Commentary

Current condition of social security administrator for health (BPJS *Kesehatan*) in Indonesia: contextual factors that affected the national health insurance

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The pandemic

In early 2020, the historical 6-year financial deficit faced by Indonesia's universal health coverage (*Jaminan Kesehatan Nasional* [JKN]) ended when the government adjusted JKN contribution to its healthcare spending.[1] On average, the amount of contribution was raised by 83%. This also marked the end of the 'structural deficit' caused by purposively setting JKN contribution lower than the actuarial requirement to match the population's ability to pay.[2]

In the same period, countries are affected by the coronavirus disease 2019 (COVID-19) pandemic, and Indonesia is not an exception. The rapid spread of the disease has also changed people's health-seeking behavior. Unless considered an emergency, patients forego treatment and avoid visiting health facilities to prevent infection.[3] The non-COVID-19 utilization rate dropped by almost 25% during the pandemic.[4] Active JKN members (marked by the number of paying members) also dropped due to economic recession and contribution evasion.[5]

On the other hand, COVID-19 healthcare utilization skyrocketed. COVID-related hospital claims reached IDR 40 trillion (approximately USD 2.7 billion) in 2020 and doubled to IDR 90 trillion (approximately USD 6.2 billion) in 2021.[6] However, this spending is excluded from JKN as the law mandated that pandemic-related health spending is covered by the government.[7]

The overall impact of JKN contribution adjustment and low healthcare utilization has resulted in a financial surplus of the JKN fund.[8] The national health insurance administrator (*Badan Penyelenggara Jaminan Sosial* [BPJS] *Kesehatan*) management still needs to anticipate the period when the government announced that the COVID-19 pandemic has ended since that is the start of the COVID-19 financing under the JKN scheme.[9]

The new focus

Given the positive financial status of the JKN fund, the BPJS *Kesehatan*'s board of directors shifted their focus from ensuring financial sustainability to improving the service quality.[10] Both healthcare and administrative services must be efficient, standardized, and integrated using information technology. An online queueing system was introduced to inform patients of the estimated arrival time at health facilities to shorten the waiting period.[11] Teleconsultation was also piloted to test its impact on healthcare access, especially in remote areas or areas without certified health facilities.[12]

Furthermore, innovative payment systems were linked to achievements in performance indicators. At the primary care level, the current performance-based capitation system, which has been introduced in 2017, will be subject to reform.[13] New indicators will be added in line with government health priorities. There is also a plan to introduce incentives and disincentives to the JKN payment system to encourage health facilities to improve their performance.

Government policies that impacted JKN

At the end of 2021, the Ministry of Social Affairs audited its 86.4 million JKN subsidy recipient database to check for data quality. As many as 9 million were removed from the list for various reasons.[14] Efforts were focused on replacing the list, but this requires massive resources to conduct a census at the village level. This sudden drop in JKN membership affected the contribution paid by the government to the JKN fund and automatically impacted the BPJS *Kesehatan*'s operational costs.

An important milestone of JKN in 2022 is the issuance of the Presidential Instruction orchestrated by the Coordinating Ministry for Human Development and Cultural Affairs. It instructed 30 ministries and

government institutions to optimize their roles in supporting JKN. This rule is vital to the effectiveness of JKN since it is a highly regulated program that needs interventions from policymakers to ensure its implementation. For example, the Ministry of Economic Coordination was instructed to issue a regulation to mandate JKN membership for money lenders. The Ministry of Home Affairs was ordered to encourage governors and mayors to oblige business permit applicants to be active JKN members as a requirement. These instructions were aimed at improving the three main pillars of JKN which are population coverage, revenue collection, and healthcare purchasing.[15]

JKN benefit package

Another important upcoming regulation is the plan to reformulate the JKN benefit package based on the principles of basic health needs. This is mandated by the latest JKN Presidential Regulation. Unfortunately, the term "basic health needs" is not clearly defined by any regulation and is prone to multiple interpretations. Several criteria were developed to determine whether a specific disease or treatment can be added to the JKN benefit package. No final consensus has been reached, but some diagnoses or treatments will possibly be covered by other financing schemes and *vice versa*.[16]

JKN benefit package reformulation includes the plan to reform JKN primary care services to emphasize disease prevention and case detection. As many as 14 new health screenings were proposed to be added to the primary care benefit package. This included screenings for cervical, colorectal, lung, and breast cancers.[17] Although most studies have shown the long-term investment benefit of adding screening services, BPJS *Kesehatan* must calculate the possibility of a short-term increase in health spending due to new case findings from the screenings.

New medicines, treatments, and medical devices are emerging every year. JKN needs to follow this development in seeking more effective and efficient treatment for better health outcomes. However, budget is always a constraint. Adding these new products to the JKN benefit package requires robust health technology assessment (HTA) studies to determine their cost-effectiveness and budget impact.[18] The government has planned to improve the capacity of researchers to perform HTA studies to achieve at least five HTA studies per year. At the end of 2024, the results of these studies are expected to be included in the JKN benefit package.

Furthermore, the government is planning to assign BPJS *Kesehatan* to manage *Jampersal*, a national program to cover childbirth for non-JKN members. BPJS is considered to have the appropriate resources to assist the government in running the program to reduce maternal and neonatal mortalities. This is a new challenge for BPJS *Kesehatan* since *Jampersal* recipients are non-members. A new system must be developed and installed to verify eligibility and channel fund from the government to health facilities.

Healthcare purchasing and infrastructure

Simultaneous with the above-planned policies, the government is in the process of readjusting JKN healthcare tariffs both at the primary care and hospital levels.[19] There is a strong urge to immediately adjust the tariff. It has been more than six years since the last adjustments in 2016 despite the regulation-mandated tariff evaluation every 2 year. A multistakeholder team was assembled under the coordination of the Ministry of Health with the main task to update tariff calculations. The final tariff decision is expected to be announced in 2022.

At the primary care level, JKN adopts a capitation payment system where payments are made for facilities based on the number of registered members. Currently, around 80% of members are registered in public health centers, which account for 45% of the total primary care facilities. This created membership maldistribution, and many parties have requested a fairer membership redistribution.[20] Redistribution requires thorough consideration due to the higher capitation rate for private compared to public. Although the referral rate and patient satisfaction index are better in private settings, this is subject to be evaluated once they receive significant additional members due to redistribution.

Based on the 2019 national health account, JKN paid for nearly 25% of total health spending in Indonesia.[21] Many parties have acknowledged the purchasing power of BPJS *Kesehatan* to influence healthcare providers' behavior. They used this phenomenon to link national health targets with JKN. For example, there was a pilot project to test the impact of an innovative payment system on maternal and new-born health. This project aimed to reduce

maternal and new-born mortality.[22] Similar initiatives will follow for other national health targets.

Another important policy to be introduced is the standard inpatient room for JKN members. The current tiered-system inpatient room accommodation for JKN members is based on three levels of JKN contribution. The first-tier members are dedicated to a two-bed inpatient room accommodation, the second-tier is entitled to a four-bed, and the third-tier will be placed in a six-bed inpatient room. Social security experts argued that this arrangement creates inequity among JKN members. The government is planning to introduce a standard inpatient room for all JKN member segments. A trial is underway to determine hospitals' readiness and JKN members' reaction toward this policy.[23]

International recognition

The dynamic development of JKN has caused BPJS *Kesehatan* to adapt quickly using new initiatives and innovations in response to regulatory changes. The ASEAN Social Security Association rewarded BPJS *Kesehatan* with the Continuous Improvement Recognition Award in 2021 for implementing information technology during the COVID-19 pandemic. Many services were transformed digitally to ensure service level agreement while maintaining physical distancing.[24]

Additionally, the International Social Security Association (ISSA) also acknowledged these achievements, and BPJS *Kesehatan* was rewarded with the most prestigious award in the ISSA Good Practice Award 2021 for the Asia Pacific. The paper entitled 'Managing and governing National Health Security Programme in a single-payer scheme' highlights the performance of BPJS *Kesehatan* in managing nearly 250 million members, 2,400 hospitals, and more than 20,000 primary care facilities. Currently, BPJS *Kesehatan* is the largest single-payer in the world.[25]

In conclusion, the current condition of JKN is marked by at least four aspects: the effect of the COVID-19 pandemic, contribution adjustment, new focus on the quality of care, and government policies that affected the JKN program. The first two aspects are responsible for the JKN fund surplus due to low healthcare utilization combined with higher revenue collected. The last two aspects interact dynamically as the BPJS *Kesehatan* management focuses on improving the quality of care, while the government focuses on achieving national health targets through program embedment to JKN. Communication and coordination between BPJS *Kesehatan* and the government are crucial to ensure synergy to achieve both focuses effectively.

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