security provided by BPJS was sufficient. There were also some of the Non-PBI participants who were not problematized the dues since they were taken from their own salary or wages. The term used in National Health Security is Non-PBI participants which are categorized as wage-earners.	Fh=100 Ft 5%=3,94 So, Fh>Ft (100>3,94) Then, alternative hypothesis is accepted. It means that there is influence difference

Source: Primary processed data, 2014

5.3.4. UHC Financial

In Indonesia, JKN is conceived to provide better health coverage for all Indonesians, by extending insurance to the entire population, including large swathes of the population not previously covered by any public insurance schemes (The Economist Intelligent Unit, 2015).

The tariff for a particular kind of health service over a fixed period is calculated by dividing the total number of claims for that service by the total usage of health services. As with usage, adjustments are also needed in calculating the tariff for the health-care service. It is also necessary to keep in mind that inflation in the health sector is usually higher than general inflation.

The Payment methods consist of:

3. Primary health care providers: capitation
4. Secondary and tertiary health care providers: Ina-CBG's (Indonesian - Case Based Groups)

A single payer model places great responsibility on the purchaser to develop a payment system that is precise and fair. Indonesia boldly implemented a new prospective case-based payment system for Jamkesmas a few years ago called INA CBGs (for Indonesia Case-Based Groups). Using the INA CBGs, payments made to advanced level facilities were reformed through Ministry of Health regulation No. 69 2013 on the standard tariff for health services.

Table 5.12. JKN Premium

MEMBER	PREMIUM	MONTHLY MEMBERSHIP FEE (IDR)	COVERAGE
SUBSIDIZED MEMBER	NOMINAL (per member)	19,225-	Class 3 IP care
CIVIL SERVANT/ARMY/POLICE/ RETIRED	5% (per household)	2% from employee 3% from employer	Class 1& 2 IP care
OTHER WORKERS WHO RECEIVE MONTHLY SALARY/WAGE	4.5 % (per household) And 5% (per household)	Until 30 June 2015: 0.5% from employee 4% from employer Start 1 July2015: 1% from employee 4% from employer	Class 1& 2 IP care
NON WAGE EARNERS/ INDEPENDENT MEMBERS (Informal Sector)	NOMINAL (per member)	1. 25,500,- 2. 42,500,- 3. 59,500,-	Class 3 IP care Class 2 IP care Class 1 IP care

Source: MOH, 2014

With the official estimates indicate that there are 76.4 million poor and near-poor beneficiaries of the 252.8 million total population in 2014, the BPJS is managing formerly Jamkesmas to cover almost one third of the population. Based on the estimate that the government finance is targeted to cover 86.4 million with the PBI premium of Rp 19,225 per person per month, the central government's contribution to BPJS would equal to Rp 19.9 trillion. Since the government budget in 2014 was only Rp 44.9 trillion, it implies that almost half of the overall government health budget would be used to finance the BPJS. Then, the consequence is straightforward: the share for financing other areas of spending such as salaries and operating costs for centrally-financed hospitals, investments in improving supply and much-needed preventive and promotive interventions would have to be shrunk. The 2015 budget is allocating Rp 47.8 trillion on health (Kumorotomo, 2015).

The central government outlays to finance the premiums of 86.4 million poor and near-poor in 2014 are expected to be IDR 19.9 trillion (~0.2% of GDP), up from 6 trillion allocated for financing Jamkesmas in 2011 (~0.1% of GDP). In addition to demand-side financing from the central government, additional supply-side financing from the central, provincial, and district governments will be needed to meet rising utilization rates as coverage expands. Indonesia’s public spending on health was only around 0.9% of GDP in 2011, one of the lowest in the world (The Economist, Intelligent Unit, 2015).

In Thailand,with the government’s attempt to help all Thai citizens to have health security coverage, the number of registered population for UC scheme will be increased every year and as a consequence the cost of health care using tax-based compulsory finance will rise respectively. The money allocated for UC scheme has increased from 56,091 million baht in 2003 to 154,258 million baht, about three times when it was first started. As previously elaborated, as more people (about 73 percent

of population) joined the UC scheme, it is the government's obligation to provide health care benefits as it promised during the election campaign in 2002. Though, looking at financial of UC Scheme, it seems to be alarming, but this money is only accounted for 1.1percent or 1.2 percent of the Annual National Gross Domestic Products (DGP), and only about 6percent of the National Budget allocated each year.

However, a closer look at the UC coverage from the data provided by NHSO, the amount of health coverage per person per year has increased more than 100percent from year 2002 to 2014, from 1202.40 Baht to 2895.09 Baht, due to the expansion of the coverage and the benefits package to include minor care to chronic diseases. The success story of Thailand should be given credits to all those behind the reform and a continuous developments of new ideas and the efficiency of funds management.

CHAPTER 6

THE SECOND YEAR RESEARCH PLAN

The research project which has five phases of study is designed for two-years. The phase of research for two-years activities is as follows:

Year-1 (2015)

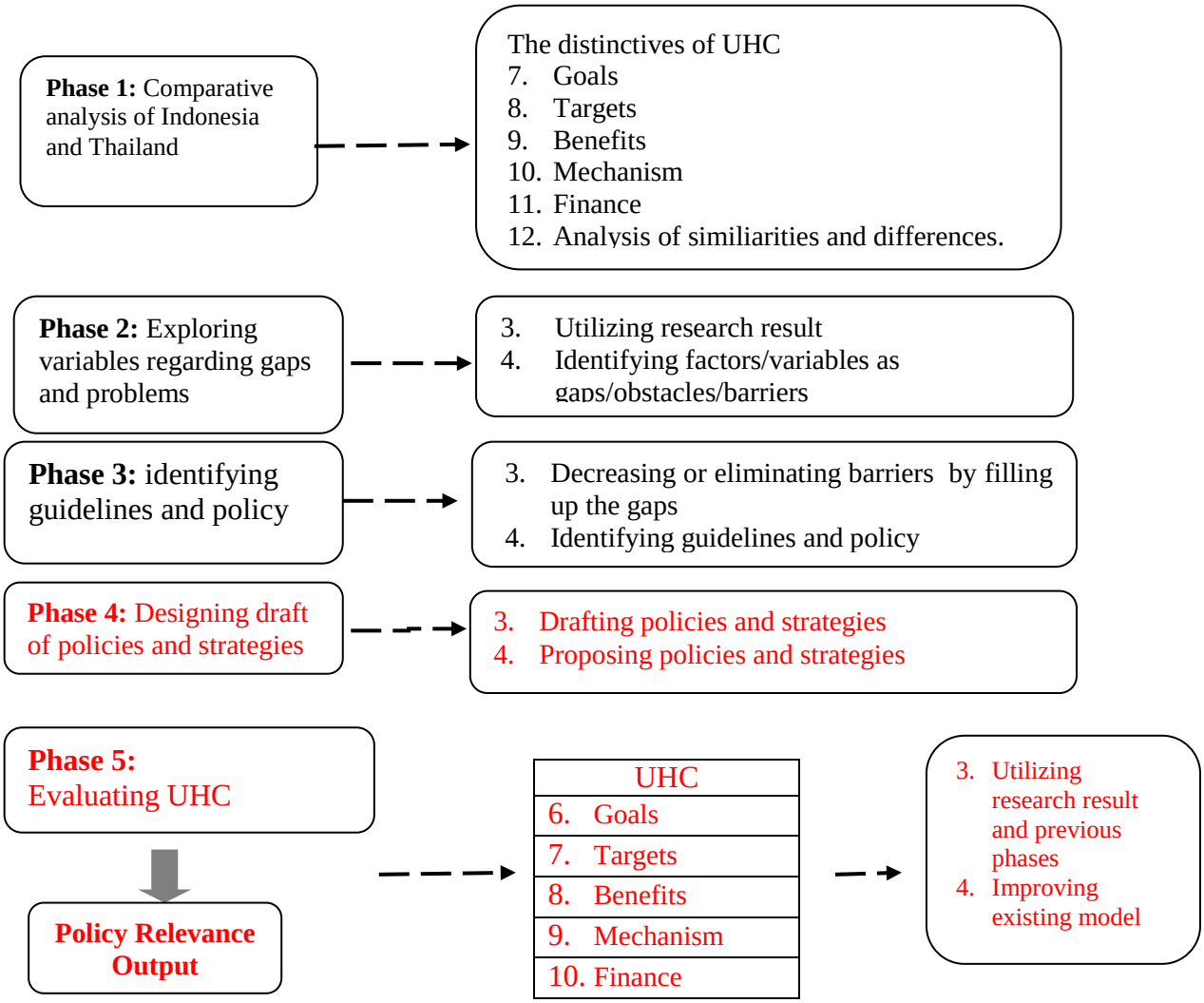
Phase 1	The 1st phase of the study will provide a comparative analysis of the similarities and differences in the UHC of Indonesia and Thailand
Phase 2	The second phase will explore the extent and policy related regarding gaps and problems of UHC by utilizing the result of first phase
Phase 3	The third phase will evaluate policy in order to fill these gaps by decreasing or eliminating obstacles to the UHCsystem of Indonesia and Thailand

Year-2 (2016)

Phase 4	The fourth phase will design draft of policies and strategy for improvement of UHC system regarding each urgent issue and over all in Indonesia and Thailand
Phase 5	The fifth phase will result improving of implementation model of UHC policy regarding as comparative analysis of policy in Indonesia and Thailand

For detail activities conducted in the year-2 of the research project can be seen in figure 4.1. as follows.

Figure 4.1. Conceptual and Evaluation Framework



CHAPTER 7

CONCLUSION

1. Thailand has one of the most complex health care systems in Asia. Prior to reform, there were about six different health benefits schemes, targeting different groups of people with different benefit packages, compare to Indonesia which has started UHC Policy in 2014,and it only has one scheme of UHC Policy with two different category of participants.
2. The Evaluation of UHC in Indonesia and Thailand results in varies remarks, but most of the results have higher remarks in Thailand.
3. The perception of respondents on implementation both UC and JKN are varies. It has five parameters in the measurement such as: Standart of Procedures of public hospital, Communication between agencies of UHC Healthcare, Medical human resources readiness, Convenient Facilities and infrastructure, and Medicine sufficiency. In Thailand, the result shown that the most higher remark is in parameter Standard of Procedures of public hospital 4.68, while the lowest remark is in parameter Convenient Facilities and infrastructure is 4.35. In Indonesia the highest remark is in parameter Convenient Facilities and infrastructure 4.20, while the lowest is parameter Communication between agencies of UHC Healthcare 3.77 only.
4. The quality of service in Thailand shows the better result compare to Indonesia. Continuous care services in Thailand has the highest result of 4.67, while the highest result of Indonesia in the same parameter has the result for 4.17.
5. Both of Thailand and Indonesia experienced the financial burden in implementing UHC Policy. The problem is more on the bulk amount of fund to cover the UHC from the annual budget which is accounted of the Annual

National Gross Domestic Products (DGP), and become the burden for the National Budget allocated each year.

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ATTACHMENT

1. Research Instrument

QUESTIONER ON UHC

SNA	NA	A	SA
Strongly not Agree	**Not Agree**	**Agree**	**Strongly agree**
1	**2**	**3**	**4**

A. SERVICES AND PROCEDURES OF UHC

1. Registration Process

No	Pernyataan	SNA	NA	A	SA
1	The mechanism of UHC registration is easy				
2	The requirement of UHC participant is easy to be fulfilled				

2. UHC Premium

3	Mechanism of UHC premium to be paid is easy				
4	The UHC premium is appropriate with ability to payoff UHC participant				

3. Government assistance on UHC

No	Pernyataan	SNA	NA	A	SA
5	The poor are the target of government assistance on UHC.				
6	Government assistance on UHC is exactly proper for the poor				

4. Benefits of UHC

7	People get many benefits from UHC	**SNA**	**NA**	**A**	**SA**
8	Government has covered my health scheme				

B. Implementation of UHC

9	UHC office gives any information to the people	**SNA**	**NA**	**A**	**SA**
10	UHC office give easy access on UHC to the people				
11	The hospital has procedure to implement the UHC				
12	The hospitals has many partner institutions to implement the UHC.				

13	The implementation of UHC is influenced by the hospital preparation/readyness.	**SNA**	**NA**	**A**	**SA**
14	The implementation of UHC is influenced by medical and non-medical resources.				

15	The implementation of UHC is influenced by infrastructures, medicines, and the equipment of the hospital.				

C. Service Quality

N	Pertanyaan	SNA	NA	A	SA
16	Doctor services are good.				
17	Medicine services are good.				
18	Health facility are good.				
19	Procedures of inpatient services is easy				
20	Procedures of outpatient services is easy.				
21	Procedures of insurance claimsis easy.				
22	Being UHC participant is lessent the cost of health finance				
23	There is no discrimination to UHC participant				
24	Procedures of claim of UHC is easy.				
25	Management of UHC is Transparent				
26	People need UHC only when they are sick.				

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2011 Governor Appointment for the Democracy – Analisis KR

2010 Anlaysis on Deconcentration and Medebewind in DIY (PT Sinergy Visi Utama- -Researcher)

2010 Institutional Capacity Building for Construction Training Board Yogyakarta (Pusbin KPK- Ministry of Public Works) - Researcher

2010 Formulation Studies on Tourist Visitor Numbers in Jogjakarta (Puspar-UGM) - Researcher

2010 The Implementation Of Special Autonomy For Papua Province Within The Context Of Indonesia Decentralization Policy – Joint International Seminar of Universitas Muhammadiyah Yogyakarta and Thammasat University – Bangkok "Impact and Challenges of Decentralization Policy towards Democratization and Development : A Comparative Perspective between Thailand and Indonesia

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2009 Transformasi Good Governance at the Local Perspective in Jawawijaya Jurnal Analisis CSIS
2008 Mapping Social Accountability Practices in Indonesia- (Sponsored by UNDP) - Researcher
2008 Monitoring and Evaluation of Indigeneous People Capacity Mapping in Papua (Sponsored by SOfEI-World Bank) - Researcher
2007 Empowering Civil Society Organizations Towards Good Governance – Jurnal Spirit Publik - UNS
2007-2008 Empowering Civil Society Group to Promote Participatory Governance in Papua (Sponsored by the United Nations Democratic Funds -UNDEF)- researcher
2007 The Evaluation of Public Space Planning in Jogjakarta - researcher.
2006 The Dinamics of Local Politics at the Grass Root Level. , book published in Bahasa Indonesia by Amara Books, Jogjakarta
2006 The Transformation of Local Governance and Public Participation : A Studi of Four Villages in Java After the Reformasi (Doctoral Thesis)
2005 Empowering Urban and Rural Communities in Public Sector Management – researcher
2004 The Role of Women's Politics after the Reform- PPI Bulletin
2004 Indonesian Worker's Management- Kedaulatan Rakyat
2003 The Quality Service of Sarjito Hospital-researcher
2002 The Total Quality Management for Higher Education in Stisipol Kartika Bangsa –Researcher
2001 Quality Service Management of Tourism Board of Yogyakarta Special Province
1995 The Evaluation of Determinant Factor Influencing the Efficiency og Trade and Industrial Agency of Pekalongan Regency.

Academic Activities

2011 Improving Indonesia Civil Servants Performance Through Job Analysis - First International Conference On Public Organization Challenge To Develop A New Public Organization Management In The Era Of Democratization –UMY- Speaker
2010 Process-Based Analysis In Indonesia's Millenium Development Goals (MDGs) Achievement For Gender Equality: Case Study Yogyakarta Special Province-Indonesia – paper in Joint International Seminar UMY dan USM Malaysia "Women in Local Governance and its Contribution to Good Governance: Challenges and Models to Global Governance" –Speaker
2010 The Implementation Of Special Autonomy For Papua Province Within The Context Of Indonesia Decentralization Policy- International Seminar on Impact and Challenges of Decentralization Policy Towards Democratization and Development - Speaker
2010 Civil Society Empowerment And The Role Of International Donor : A Case Study Of Jayawijaya District, Papua , Indonesia, International Seminar on Globalization, Benefits and Its Costs for The Thirld World. - Speaker

2009 Technical assistance on Legislative capacity building - Trainer
2009 Training on Government Performance Report -INDES-Trainer
2009 Workshop on Public Service Standard– INDES-Trainer
2009 Workshop on Legal Drafting – Lembaga Pengembangan Profesi dan Aktualisasi - Trainer
2008 Training on Tourism Planning –Wana Wiyata-Trainer
2009 Training on Tourism Strategic Area Planning – Wana Wiyata – Trainer
2009 Workshop on National Program for Community Empowering on Tourism (PNPM Pariwisata) – PT Maton Selaras - Trainer
2008 Workshop on Staffing Administration Policy- INDES-Trainer
2008 Workshop on Job Analysis- Cendekia Utama - Pemateri
2007 Workshop on Tourism Development Planning for Local Level –Wana Wiyata-Pemateri
2007 Workshop on Tourism Planning- Puspar UGM
2007 Workshop on Job Analysis and Staffing– Puspitnak- Misnistry of Agriculture-Presenter
2007 Training Sispimnas III- Pusdiklat Regional III Yogyakarta - Speaker
2007 Seminar on Tourism Industrial Development – Magelang-speaker
2006 Seminar on Public Service Reform – Purworejo Regency -Speaker
2006 Seminar on Public Service Delivery –TVRI – Taman Gabusan- Speaker
2005 Regional Conference on Community Base Peace Building Initiative, 29 April-2 Mei 2005, Penang –Malaysia-presenter
2005 Workshop Nasional Community Base Peace Building Initiative,Jakarta, 13 April 2005-presenter
2004 The International Conference on Conflict Resolution in Asia, SEACSN (Southeast Asia Conflict Studies Network), Penang, Malaysia – speaker
2004 The International Conference on Conflict Resolution in Asia, SEACSN (Southeast Asia Conflict Studies Network), Penang, Malaysia -- participant
2003 Workshop on Data Analysis – Faculty of Social Science, University Sains Malaysia (USM) -- participant
2003 Workshop on Social Methodology – Faculty of Social Science, University Sains Malaysia (USM) --participant
2002 Workshop on Thesis Writing – Faculty of Social Science, University Sains Malaysia (USM) – participant
2002 ASIA Fellowship- Bangkok - participant
1999 The Indonesia - Japan Economic Cooperation in the Twenty-First Century, Centre for Asia and Pacific Studies, Gadjah Mada University -- participant
1997 National Seminar on Local Government Autonomy: The Evaluation Studies for the Pilot-Project on the Stage II Local Government Autonomy, Yogyakarta – participant
1996 National Seminar on Decentralisation in Indonesia: Retrospect and Prospect in 2nd Long-term Development Planning, Persadi (The Indonesian Forum for Administrative Sciences) – participant
1996 Seminar on Corruption and Collusion in Public Administration, Gadjah Mada University – participant

Yogyakarta, November 10, 2015

Dr. Dyah Mutiarin

CURRICULUM VITAE

NAME	:	Suranto, Drs. (UGM), M.Pol. (UOW), Dr. (Pajajaran University)
PLACE/DATE OF BIRTH	:	Yogyakarta, May 12, 1965
NATIONALITY	:	Indonesian
ADDRESS	:	Geblak Rt 03 Bantul, Kec Bantul, Bantul.Daerah Istimewa Yogyakarta 55711, Indonesia
PHONE/FAX	:	(62) (274) 387646 (Fax) (62) (274) 367 458 (Phone) (62) 81 668 6596 (Mobile Phone)
E-MAIL	:	suranto_umy@yahoo.com suranto@umy.ac.id

EDUCATION:

2010 Doctor of Philosophy (Dr) in Public Administration, Postgraduate Program, Padjadjaran University, Bandung, Indonesia.

1995 Master of Policy (M.Pol), Sociology Department, Faculty of Arts, University of Wollongong, Wollongong, NSW, Australia.

1989 Sarjana Degree (Drs), Governmental Studies Department, Faculty of Social and Political Science, Gadjah Mada University, Yogyakarta, Indonesia.

OTHER TRAINING:

2012	Research Methodology Training, Higher Education Directorate of Education Ministry, at Saphire Hotel Yogyakarta, Indonesia.
2011	Publication Writing Training, Higher Education Directorate of Education Ministry, at Saphire Hotel Yogyakarta, Indonesia.
2010	Academic Writing Training, Malang State University, at Batu Malang, East Java.

PROFESSIONAL EXPERIENCE:

2010 - present	Head of Department, Governmental Studies Department, Faculty Social and Political Science, Muhammadiyah University of Yogyakarta, Indonesia.
2001 - 2003	Dean, Faculty Social and Political Science, Muhammadiyah University of Yogyakarta Indonesia.
1999 - 2001	Vice Dean for Academic Affairs, Faculty Social and Political Science, Muhammadiyah University of Yogyakarta Indonesia
1996 - 1999	Head of Department, Governmental Studies Department, Faculty Social and Political Science, Muhammadiyah University of Yogyakarta, Indonesia.

RESEARCHS:

1. Public-Private Partnership in Providing Public Services (A Study in Yogyakarta City), 2002
2. Public-Private Partnership in Urban Waste Cleaning Services (A Case study in Bantul Regency). 2003.
3. The Influence of Work Activities on the Women's Role in her Household (A Case Study in Muhammadiyah University of Yogyakarta), 2007.
4. The Influence of Job Training, Job Incentives and Workload on Academic Services Quality (A Study in Fisipol, Muhammadiyah University of Yogyakarta. 2008
5. Identification of Determeninant Factors on Academic Services of Private Universities in Yogyakarta Special Region. 2009
6. The Effect of Educational Sector Devolution Policy Implementation on Basic Education Services Quality (A Study in Yogyakarta City). 2010
7. The Policy Evaluation of Business Service Board (Case Study at Sardjito Hospital, Yogyakarta). 2011
8. Feasibility Study of Bintan Regency Development. 2012.
9. Feasibility Study of Nunukan Regency Development. 2013
10. Strategy Reformulation for Poverty Reduction in Bantul Regency (2013-2015), 2013.

PUBLICATIONS:

1. Public Service Quality: Determinant Factors Analysis. Yogyakarta: LP3M UMY, 2013. Book: ISBN:978-602-199218-x
2. The Strategy for Improving Public Services in Indonesia, published in ICONPO Proceeding, 2011.
3. Effectiveness of Tourism Development Program in Parangtritis Beach, 2008, published in Jurnal Sosial dan Politik (Accredited).

SEMINARS:

1. A Speaker at the Seminar of Election Champaign Socialization for Parties Activists in Bantul Regency. 2012.
2. A Speaker at the Seminar of Youth Political Consciousness in Bantul Regency. 2013.
3. Instructor at the Training for Journalist who Interest on Village Issues. 2011
4. A Speaker at the Seminar of Society Empowerment for NGO in Bantul Regency. 2011.
5. Instructor at the Workshop of Balanced Scorecard for Local Government. 2012.
6. Instructor at the Workshop of Public Organization Performance Evaluation. 2012.
7. Instructor at the Workshop of Public Policy Formulation for Legislators. 2013
8. Instructor at the Workshop of Local Government Cooperation Opportunities. 2013.

MEMBERSHIP IN PROFESSIONAL SOCIETIES:

- Asia Pacific Studies of Public Affairs (APSPA)
- Indonesian Government Science Society (MIPI)
- Association of Indonesia Political Sciance (AIPI)

Yogyakarta, November 10,2015

Dr. Suranto, M.Pol.

CURRICULUM VITAE

Associate Professor Amporn W. Tamronglak, Ph.D.
Faculty of Political Science, Thammasat University
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Mobile: +66 81-498-7039

Education
Ph.D. (Public Administration and Public Affairs), Virginia Polytechnic Institute & State University (Virginia Tech University), Blacksburg, Virginia, U.S.A. 1994

M.A.P.A. (Master of Arts in Public Administration), Northern Illinois University, DeKalb, Illinois, U.S.A.1987 (Major in Comparative Public Administration and Local Administration)

Bachelor's of Arts in Political Science, Major in Public Administration. Bhumibol Awards for Academic Excellence, First Class Honor with the highest record in Class of 1985

Current Position
Secretary-General to The Public Administration Association of Thailand (PAAT) (June 2011 – Present)
Member of the Research and Development Committee to the Senate (March 2011 – Present)
Member of the Research and Development Sub-committee to the Senate (March 2011 – Present)
Advisor to the Restructuring of the Secretariat to the Senate (March 2012 – Present)
Member of the Journal of Governance and Development (JGD) Editorial Board (June 2013-May 2015)
Member of Executive Public Administration (EPA) Program, Faculty of Political Science, Thammasat University (July, 2013-Present)

Courses (Current Teaching)
Undergraduate Level
o Organization Theory and Management
o Project Management
o Project Evaluation
o Administrative/Information Technology
o Thai Public Organization and Management
o Integrated Social Sciences, International Program, Faculty of Journalism and Mass Communication, Thammasat University, Rangsit Campus
o Seminars in Public Administration, International Program, Faculty of Political Science, Thammasat University

Master's Degree Level
o Human Resource Management
o Human Resource Development
o Organization and Management, Executive Public Administration Program (EPA), Faculty of Political Science, Thammasat University
o Organization and Management, M.A. program, Faculty of Political Science, Thammasat University
o Public Management in the Context of Postmodernism, Executive Public Administration Program, Sripatum University, Phyathai Campus
o Public Administration Theory, Public Administration Program, Sripatum University, Bangkhen Campus
o English for Public Administration, English for Career Program, English Institute, International Program, Thammasat University, Thaprachan Campus

Doctoral Level
o Field Seminar in Public Administration and Public Affairs, Faculty of Political Science, Thammasat University
o Advanced Seminar in Human Resource Management, Sripatum University, Phyathai Campus
o Problems and Issues in Human Resource Management , Sripatum University, Phyathai Campus
o Qualitative Methods, Sripatum University, Phyathai Campus
o Postmodernism Public Administration, Krirk University

Personal Interests and Expertise
Providing consultations on Organizational Development and Human Resource Management and Development to Public and Private sectors
Guest Lecturer on the Topics of_Organizational Development and Human Resource Management and Development at the graduate levels, both Master's and Doctoral students
Special guest lecturer on various topics in Public Administration and Management, for instance, Result-Based Management (RBM), Project Management, Project Evaluation, Accountability and other related administrative tools
Organization and Management, Organizational Structure, Public Administration Theory, Public Accountability, Human Resource Management and Development, Public Budgeting, Sexual Harassment, Ethics, Administrative Technology, Gender Inequality in Politics and Public Administration, Project Management and Project Evaluation, etc.

Administrative Experiences
Director of Executive Program in Public Affairs (EPA) (December 2010 – January 2013)
Member of Faculty of Political Science Board (February 2010 -January 2013)_
Member of Recruitment and Selection Committee (February 2010 - January 2013)
Head of Public Administration Department (February 2010 –February 2012)
Advisor to Graduate Study Program, Faculty of Political Science, Thammasat University (2008- 2010)
Serve on Internal Quality Assurance Control Committee, Faculty of Political Science, Thammasat University (2008- 2010)
Serve on Doctoral Program in Political Science Committee, Faculty of Political Science, Thammasat University (2002- 2008)

Serve on Risk Management Committee, Faculty of Political Science, Thammasat University (2008-2009)
Serve as Leader in Drafting Undergraduate Curriculum, major in Public Administration (2009)
Serve on Doctoral Program in Political Science Committee in drafting the curriculum, (2009)
Serve on Executive Public Administration (EPA) Program Committee, Faculty of Political Science, Thammasat University (2008- 2010)
Serve on Quality Assurance Committee, Faculty of Political Science, Thammasat University (2000- 2002)
Deputy Dean in Special Project, Faculty of Political Science, Thammasat University (2004- 2006)
Head of Social Service Program, Faculty of Political Science, Thammasat University (2004- 2006)
Serve on Permanent Faculty Committee, Faculty of Political Science, Thammasat University (2004- 2006)
Head of E-Learning_Projects (2004-2005)
Faculty Representative serving on Education Quality Assurance (2004- 2006)
Head of Special Projects in organizing Academic Cooperation between Kampaengpetch Province and Thammasat University (2004- 2006)

On-going Research/Text Books
Leading Research Project on "The establishment of Thailand Security Study Think Tank Phase II", supported by the Office of the National Security Council (NSC). It is expected to finish by June 2014.
A Text Book on ***Public Organizations.***_Expected finished date: December 2014
Leading Research Project on **"The Evaluation of the State of Education in Political Sciences and Public Administration in Thailand (from 1997 to present)**" November 2013, supported by the Office of the National Research Council of Thailand (NRCT). The final report is currently under the committee's approval.
Research on **"The Evaluation of the State of the Public Administration Education in Thailand: Current State and Future Directions**" expected to finish by March 2013, supported by the Office of the National Research Council of Thailand (NRCT). The final report is currently under the committee's approval.
Research on "Recruitment and Selection of BAAC Personnel" for Bank for Agriculture and Agricultural Co-operatives (BAAC). The final report is currently under the committee's approval.

Experiences
Consultant to Civil Service Commission (CSC) to study "Pilot Project in Applying Accountability Measure to Human Resource Personnel," September 2007. Responsible for investigating and designing the accountability system and measure, and applying the measure to Human Resource position in Thai pubic service.
Advisor and Organizer in arranging public hearing on the Constitutional Draft 1997_around the country
Training Organizer for all civil services from Kampaengpetch Province composing 5 training courses, 2005.
Deputy Director, Executive Public Administration Program, 2005.
Director, Master's Degree Program in Political Science, Faculty of Political Science, Thammasat University. 1994-1997.
Faculty of Political Science Representative in Faculty Council Committee

Representative in Faculty Council Committee
Consultant to Public and Private Sectors on Organizational Development and Human Resource Management and Development
Guest Lecturer on Public Administration and Management from undergraduate level to graduate levels

Academic Work
1989-1999
Research on "Review on Organizational Culture and Management" May 1989.
"Senior Executive Services Candidates Development Program: Descriptive Analysis of Five Federal Agencies" 1994 Doctoral Dissertation, Virginia Polytechnic Institute & State University (Virginia Tech University), Virginia, U.S.A.
Co-Research and research coordinator on "The Evaluation Study of Budgets Allocated to Political Parties According to the Special Projects Proposed by the Representatives, the Provincial Development Projects Proposed by the Representatives and Provincial Development Projects (budgeted in support to Regional and Local Government)." The project was funded by Budget Bureau Office 1997.
Research on "Postmodern Organization Theory," 1999.

2001
Research on "Senior Executive Development: A Case Study of Bangkok Metropolitan Authority," January 2001.
Research on ""Senior Executive Development: A Case Study of Civil Service Commission," June 2001
Co-Research on "The Development of Office of the National Valuation Authority into Public Organization," responsible for the proposal design of organizational structure for the Public
Organization._September 2001
Co-Research on "The Monitoring Assessment of Expenses Allocated to Political Parties in Fiscal Year 2001." The Project was financially support by Election Commission, December 2001.

2002
Co-Research on "Accountability in Pubic Service," January 2002.
Co-Research on "The Feasibility in Setting Up Asset Management Company for Thai Railroad," February 2002.
Co-Research on "The Capacity Building for Local Governments through Regional Comptroller General and Chief Financial Official," November 2002.
Co-Research on "The Setting up of Social Security Office As Public Organization," December 2002.
Co-Research on "The Monitoring Assessment of Expenses Allocated to Political Parties in Fiscal Year 2002." The Project was financially support by Election Commission, December 2002.
Co-Research on _The Study to Develop Good Governance Indicators," led by King Prachadhipok's Institute, submitted to and funded by Office of the National Economic and Social Development Board (NESDB), September 2002.

2003
Book Editor in translating the book into Thai Language, titled **"Refounding Public Administration,"** edited by Gary Wamsley, Bangkok: Kopfai, 2003.

Chapter translation "Agency Perspective: Public Administrator as Agential Leader," in **"Refounding Public Administration,"** edited by Gary Wamsley, Bangkok: Kopfai, 2003, pp. 125-180.

2005

Co-Research on _The Evaluation of Traffic Accident Prevention Policy," led by King Prachadhipok's Institute, submitted to Thai Health Promotion Foundation, 2005.
Co-Research on _The Expansion of Applying Good Governance Indicators at the Organizational Level to Practice," led by King Prachadhipok's Institute, submitted to Office of the National Economic and Social Development Board (NESDB), June 2005.
Co-Research on "The Development of_Multimodal Transport System Model and Continuing Logistic Management in to Practice," responsible for the organizational design, 2005.
Research on "The Development of Accountability System and Accountability Benchmark for Different Functions," submitted to the Civil Service Commission (CSC), September 2005.

2006

Research on "The Feasibility Study and Survey to Develop Infrastructure and Logistic Linkages for Ang-Thong Province," submitted to Ang-Thong Province, 2006.

2007

Research on "The Pilot Study of the Application of Accountability Measure to Human Resource Personnel," supported by the Civil Service Commission, September 2007.
Teaching Material on "Public Organization Management,"_Faculty of Political Science, Thammasat University, 2007.
Teaching Material on "Governing by Network" Faculty of Political Science, Thammasat University, 2007.

2008

Teaching Material on "Public Organization Management,"_Faculty of Political Science, Thammasat University, updated in January 2008.
Teaching Material on "Governing by Network" Faculty of Political Science, Thammasat University, updated in 2008.
Teaching Material on "Accountability in Public Organizations," Faculty of Political Science, Thammasat University, 2008.
Co-Research on "Contribution to Provincial Governors by Partnership Management, CPGM) in Fiscal Year 2007," submitted to and funded by Department of Public Works and Planning,
February 2008.
Co-Research on "An Evaluation Review of the Assessment of Administrative Tools in Thai Public Service," submitted to and funded by _the Office of Public Sector Development Commission (OPDC). Responsible in evaluating the application of Balanced Scorecard__BSC)_and Internal Performance Agreement / Individual Scorecard (IPA)_to the entire public service in the past Fiscal Year
Book Chapter on "Political Participation of Thai Middle Class Women," co-author with Associate Professor Tongchai Wongchaisuwan, **Women and Politics in Thailand** edited by
Kazuki Iwanaka, 2008. Sweden: Nordic Institute of Asian Studies (NIAS).
Text Book titled, ***Organization: Theory, Structure and Design.Bangkok:*** Thammasat University Publishing. June 2008.

2009

Research on "The Study of Salary Structure and Academic Standard Pay for Certified Teachers and Educational Personnel," submitted to Office of the Teacher Civil Service and Educational Personnel Commission, September 2009.

Book Review, titled **Invitation to Public Administration.** By McSwite, O.C. Armonk, NY: M.E. Sharp, 2002 ***in Sripatum Review*** Issue_8, No. 2 (July-December 2009).

Research on "Postmodern Public Administration," May 2009

Research on "Sexual Harassment in Secondary Schools in Bangkok," May 2009.

Article based on Research on "Postmodern Public Administration,"Political Science Journal. Issue 2009, Vol. 4 on the 60th years cerebration of Faculty of Political Science, Thammasat University.

Article based on Research on "Sexual Harassment in Secondary and High School in Bangkok Metropolitan Area: Causes and Policy Implication,"_Rajchaphat Buriram Journal. Vol. 1 inaugural issue (January-June 2009), pp. 31-47.

"Postmodern Public Administration and Governance: a Fit or Disparity of Theory and Practice," Paper Presented at the 10th Annual Conference on Political Science and Public Administration, Songkhla University, Songkhla Province, December 1-2, 2009.

.

2010

Book Review, Rosemary O'Leary. (2006). ***The Ethics of Dissent: Managing Guerrilla Government.*** Washington, D.C.: CQ Press, A Division of Congressional Quarterly, Inc. _Sri Pathum Journal. Vol. 10, No.1, January-June 2010.

Text Book, editor, ***Public Governance: Public Administration in the 21st Century.*** Bangkok: Thammasat University Publishing**,** 2010.

Research on "Workforce Planning of the Office of the National Research Council of Thailand (NRCT)," supported by NRCT. The final report is currently reviewed by the committee. October 2010.

Research on "Strategy Development for Rice Department 2010- 2013," responsible for organizational structure analysis and design. The project is financially supported by Rice Department, Ministry of Agriculture. July 2010.

Updated Text Book titled, ***Organization: Theory, Structure and Design.*** Second edition. Bangkok: Thammasat University Publishing. November 2010.

2011

"An Empirical Study of the Autonomy of Thai (Autonomous) Public Organizations" paper presented at the First International Conference on Public Administration, "Challenge to Develop a New Public Organization Management in the Era of Democratization," Universitas Muhammadiyah Yogyakarta, Jl. Lingkar Barat, Bantul Yogyakarta, Indonesia, Friday - Saturday, January 21st – 22nd, 2011.

Text Book (editor) on ***Theory and Methods from Modern to Postmodern Political Science and Public Administration.*** The project is supported by the National Research Council of Thailand (NRCT). March 2011.

Research on "The Study of Independence and Accountability of Thai Public Organizations," with financial support from the Faculty of Political Science, Thammasat University. September 2011.

Co-research on "The Corroboration Linkages with Civil Society Network Organizations in Reflecting Citizen's Issues to Government," supported by Office of the National Economic and Social Advisory Council. August 2011.

2012

Research on_"The Development of Teacher and Educational Personnel Promotional Assessment Framework," supported by Office of the Teacher Civil Service and Educational Personnel Commission (Ministry of Education). February 2012.

2013
Research on "The Establishment of Think Thank on Security Study Phase I" for The Office of National Security Council (NSC). July 2013.

Awards and Scholarships
Bhumibol Award for Academic Excellence in Public Administration, Academic Year 1984.
Research Excellent Award Year 2004, Office of the National Research Council of Thailand (NRCT) for the research on "The Study to Develop Good Governance Indicators."
Academic Excellent Award for TU Political Science_Alumni, Faculty of Political Science, Thammasat University, 2012.