Evaluation of Universal Health Coverage Policy : A Comparison Study between Indonesia and Thailand

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Abstract : *This research basically is an evaluation study on Universal Health Coverage (UHC) both in Indonesia (known as National Health Insurance/ Jaminan Kesehatan Nasional/JKN) and Thailand (known as Universal Coverage/UC). 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.*

The research addressed the evaluation of two things, first, how do the UHC has been implemented in Indonesia and Thailand. Second is how do the financial aspect and quality of service in UHC both in Thailand and Indonesia. The research area focused on the hospital with best practices both of in Indonesia and Thailand. The analytical approach of this study was derived from a combination of both quantitative and qualitative research methods. In this mix methods, the quantitative approach was used on descriptive quantitative parameter such as frequency and the average of dispersion by conducting survey. In addition, the qualitative research used the interview guide and focus group discussion to explore the information that has not been covered by survey.

The research results shows the problems deriving from the implementation of UHC in Indonesia on covering targeted people, facing insufficient funds for the health care, and the service quality of JKN in Indonesia. While in Thailand, the results show that implementation of UC generally successfull because of the government maintaining the standard of facilities and quality services of the hospitals. However, UC in Thailand also facing the financial burden of the government spending and also the quality of medical treatment with respectable and responsible services to poor people needs to be improved.

Keywords: *implementation of UHC, quality service, UHC financial burden.*

INTRODUCTION

1. Background

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

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problem of inequality and poor quality still remains as the basic problem for both UHC in Indonesia and Thailand (Prakongsai et al. 2009; Limwattananon 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).

Simmonds and Hort (2013), state that there were potential inequalities in implementing universal health coverage in Indonesia. Indonesia has been facing issues of poor quality and unequal distribution of government health facilities 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.

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 centres, district hospitals, and provincial hospitals were pro poor while university hospitals seem to pro rich. This result can be implied that district health centres, 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).

2. Research Objectives

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. In response to 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. this 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.

3. Significance of the Study

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. The idea of universal coverage is to protect people, at all income levels, from financial risks associated with ill health. One should note, however, that the concept of universal coverage is not based on subjective judgment of the policy makers. Many politicians say that they have launched a social health protection and are committed to implement health finance for all. Yet political statements and program launching is not enough. The conceptual fault here is that universal coverage sometimes can be used to justify practically any health financing reform (Kutzin, 2013) while the objective coverage is not entirely attained. The objective of universal coverage is efficiency and equity in health resource distribution so that objectivity, transparency and accountability have to be assured (Kumorotomo,2015).

The ineffective free-market mechanism to provide health services for the poor is the main reason for many countries to embrace universal coverage. Therefore, it is encouraging that the USA and China, the two major economic powers that previously relied on private insurance for health care, are currently moving back to universal coverage policy. Countries in Africa, such as Ghana, Moldova and Rwanda are adopting the new health systems to cover all the citizens. In Asia, similar policies have been implemented in Kyrgystan, Malaysia, Thailand and Indonesia (Kumorotomo,2015). According to the above previous studies, this research is trying to explore the implementation of Universal Health care from aspect of UHC coverage, UHC quality service and UHC Financial.

4. Research Setting

Indonesia and Thailand (as members of ASEAN countries) are chosen as the research setting considering both of them are the countries that have been implementing UHC as a commitment on Health Policy in their countries. It appeared that the Indonesian and Thailand government implementing UHC as a deal with a far-reaching health-care reform.

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 /Jaminan Keschatan Nasional /JKN. It is an attempt to unified previous various social health insurance under a single social security agency.While in Thailand,the Universal Coverage (UC) started on 2002, based on the National Health Security Act 2002. 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.

Thus, it is important to the existing policy framework and strategic plans for the UHC, the National health insurance budget distribution, the constraints of UHC, and as well as the quality service of UHC.

5. Conceptual Framework

a. 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.

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.

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-care costs (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 political 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.

b. 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.

According to Susilawaty (2007), the purpose of health policy is to achieve national development in the health sector which is based on the initiative and aspirations by empowering, collecting, and optimizing potential areas for the benefit of local and national priorities.

Health policy in practice is not confined to the interests of individuals as the scope is very broad covering the public interest, general purpose and citizens in general. Thus, a health policy should be able to empower and improve community participation in health development. Thus, the health policy must seek the availability of health services which are equitable and evenly without differentiating between segments of society with each other including in ensuring the availability of health services for the poor and the nearly poor.

In general, policy implementation is a dynamic process, where the implementers perform an activity or activities that are likely to get a result that is consistent with the objectives or goals of the policy itself (Agustino, 2012: 139). While Nugroho (2012: 674) explains that the implementation of the policy in principle is a way for a policy to be able to achieve its objectives. Basically the policy implementation is an action/real program implemented based on the formulation of policies that have been developed previously to achieve specific goals. Nugroho (2012: 675) adds that the series of policy implementation include the start of the program, the project, and all activities.

Different from Nugroho, Suharno (2013: 169) argues that the implementation of policies that have gone through the stage of recommendation is a relatively complex procedure, so that there is not always a guarantee that the policy will work in practice. Meanwhile Agustino (2012: 140) argues that policy implementation is a very important stage in the overall structure of a policy, because through this procedure the overall policy process can be influenced by the level of success or failure in achieving goals. This was confirmed by Udoji (1981) in Agustino (2012:140) that implementation is a policy even more important than policy-making. These policies will only be a dream or a good plan neatly stored in the archive if not implemented ".

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.

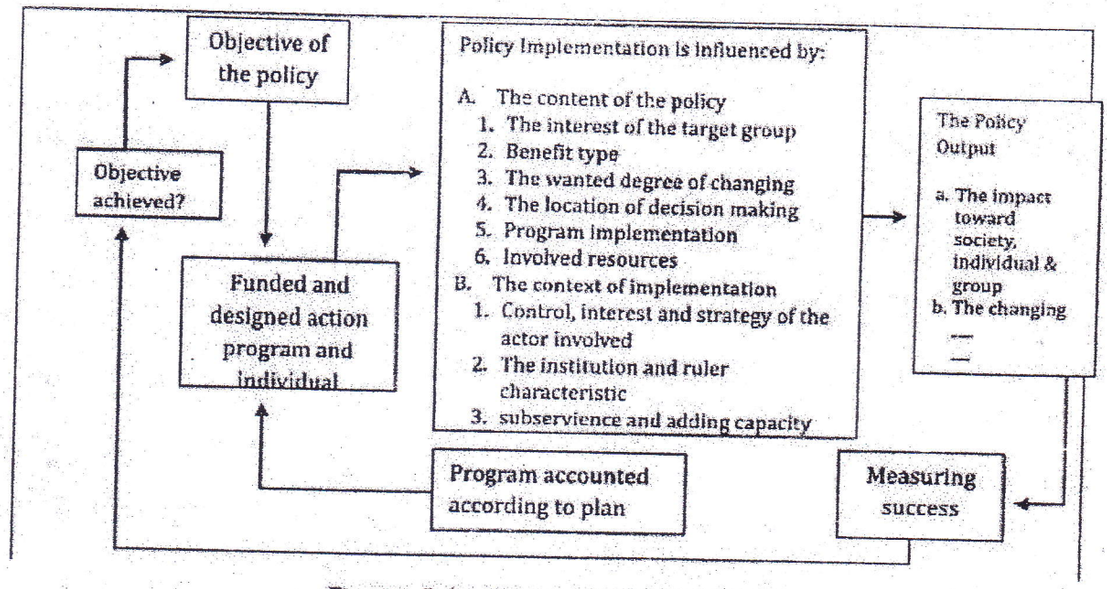

Figure 1. Policy Framework (Grindle, 1980)

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. To meet various accountability requirements : impact accountability, efficiency accountability, coverage accountability, service delivery accountability, fiscal accountability, legal accountability

6. Methodology

This evaluation is based on the policy evaluation of health insurance in the selected areas. 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). The instruments for qualitative approach in this research is using interview guide and Focus Group Discussion.

In-depth interviews and questionnaires distribution to the key informants from government health agencies were conducted. Most of the key persons are from state hospitals, doctors and the patients in both countries.

The technique sampling in this research using Nonprobability Sampling with Quota

Sampling procedure. Response rate as expected is minimal at 60 percent. Sampling is based 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 1. Samples of Research

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

The Location of the sample mostly from Bangkok of Thailand and Yogyakarta Special Region of Indonesia, and also cover from outside of those two regions. Data analysis technique used to describe the implementation of UHC policy in Indonesia and Thailand was descriptive qualitative analysis. A Likert scale from 1-5, the least satisfied to the most satisfied, was employed in this study, asking the patients to assess the quality of service at the hospital selected for the study. The levels of satisfactions were divided into 5 levels for data (maximum-minimum/5 = 0.80) interpretation and analysisas follows:

Mean	Opinion levels
4.21 - 5.00	Highly Satisfied
3.41 - 4.20	Very satisfied
2.61 - 3.40	Satisfied
1.81 - 2.60	Less satisfied
1.00 - 1.80	The least satisfied

FINDINGS AND RESULTS

1. Profiles of UHC in Indonesia and Thailand.

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.

National Health Insurance (JKN) is the government's commitment to providing health insurance to all Indonesians. 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

Health Care Benefitsof 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 income 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.

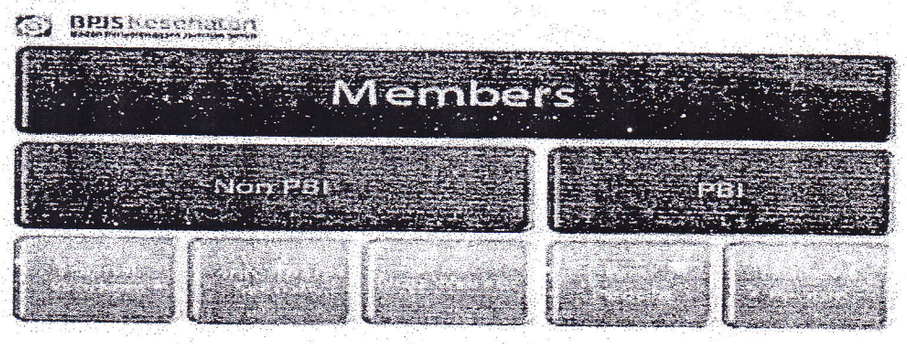

Figure 2. Category of JKN

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.

2. Non Receiving Wage Workers and Non-Workers: Participants can include family members who want (unlimited).
3. Participants can include additional family members, including children 4 and so on, father, mother and in-laws.
4. Participants can include additional family members, which include other relatives such as siblings / in-laws, household assistant, etc.

While in Thailand, Universal Coverage (UC) implemented based on the National Health Security Act 2002 for all Thais people.

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.

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. The National Health Service Reform had been officially initiated since 2001 under the "30 Baht

Health Care Project". 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. 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.

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.

2. The Implementation of UHC

Based on the questionnaires collected in both countries (table 3) 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 (18.50percent), 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.[2]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 2. Geographical background of samplings

Sampling properties	THAILAND		INDONESIA	
	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
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

Sampling properties	THAILAND		INDONESIA	
7. Income per month (Baht equivalent to Rupiah)	Frequency	Percentage	Frequency	Percentage
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

The perception of respondents on implementation both UC anad 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 3. Parameters of implementation UHC

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 4.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%	1,261	3,205	1237	23	4	-
Region 2 Pitsanulok	54	4.63%	709	3,688	685	24	-	-
Region 3 Nakhornsawan	52	1.46%	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	978	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	883	37	4	1
Region 13 Bangkok	179	15.34%	269	14,413	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.

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 contray, 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. Parameters on Quality Service of UHC

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 Satisfied	3.99	Very Satisfied
7. Customers Care(medical ersonnel)	4.53	Highly Satisfied	4.12	Very Satisfied

Source: Primary Data

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:

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 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 (Kumorotomo, 2015).

Table 6. 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. (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.

CONCLUSIONS

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 5 parameters in the measurement 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. 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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