Policy Analysis

What are the JKN Policy Options; At this time?

An analysis of JKN policies in the Equitable, Quality and Sustainable Health Care Equity Perspective

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Steps in Policy Analysis;

1. Statement of Policy Problem
2. Criteria for Assessing Options
3. Identification of Options
4. Comparison of Options
5. Recommendation of the best Options (yet to be discussed)

1. Issues in JKN policy

Health access equity issue; *Who gets what in the health insurance system?* PBI participant funds have been used to cover losses in PBPU participant groups.

Communities in difficult areas such as in East Nusa Tenggara enjoy far fewer benefits packages compared to Yogyakarta. The compensation policy is not yet running. Inter-provincial Portability Policy can only be enjoyed by members with relatively economically capable. This situation has deviated from the 1945 Constitution. Although, It is quite clear that the objectives of the SJSN Law and the BPJS Law state:

> *The National Social Security System is organized based on humanitarian principles, benefit principles, and the principle of social justice for all Indonesian people.*

Dana PBI di dalam UU SJSN seharusnya dipergunakan oleh masyarakat miskin dan tidak mampu.

Problems in JKN Policy

- The difference between BPJS Kesehatan centralized system and local government decentralized system has led JKN policy and decision-making not being done based on the data and involvement of all the stakeholders at both national and local level.
- The JKN funding deficit has not been monitored in detail, in particular the investigation on the causes of deficits based on membership segments and premium adequacy.
- The data indicates *Adverse selection* in PBPU group causing high claim costs.
- System for Quality was recently built in 2019. The potential for fraud is still in the condition where legal actions have never been carried out.

These problems, if not addressed, will jeopardize the outcome of the **SJSN Act and BPJS Act.**

2. Criteria for Assessing JKN Policy Options

Criteria	What is being assessed?
***Equity*:**	PBI funds is focused on the poor and disadvantaged under developed regions receive attention so that access to benefit packages is more evenly distributed (Concerning the supply-side) Compensation policy runs well.
***Effectiveness**:*	Quality of Care further improved Data on clinical care more intensively used to assess benefits
Responsiveness	People are more compliant to pay Local governments have control over health care quality People can voice their concerns Hospitals and all kinds of professions/associations can voice their concerns
***Economic and financial possibility**:*	BPJS deficit decreased because the people can afford to pay more The central and local governments pay to BPJS Kesehatan for the poor and disadvantaged in a just manner BPJS Kesehatan deficit is borne by local government and privileged society
***Political viability**:*	Changes in policy does not cause political upheaval

3. Identification of Options

Policy Options on Policy Problems

Option 1:

The SJSN Law and the BPJS Law are not amended. The SJSN Law and the BPJS Law remain like this with problematic implementation particularly concerning the issue of health care equity and quality.

Option 2:

BPJS remains the only social security administrative body, but there is a collective agreement to create a tight wall of separation (firewalls) between PBI *pooling* with PPU *pooling*, and PBPU *pooling*. The presence of firewalls or compartments it is expected to keep PBI funds prioritized for the poor, vulnerable or incapable (a form of social justice for all Indonesian people).

Option 3:

There is other insurance institution (other *pooling*) outside of BPJS Kesehatan. People have the option to not become BPJS Kesehatan member. But they must have commercial health insurance. Privileged society may become BPJS Kesehatan member and only provided with standard class. There is no longer class 1, 2,3

4. Comparison between Options

Option 1:
No changes in SJSN and BPJS Law.

- The SJSN Law and the BPJS Law remain like this with problematic implementation particularly concerning the issue of health care equity and quality.

Option 1. Alternative Policy; SJSN and BPJS Law are not amended

Forecasting:

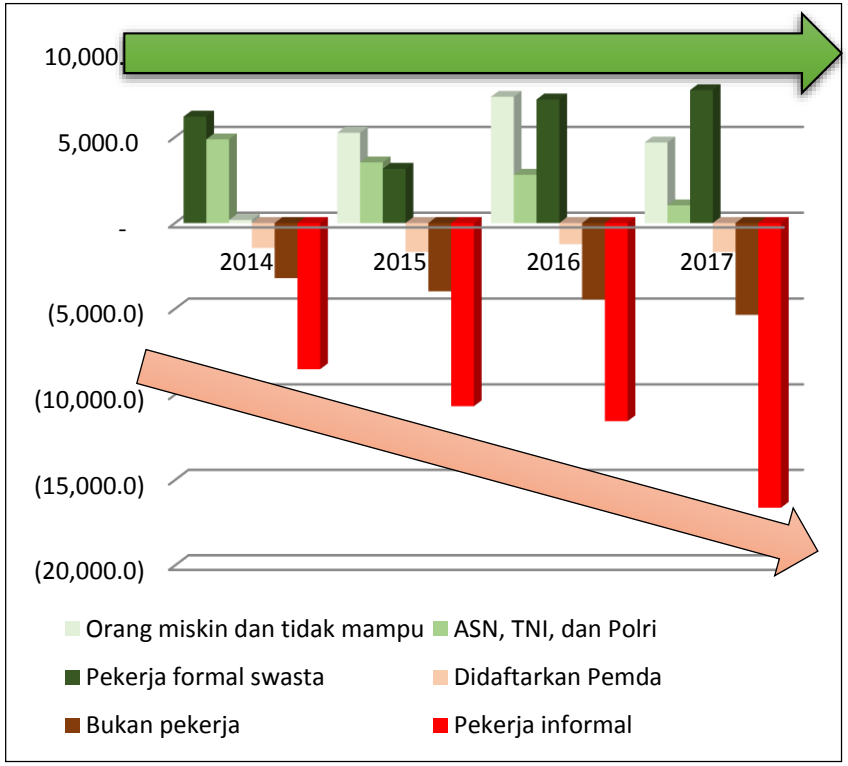
Criteria	Status Quo	Projection
Equity	❑ Compensation policy has not run. ❑ The JKN funding deficit has not been formally monitored ❑ PBI participant segments use CVD services more at FKTP level and use less at FKTL level. In contrast, CVD service utilization for non-PBI participants is more concentrated at FKTL levels ❑ Adverse selection in the PBPU group caused high costs and was the main cause of the deficit in JKN financing	❑ The situation of BPJS Kesehatan funding will continue to deteriorate. ❑ Due to the deficit pressure and the impact of the single pool, the remaining PBI funds intended for under developed regions such as East Nusa Tenggara and Papua will not be used to fund compensation policies ❑ *Further access of gap (FKTL)* will continue to increase

Impact : The purpose of SJSN and BPJS Law that states "*The National Social Security System established based on the principle of humanity, the principle of benefit, and the principle of social justice for all Indonesian people, will not be achieved*".

Option 1. Alternative Policy; SJSN and BPJS Law are not amended

Forecasting:

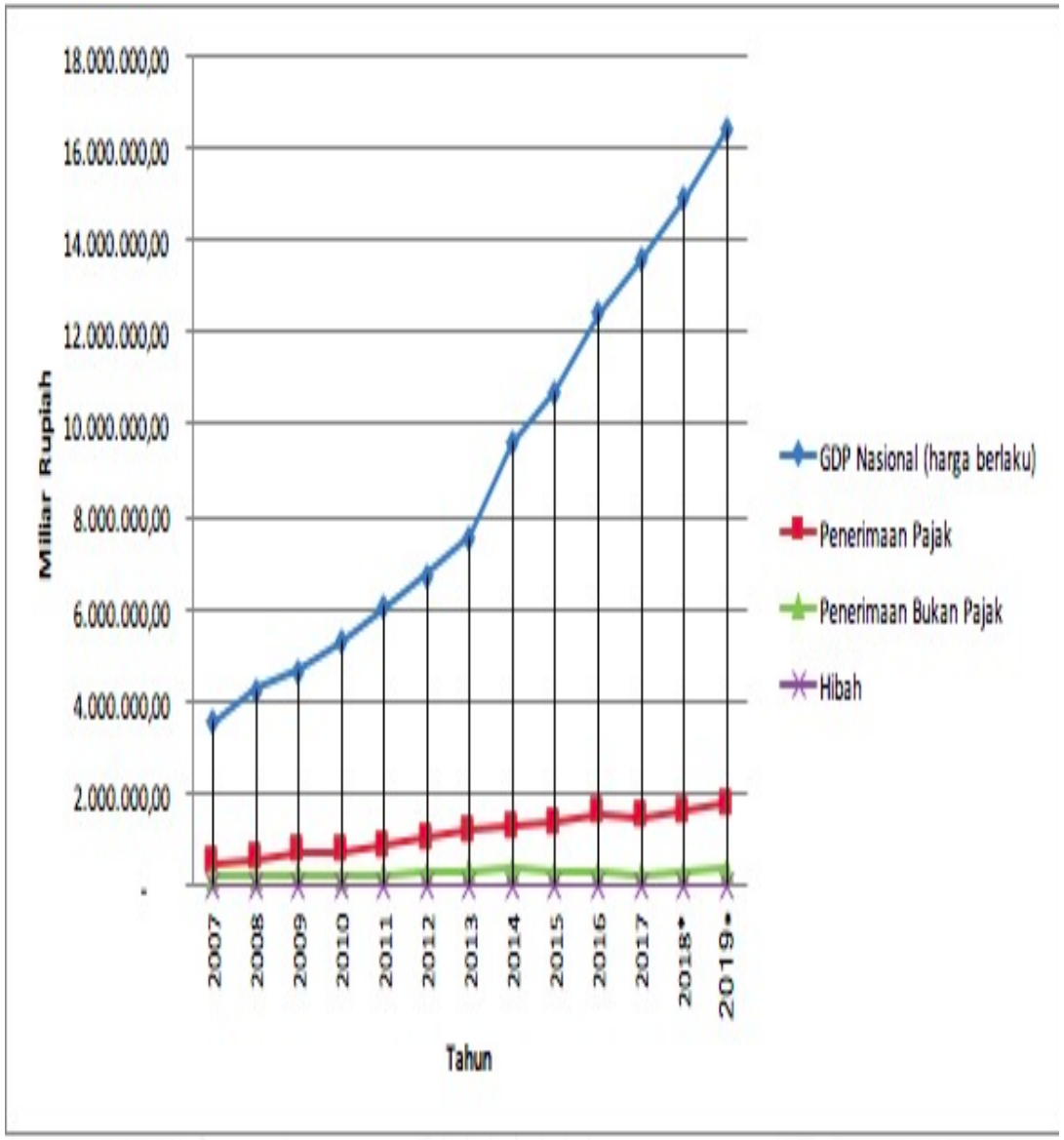
Criteria	Status Quo	Projection
Economic and financial possibility	The tax-backed state budget currently also bears the burden on infrastructure. The state budget in law should focus on the poor and marginalized. In the future, by looking at the GDP trend and the collection of the National Budget, there is still a limited budget for the BPJS Kesehatan budget.	❑ Without raising PBPU premiums and quality control, the deficit in the PBPU segment is projected to increase. ❑ Option 1 has unsustainable prospects from the financial aspect. The health system, especially health insurance, will increasingly depend on the state budget and political decisions in the House of Representative (DPR). There are possibilities potential community funds cannot be directed to health.



Surplus for members in the PBI, ASN and Formal members categories

The deficit continues to increase in the segment of non workers and informal workers members

Source: Ministry of Finance, BPJS Kesehatan, 2018



Option 1. Alternative Policy; SJSN and BPJS Law are not amended

Forecasting:

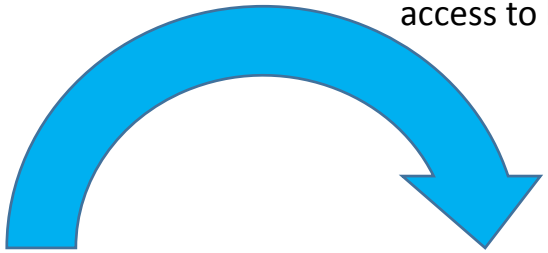
Criteria	Status Quo	Projection
Effectiveness	❑ The quality situation has not been managed properly. ❑ New quality framework recently implemented in 2019. ❑ BPJS payments that often deferred can affect service quality.	❑ Quality of Care becomes increasingly difficult to manage. ❑ The tendency for fraud will be more severe if there is no action. The concept of fraud on the basis of coping strategy will be increasingly popular.
Political viability	Politically, there are not many negative reactions if the policy is continued without change. Middle and upper class people who become BPJS members by paying very little will not react much. But politically, health workers and hospital managers can express disagreement with the JKN policy. In the end it will become a political problem too.	

Option 1. Alternative Policy; SJSN and BPJS Law are not amended

Forecasting:

Criteria	Status Quo	Projection
Responsiveness	At present time local government does not have ownership over JKN program. The difference between centralized BPJS Kesehatan system and decentralized local government systems led to JKN policies and decision-making not based on data and coordination with relevant stakeholders (Local government)	This situation of separation, if left unchecked, will cause unresponsiveness of the regional government to what happened in the implementation of JKN.
	The problem faced by BPJS Health is that it does not cover all communities that can afford it, and the collectability of the PBPU group. Until 2018 there are still around 15-20% of the Indonesian people who have yet to join BPJS. (Community)	People who are able to become less willing to become JKN participants. This community preference does not match the nature of the BPJS Kesehatan which must be subject to strict referrals. The collectability problem is likely to increase, with the possibility of a PBPU premium increase.

That is, it needs to be stressed that the JKN contribution subsidy from the state budget is really intended for the poor, weak or unable not only in the form of curative, but the provision of health facilities and access to health services.



Option 2. Revised Law for SJSN and BPJS

Revision: BPJS remains *single pool*.

BPJS remains the only social security manager. The changes made are by adding the function of compartments or firewalls in the fund pooling of social security funds. This second option does not change the single-payer system which is currently being implemented into a multi-payer system.

The purposes of this option are:

- guarding JKN policy to remain within the ideological corridor contained in Article 34 Paragraph 2 that states "*The state develops social security for all people and empowers people who are weak and unable to live with basic human dignity*". Meaning, it is it needs to be stressed that the subsidy for JKN premium from the national budget is truly intended for the poor, weak, and unable to live with basic human dignity and not only in the form of curative, but the provision of health facilities and access to healthcare services.
- If this ideological belief is not implemented, JKN's financial viability will be difficult and will affect service quality.

Option 2. The SJSN and BPJS Law undergo revision: BPJS remains *single pool*.

Forecasting:

Criteria	Status Quo	Projection
Equity:	❑ The biggest *Capital Health Pooling* is currently in BPJS Kesehatan (Single pooling)*, Evidence showed due to single pool in the past 5 years there has been usage of PBI funds by able communities (PBPU)* ❑ Budget synchronization — available budget in ministries and local governments with the budget included in BPJS Kesehatan. ❑ Table 1 provides information that cardiac utilization is widely used by the capable community (PBPU). In fact, the distribution of PBI participant data that accesses heart services at the primary care level (puskesmas / FKTP) is quite large	❑ With the compartment or a separation wall (firewall) between PBIs, PBPUs and PPUs pooling, it will stop the flow of poor community funds (PBI) to capable communities (PBPU). ❑ implementation of compensation policies or affirmative policies will be possible because of the availability of BPJS funds for the poor and disadvantaged. ❑ There will be greater opportunities for the poor to access health services.

Impact **:** This policy option serve as a protection against unjust situation in terms of access to health and to realize the outcomes of the SJSN Law and BPJS Law which are based on humanitarian principles, benefit principles, and the principle of social justice for all Indonesian people, will be achieved ".

Tabel 1. Sebaran data Peserta JKN yang mengakses layanan Kardiovaskuler BPJS Kesehatan Berdasarkan ID Peserta JKN

	KEPERSERTAAN	KUNJUNGAN FKTP				KUNJUNGAN FKTL			
PROVINSI	JML	Kunjungan CVD	Total Kunjungan	Rasio CVD per kunjungan (tertimbang)	Rasio CVD per total peserta (tertimbang)	Kunjungan CVD FKTL	Total Kunjungan FKTL	Rasio CVD per kunjungan (tertimbang)	Rasio CVD per total peserta (tertimbang)
	A	B	C	D = (B/C) %	E= (B/A) %	F	G	H= (F/G) %	I= (F/A) %
SUMATERA UTARA	103,193	2,478	25,158	9.81%	1.84%	679	30,772	5.50%	0.74%
BENGKULU	24,954	608	6,137	9.47%	2.21%	147	3,641	3.76%	0.64%
DKI JAKARTA	47,042	1,515	14,112	10.42%	2.46%	397	5,096	4.78%	0.75%
JAWA TENGAH	201,634	7,718	66,759	11.32%	3.76%	2,024	5,386	6.60%	1.00%
DIY	24,224	1,344	9,193	14.34%	6.16%	254	3,898	6.08%	1.15%
JAWA TIMUR	175,859	7,082	56,950	11.80%	3.81%	1,522	6,344	5.25%	0.69%
NTT	54,702	731	11,067	6.06%	1.22%	261	9,800	4.65%	0.43%
KALIMANTAN TIMUR	34,021	796	8,385	9.69%	1.82%	203	7,694	3.55%	0.52%
SULAWESI SELATAN	70,462	2,040	18,446	10.08%	2.62%	511	26,410	4.98%	0.75%
PAPUA	61,221	253	5,533	6.76%	0.36%	103	13,220	1.97%	0.16%
TOTAL	797,312	22,087	196,582	11.08%	3.08%	6,101	112,261	5.43%	0.77%

Sumber: BPJS Kesehatan, 2019

This CVD ratio per total members in FKTP (B / A) was obtained by comparing data on the number of members visiting weighted FKTP health facilities compared to the total weighted members in the province.

FKTL visit data shows that provinces with sufficient availability of health facilities such as South Sulawesi and North Sumatra help increase the ratio of CVD visits in FKTL. The CVD ratio per total participant in FKTL (F / A) is a comparison between the number of weighted participants who visited FKTL health facilities for heart services compared to the total weighted participants in the province.

The ratio of CVD visits in FKTL will increase if there are fairly good health facilities like in the said province. This finding tells us that JKN members from provinces that have limited health facilities such as Papua and East Nusa Tenggara have limited access to cardiovascular services compared to other provinces with better availability of health facilities.

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Tabel 2. Rata-Rata Jumlah Klaim Layanan Cardiovaskuler berdasarkan Provinsi dan Segmen Kepesertaan

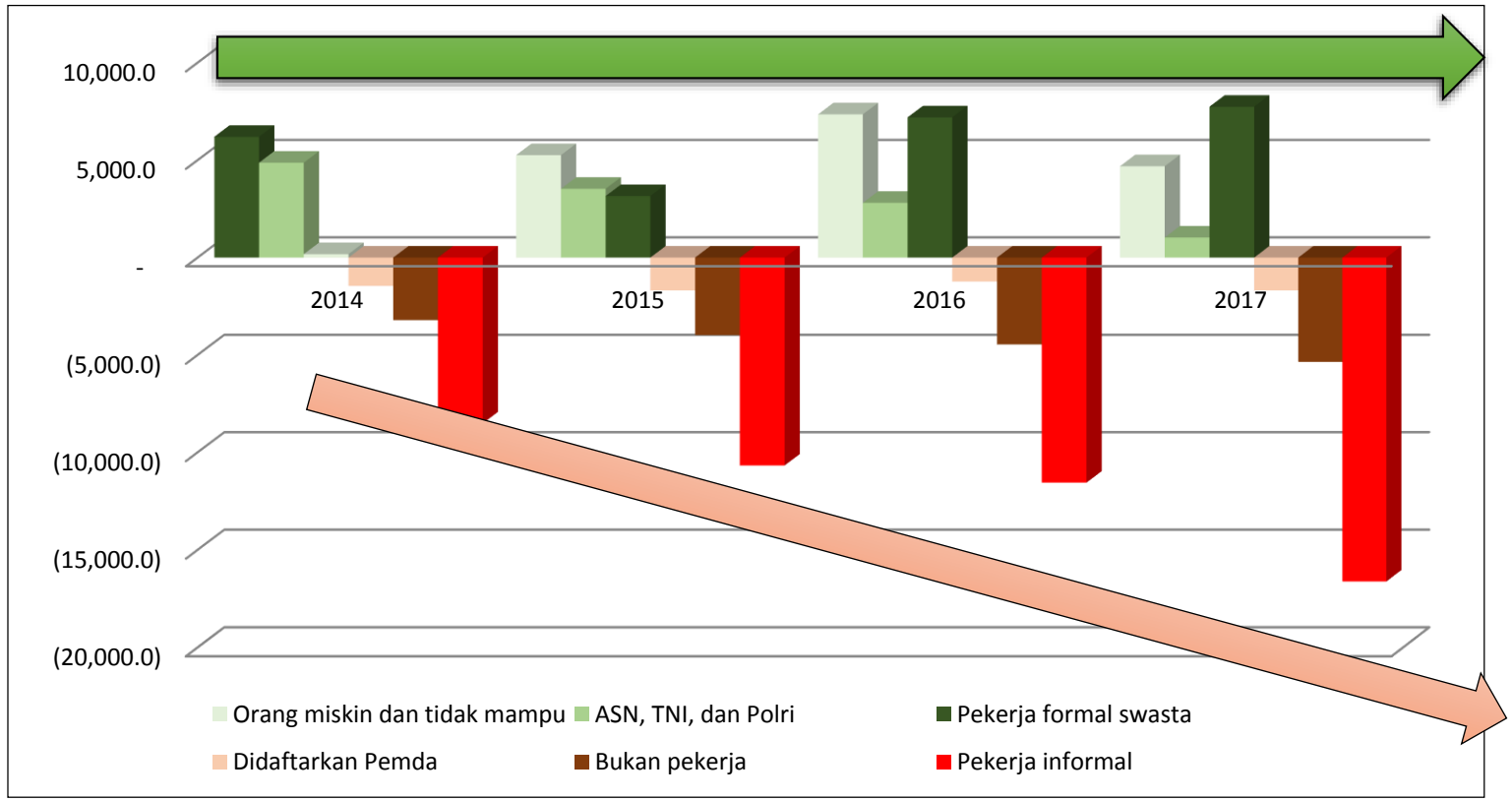
PROVINSI FASKES	SEGMENTASI PESERTA					
	BUKAN PEKERJA	PBI APBN	PBI APBD	PBPU	PPU	TOTAL
	RATA-RATA					
SUMATERA UTARA	5,519,098	3,538,372	3,524,976	6,961,265	9,421,658	6,275,851
BENGKULU	4,883,673	4,206,083	2,951,856	5,003,287	4,143,428	4,567,926
DKI JAKARTA	11,113,332	4,413,816	8,591,514	11,437,242	10,554,855	10,155,466
JAWA TENGAH	7,192,051	4,343,183	4,222,204	5,797,133	7,032,066	5,735,503
D I YOGYAKARTA	7,252,775	6,866,717	7,195,897	4,074,995	5,221,917	5,956,670
JAWA TIMUR	6,421,954	4,411,654	5,459,530	5,977,753	5,308,898	5,467,470
NTT	4,914,888	4,820,015	3,517,628	4,537,394	5,089,585	4,826,790
KALIMANTAN TIMUR	13,413,172	6,794,765	4,190,803	5,849,608	6,435,023	6,695,961
SULAWESI SELATAN	5,773,847	3,934,828	3,994,847	4,834,117	9,715,703	6,171,891
PAPUA	3,253,093	3,416,266	4,765,000	6,613,310	4,522,918	4,148,858
RATA-RATA 10 PROVINSI	7,117,542	4,532,929	6,708,177	6,679,368	7,153,328	6,324,620
	STANDARD DEVIASI					
SUMATERA UTARA	4,687,690	1,743,780	3,145,069	9,902,647	15,539,859	9,326,200
BENGKULU	3,303,106	3,254,017	1,759,042	6,233,941	5,628,451	5,226,639
DKI JAKARTA	18,231,156	2,861,658	14,233,238	18,859,542	14,207,276	16,377,750
JAWA TENGAH	11,849,643	3,229,028	1,240,100	8,682,387	12,615,667	8,891,511
DIY	12,339,056	15,945,532	1,672,621	7,645,968	11,072,191	12,596,290
JAWA TIMUR	8,275,310	3,162,730	3,715,808	8,565,143	7,137,166	7,027,343
NTT	1,777,576	4,544,449	1,563,505	5,011,364	4,702,446	4,180,607
KALIMANTAN TIMUR	15,895,431	10,724,854	2,993,956	3,569,185	7,197,387	8,468,621
SULAWESI SELATAN	3,530,376	2,169,229	1,471,278	5,219,621	14,122,793	8,085,905
PAPUA	2,815,861	2,468,926		3,437,431	3,319,606	3,064,262
RATA-RATA SD	10,897,175	5,514,040	11,078,798	10,883,989	11,523,723	10,017,064

The findings reinforce information about regions with the availability of CVD services that better affect higher service prices (claims).

The rate of increase for catastrophic services will continue to increase and need to be prevented by improving lifestyle, exercising regularly. But the advancement of medical technology and the expansion of heart health facilities will drive this increase in spending. The capacity of the APBN in the future will be difficult to pay such as experiences in various other countries. On the other hand the APBN and APBD are needed for the expansion of health services.

Source: BPJS Kesehatan Data Sample, 2019

Compartmentalization: Prevention for the use of BPI funds to cover losses at the PBPU



Surplus for participants in the PBI, ASN and Formal Participants categories

The deficit continues to increase in the segment of participants not workers and informal workers

Source: Ministry of Finance, BPJS Kesehatan, 2018

Option 2. The SJSN and BPJS Law undergo revision: BPJS remains *single pool*.

Forecasting:

Criteria	Status Quo	Projection
Effectiveness	The system used by BPJS Kesehatan does not take into account the aspects of service quality in claim payments.	❑ This policy option is projected to be a solution to overcome the dilemma between maintaining quality and expanding health service coverage in areas with minimal access / supply side. ❑ The tendency for potential fraud will be minimized.
Economic and financial possibility	❑ BPJS Kesehatan for 5 years experienced a deficit, annually (Pribakti B, 2018). ❑ The number of deficits increases every year. The deficit from 2014 to 2016 was recorded as 2.8 trillion, 5.85 trillion and 9 trillion. ❑ The BPJS Health deficit is estimated to reach Rp 10.93 trillion for 2018. The causes of the BPJS Kesehatan deficit are low actuarial values, clinical service inefficiencies, and almost half the PBPU group deferred payment	❑ able communities are expected to use their own funds to purchase additional health insurance. This will reduce pressure for the APBN so that health funds can be used to improve infrastructure inequality and prevent disease. ❑ With the increase in GDP for the health sector, health services, utilization of health workers, and the pharmaceutical / medical sector can develop better.

Option 2. The SJSN and BPJS Law undergo revision: BPJS remains *single pool*.

Forecasting:

Criteria	Status Quo	Projection
Responsiveness	At present time, accreditation or credentials to maintain the quality of services is difficult for hospitals or health facilities in areas with minimal access.(Local Government)	❑ Through Option 2 policies are formulated to give responsibility to local governments. The hope is that this option will create a situation of ease of data access. JKN data will be useful for health development planning in the region, monitoring the quality of health services purchased by BPJS Kesehatan and negotiating rates between local governments, health workers in the regions and BPJS Kesehatan. ❑ This option is projected so that the burden of deficit is not borne solely on BPJS Kesehatan or the national government.
	Research Findings by way of *realist evaluation* (PKMK FKKMK UGM, 2018) shows that in the context of an area that has adequate resources, essential services such as cardiovascular have access aspect that is availability. On the other hand, the community or JKN participants in the limited area are also difficult to access / do not have the opportunity or the same health access situation.*(community)*	❑ Through the option of compartment pooling, participation is possible with restrictions on services to the able community (PBPU). ❑ Limitation of service will bring justice to the poor, weak or marginalized groups to have more opportunities for continued access to health. ❑ Complaints that may arise are PBPUs or non-workers that are in middle-range status since they will be burdened, if the BPJS premium in its compartment exceeds the ability limit.

Opsi 2. UU SJSN dan UU BPJS direvisi: BPJS tetap *single pool*.

Forecasting:

Criteria	Status Quo	Projection
Political viability	Problems that might be encountered if this option is carried out are ideological differences, interpretations, and / or political support. There will be many debates with input from various interestt group. Middle and upper economic groups that are accustomed to government subsidies through the BPJS Kesehatan (APBN) will tend to oppose this Option. And perhaps there could be a political uproar. A detailed explanation of what is happening at this time needs to be socialized well to the community. The idea that the responsibility for health insurance payment is not only by the government, this needs to be placed in the mind of the people. Without this understanding, Option 2 will not work well.	

Option 3. The SJSN Law and BPJS Law are revised: There is Insurance body (other *pools*) outside of BPJS Kesehatan.

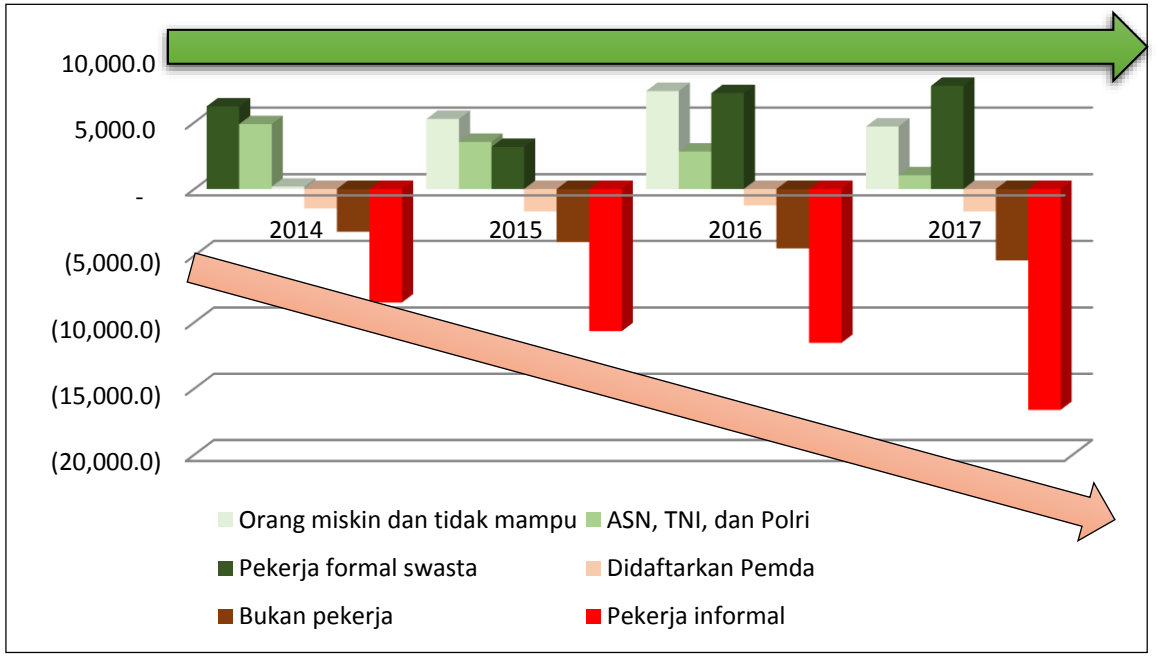
This option is a policy that changes the BPJS Kesehatan to not be the only health insurance pool. Able communities are to be allowed to not become members of the BPJS Kesehatan. However, it is required for them to have commercial health insurance. Able communities can become members of the BPJS Kesehatan as well. Able communities membership in BPJS receive standard classes and may not request for an upgrade.

This option is implemented by first making rules regarding the limitation of the package of health service benefits according to economic capacity. This is to maintain the stability of the JKN program and the limited ability of the state to prioritize weak, poor or poor people

This option is projected to be able to provide incentives (compensation) to limited access areas in order to be able to meet the availability of health facilities, so that the goal of social insurance ensures access to for all citizens is achieved.

The Principle:

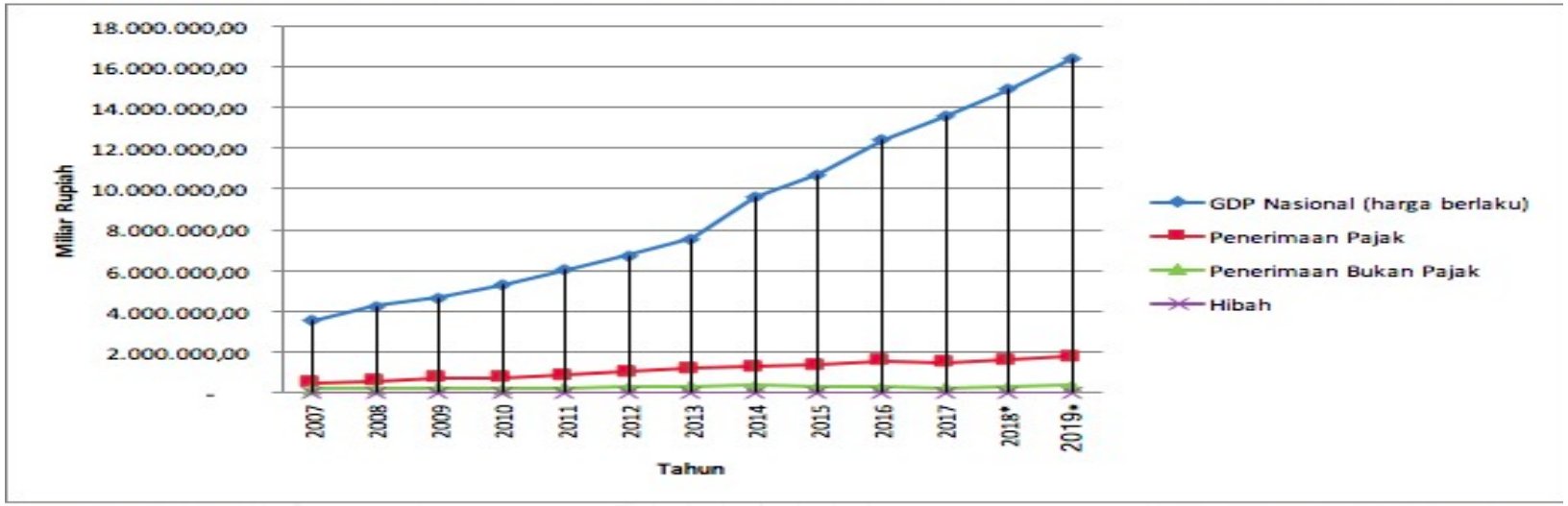
- Prevent the use of PBIs funds for able classes
- Explore potential funding sources in GDP



Surplus for participants in the PBI, ASN and Formal Participants categories

The deficit continues to increase in the segment of participants not workers and informal workers

Source: Ministry of Finance, BPJS Kesehatan, 2018



The SJSN Law and BPJS Law are revised: There is Insurance body (other *pools*) outside of BPJS Kesehatan. *Forecasting:*

Criteria	Status Quo	Projection
Equity	❑ Data shows that pool membership is a variable that affects the utilization of health insurance. The results of the membership pooling variables analysis indicate that the able member group (PBPU) is the pool that uses the most of the health care cover(PKMK FK-KMK UGM, 2019). ❑ The beneficiaries of this cheap premium payments . Although premiums are very cheap, there are still around 45% of PBPU members who do not pay well. On the other hand, until 2019 there are around 40 million Indonesians who have not yet entered the BPJS.	❑ By releasing the PBPU to the market mechanism, the public is able to choose the health insurance system that suits their wishes. However, for those who are unable to change to PBI, or the government provides subsidies to enter the standard class, and they may not upgrade their class. ❑ It is projected that some of the PBPU that have different demands for health services from BPJS Health will most likely choose this option. ❑ APBN funds that have been widely used to cover PBPU losses can be used to fund compensation policies.

Impact/prospect :to demand for proportional payment of the utilized health services by the community in order to realize social justice or realize the right to obtain health services, the right to get the same opportunities and benefits in order to achieve equality and justice, and the right to social security which enables the development of him or her as a dignified human being "(Article 28 H of the 1945 Constitution)

Option 3. The SJSN Law and BPJS Law are revised: There is Insurance body (other *pools*) outside of BPJS Kesehatan.

Forecasting:

Criteria	Status Quo	Projection
Effectiveness	❑ Service quality is currently not well managed. ❑ In fact, claims and capitation funds from BPJS are considered low. ❑ And the referral system applied tends to be based on consideration of profit and loss, not the quality of health services. ❑ BPJS Kesehatan for the past 5 years has purchased health services without involving the local government for the quality assurance system	❑Service quality can be controlled, because this option encourages health facilities not to operate with below costs as they currently do. ❑Fraud monitoring is predicted to be weak due to lack of funds as well as motivation to copy to get additional claims. With the presence of more funds entering the hospital sector, it is expected that there will be a decrease in potential fraud because the amount of claims and capitation improves. ❑There is a possibility of two-tier health services with various side effects. These side effects can be reduced if more funds allocated for BPJS Kesehatan so that the quality of JKN services can improve.

Option 3. The SJSN Law and BPJS Law are revised: There is Insurance body (other *pools*) outside of BPJS Kesehatan.

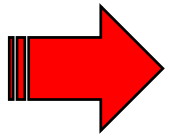
Forecasting:

Criteria	Status Quo	Projection
Economic and financial possibility	❑ Indonesia is currently implementing a national health service / financing system that relies on taxes and the state budget, as well as the local budget. ❑ Individual tax paid in Indonesia is not progressive and low in number. ❑ Meanwhile, more health funds are allocated to curative efforts that are enjoyed more by capable BPJS members. ❑ On the other hand, the amount of funds allocated for promotion and preventive efforts is very limited. Health fund expenditure has not been balanced to achieve prosperity.	❑Option 3 is expected to increase the funds from the able public for health sector, especially curative so that the amount of health funds per-person increases. ❑Option 3 is formulated so that government funding is prioritized to focus on the poor and disadvantaged, and provides space for the government to increase the budget for preventive and promotion services and expansion of health service infrastructure. ❑The third option will provide additional funds for the health sector through the payment of able people through commercial health insurance institutions.

Option 3. The SJSN Law and BPJS Law are revised: There is Insurance body (other *pools*) outside of BPJS Kesehatan.

Forecasting:

Criteria	Projection
Responsiveness	Tariff suitability, service quality, activity to pay premiums and development of health programs can be initiated by local governments and professional associations / health facilities, naturally organized together with BPJS Kesehatan to discuss together concerning medical cost control and certainty of proper income for health workers.
	❑ This option will make the JKN Program successfully respond to all the basic medical needs of the entire population, namely with established schemes, which first and foremost to provide benefits to the poor, weak or disable. ❑ Middle to upper society (who are able) will be more satisfied with the choices of health insurance system that suits their wishes. ❑ Various commercial health insurance packages can develop with attractive innovations in accordance with the wishes of the community. Attractive innovations include combined health care such as fitness, home-care services, and so on.
Political viability	Policy options are predicted to cause a long commotion or debate, because there are very large changes in the health insurance system in Indonesia. This debate needs to be based on ethical thinking from Rawlsian where it is expected that all parties realize that ethically this policy does not harm any community group.



Impact/Prospect

- ❑ The development of good governance will be realized in the management of the JKN program because this option is projected to anticipate the monopsonistic actions of the BPJS in purchasing health services.
- ❑ BPJS Kesehatan functions purely as a payer for social health insurance. Programs and policies that are formed must be based on local needs (social, economic and geographical) and decided with evidence of quality and legitimized by normative instruments. There is a possibility that localization of BPJS will occur according to the health situation. There will be a market for commercial health insurance.
- ❑ There will be an increase in the allocation of health funds of at least 5% of the National Budget and at least 10% of the local Budget in accordance with Articles 170 - 171 of UU No. 36/2009 tentang Kesehatan

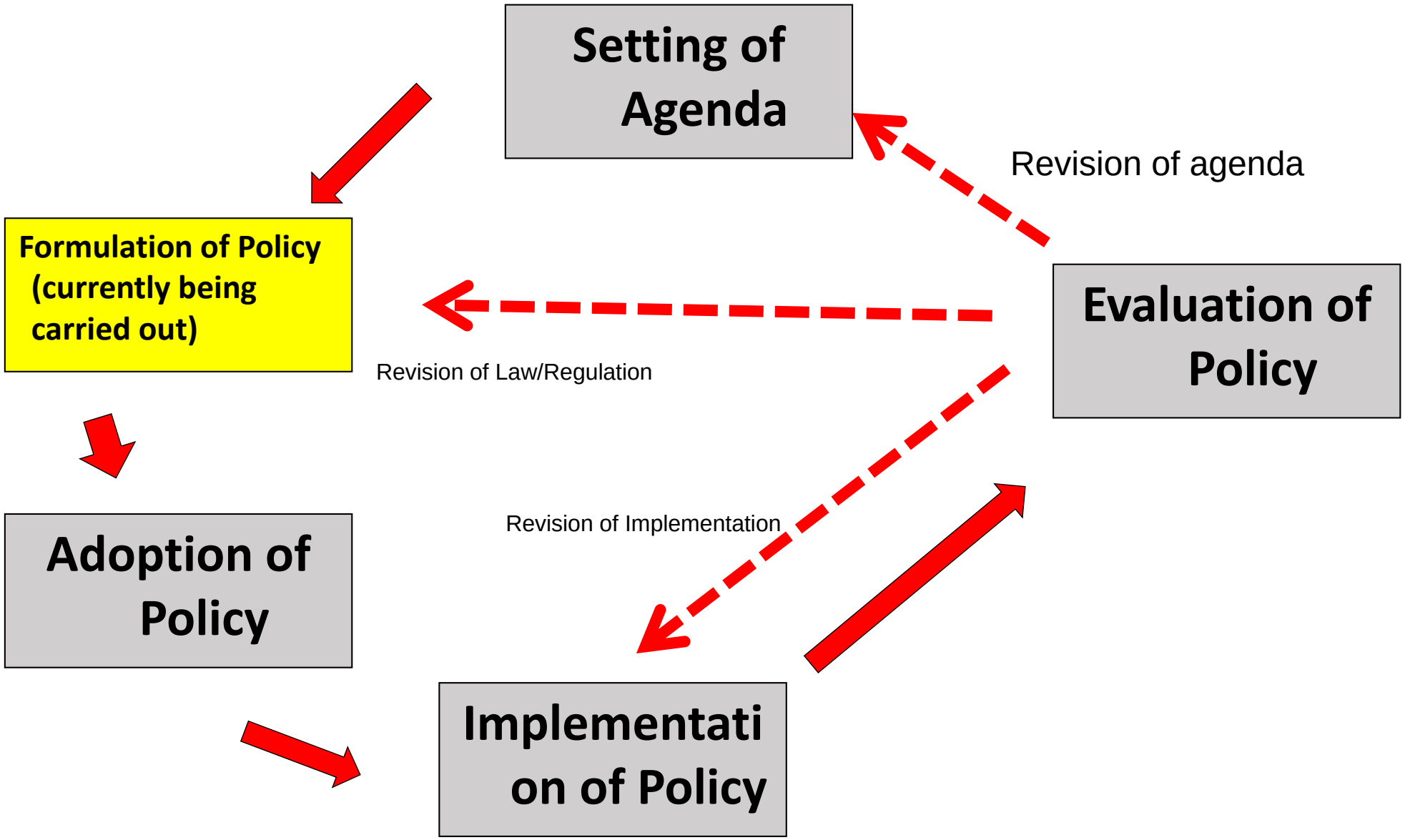
Before Recommendation

These options need to be discussed ideologically with various stakeholders. The discussion is based on an understanding of the ideological foundations used in this policy analysis.

The policy changes proposed in this Policy Analysis is using the ideology embedded in the 1945 Constitution. The government must prioritize paying the poor and disadvantage. People who are able, within the limited capacity of the government, need to pay more for health matters. The need to purchase health insurance among the well-off must start from a young age.

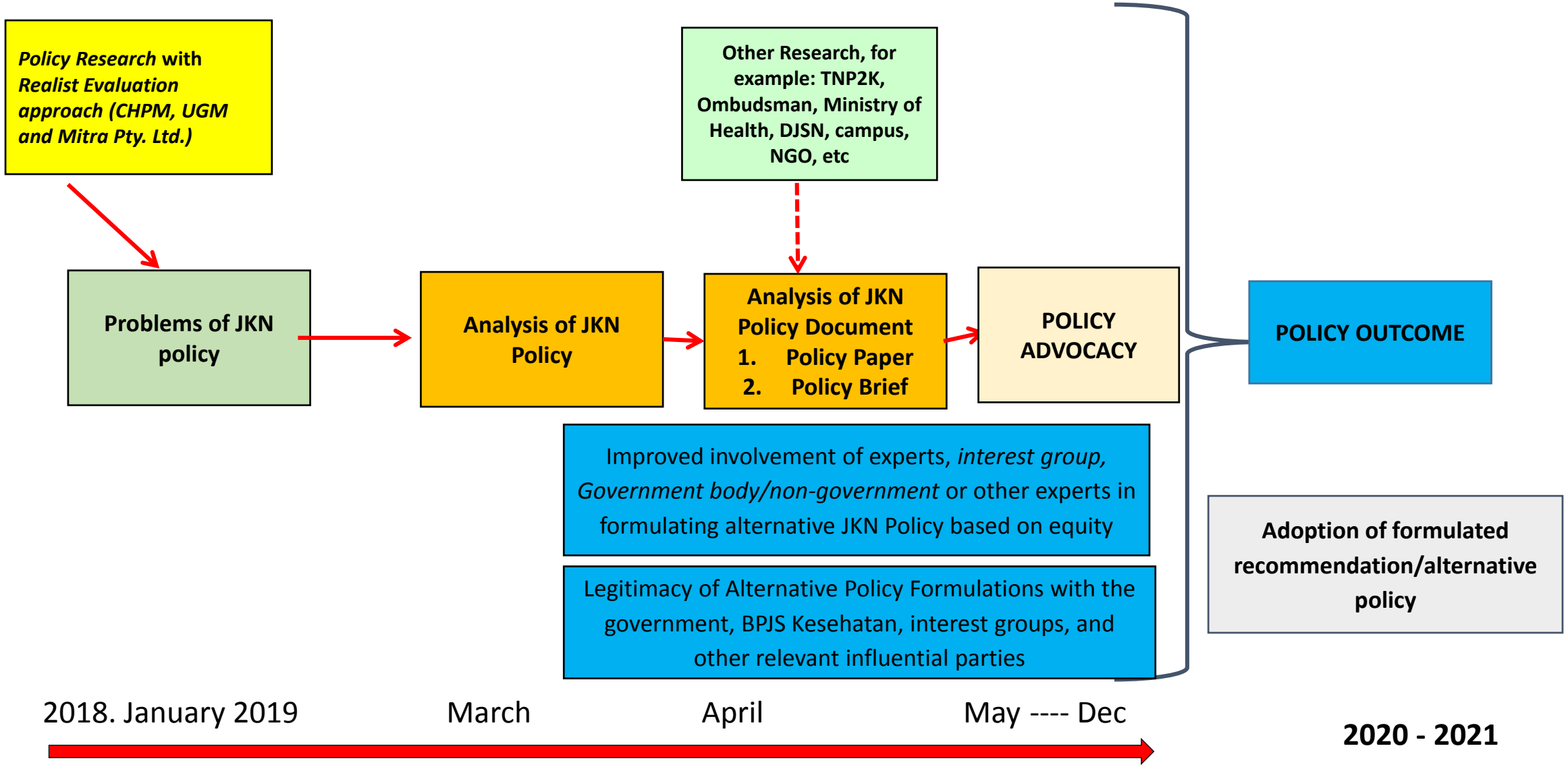
This change also uses the basic thinking of the availability of economic potential in GDP for health. This economic potential can be used by the health sector through tax mechanisms and payment mechanisms by the community itself. Economic potential in GDP for health can be taken by other sectors.

This change also uses the cultural approach, preferences and community access to health services. Without the separation of health insurance funds, there is a continuity of BPJS Kesehatan funds for relatively able communities.



The Cycle of Policy Process: After 5 years

The planned JKN Policy Evaluation Activity
CHPM Faculty Medicine, Public Health, and Nursing UGM:



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