Roadmap toward

THE NATIONAL HEALTH INSURANCE OF INDONESIA (INA MEDICARE)

2012 - 2019
ROADMAP
TOWARD THE NATIONAL HEALTH INSURANCE
2012-2019

JOINTLY PRODUCED BY:

THE COORDINATING MINISTRY FOR PEOPLE’S WELFARE
THE NATIONAL SOCIAL SECURITY COUNCIL
THE MINISTRY OF HEALTH
THE MINISTRY OF NATIONAL DEVELOPMENT PLANNING/
THE NATIONAL DEVELOPMENT PLANNING AGENCY
THE MINISTRY OF FINANCE
THE STATE MINISTRY OF STATE-OWNED ENTERPRISES
THE MINISTRY OF MANPOWER AND TRANSMIGRATION
THE MINISTRY OF SOCIAL AFFAIRS
THE MINISTRY OF DEFENSE
THE MINISTRY OF HOME AFFAIRS
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THE REPUBLIC OF INDONESIA
THE NATIONAL TEAM FOR POVERTY REDUCTION ACCELERATION
(TNP2K) OF THE VICE PRESIDENT OFFICE
PT (PERSERO) ASKES INDONESIA
PT (PERSERO) JAMSOSTEK

SUPPORTED BY:

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INTRODUCTION AND TARGETS

In 1999, the Indonesian 1945 Constitution was amended by including the right to social security and health care for all people (article 28H) and in 2002, under the fourth amendment, the State was instructed to develop a social security system for all Indonesians. As a follow up, in 2004, the Law Number 40 Year 2004 concerning the National Social Security System was enacted. Seven years later, the Law Number 24 Year 2011 regarding the Social Security Corporation Corporations (BPJS) was enacted. The latter stipulates that PT (Persero) Asuransi Kesehatan Indonesia (commonly known as PT Askes) shall be transformed into Corporation the Social Security Corporation (BPJS) for Health (further referred as the National Health Insurane Corporation, NHIC, of Indonesia) by January 1, 2014. With the establishmen of the NHIC, Indonesia entered a new era of a single payer system to insure medical care for all Indonesian people. This system constitutes an equitable financing for all people; at the same time, the system will be able to control health care costs by its purchasing power.

It is extremely important in developing a large system the roadmap to be understood by all stakeholders and be executed in one direction as synchronous efforts to achieve the goal of INA Medicare within the expected time frame. Therefore, this roadmap serves as the manual for all stakeholders to reach universal health care for all Indonesians.

The roadmap also aims at providing measures and indicators, which need to be taken in a systematic, consistent, coherent, integrated, and measurable manner from time to time. Broadly, this road map guides:
1. Developing all standard procedures of the NHIC (BPJS Kesehatan) to be used starting on January 1, 2014;
2. The proper implementation of a National Health Insurance (further referred to as INA-Medicare) to cover all Indonesian people;
3. Administrative compliances to the Law Number 40 Year 2004 and the Law Number 24/2011 as well as all other relevant implementing regulations.

This roadmap shall serve as a reference for all parties in order to prepare themselves to play active roles before and after the January 1, 2014 in reaching the universal coverage by 2019. For that purpose, eight targets to be achieved by 2014 and by 2019 have been set. The Eight (8) Basic Targets are as follows (Table 1):

### Table 1.
Eight Basic Targets of the 2012-2019 National Health Insurance Roadmap

<table>
<thead>
<tr>
<th>TARGETS FOR JANUARY 1, 2014</th>
<th>TARGETS FOR 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The National Health Insurance Corporation shall commence its operations.</td>
<td>1. The National Health Insurance Corporation shall operate properly.</td>
</tr>
<tr>
<td>2. The National Health Insurance Corporation shall insure at least 121.6 million people</td>
<td>2. All Indonesian people (which are estimated to be approximately 257.5 million people) shall be insured by the NHIC of Indonesia.</td>
</tr>
<tr>
<td>(approximately 50 million peoples will remain be insured by other insurers)</td>
<td></td>
</tr>
<tr>
<td>3. The medical benefits shall cover all of the most efficient treatments of all diseases.</td>
<td>3. There shall be uniform benefit packages (including hospital accommodation) in order to ensure social justice for all.</td>
</tr>
<tr>
<td>TARGETS FOR JANUARY 1, 2014</td>
<td>TARGETS FOR 2019</td>
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<td>---------------------------</td>
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<tr>
<td>those who pay contributions and for non-paying members (those whose contribution are paid by the Government).</td>
<td>4. The number and distribution of health facilities (including personnel and equipments) and quality of services are acceptable to meet the needs of health care of all Indonesians.</td>
</tr>
<tr>
<td>4. To prepare and begin to implement Action Plans development to ensure facilities are available, reachable, and the quality of services are acceptable in most regions.</td>
<td>4. All implementing regulations (Government Regulations, Presidential Regulations, Ministerial Regulations, and procedures issued by the NHIC) shall have been enacted and issued.</td>
</tr>
<tr>
<td>5. All implementing regulations (Government Regulations, Presidential Regulations, Ministerial Regulations, and procedures issued by the NHIC) shall have been enacted and issued.</td>
<td>5. All implementing regulations shall have been amended periodically in order to ensure quality of services are delivered at the most appropriate prices.</td>
</tr>
<tr>
<td>6. At least 75 percent of the members shall satisfy with the services provided at the NHIC and by health care providers contracted by the NHIC.</td>
<td>6. At least 85 percent of the members shall satisfy with the services provided by the NHIC and by the health care providers contracted by NHIC.</td>
</tr>
<tr>
<td>7. At least 65 percent of the health workers and health care providers shall satisfy with and or receive appropriate payment by the NHIC.</td>
<td>7. At least 80 percent of the health workers and health care providers shall satisfy with and or receive appropriate payment by the NHIC.</td>
</tr>
<tr>
<td>8. The NHIC shall be managed in a transparent, efficient, and accountable manner.</td>
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</tr>
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</table>
MAIN ACTIVITIES

In order to achieve the above targets, the following activities will be conducted for the following aspects: laws and regulations, membership, benefit package and contribution, health care providers, as well as financial, organizational, and institutional aspects. In more detail, the main activities for each aspect are as follow:

I. THE ASPECT OF LAWS AND REGULATIONS

From 2012 through the end of 2013, the following laws and regulations will be issued:

1. The Presidential Regulation concerning the benefit package, procedures, and contribution for health coverage;

2. The Government Regulation concerning Recipients (the low income) of Financial Assistance for Contribution (Penerima Bantuan Iuran);

3. The Government Regulation pertaining to the implementation of Law No. 24 Year 2011, which regulates good governance of the Social Security Corporations. The regulations will cover both the NHIC and the Labor Social Security Corporation.;

4. The Presidential Regulation regarding the Procedures for the Selection and Stipulation of the Supervisory Board and Board of Directors of the Social Security Corporations.
5. The Presidential Regulation concerning the Remuneration of the Supervisory Board and Board of Directors of the Social Security Corporations.


7. The Presidential Decree concerning the Appointment of the current Board of Commissioners (Dewan Komisaris) and the current Board of Directors (Dewan Direksi) of PT. (Persero) Askes to become the Supervisory Board Members (Dewan Pengawas) and Board of Directors (Dewan Direksi) of the NHIC

In order to finalize all Government Regulations and Presidential Regulations, all stakeholders must reach a consensus on the main principles of all aspects by the end of 2012. In order to ensure that all people have completed understanding of the INA Medicare, all Government Regulations and Presidential Regulations concerning INA Medicare must be completed by no later than June 1, 2013. A minimum period of 6 (six) months is required for the socialization or public education regarding various aspects and procedures of the INA Medicare.

J. THE ASPECT OF MEMBERSHIP

In mid-2012, it was estimated that 151.5 million (63 percent) of the Indonesian people have had Health Insurance in various forms and with various benefit packages. In 2012, the number of population was estimated at 239.7 millions. Therefore, efforts to expand population
coverage for the remaining 88.1 million people (37 percent) and to integrate all people under the NHIC, will require coordination and synchronization. In addition, the expansion of population coverage will also be accompanied by unifying the benefit package for all.

Table 2
The Estimate Number of Population covered by Types of Health Insurance in 2012 (in Million)

<table>
<thead>
<tr>
<th>TYPES OF HEALTH INSURANCE</th>
<th>MEMBERS (MILLION PEOPLE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Civil Servant Health Insurance</td>
<td>17.3</td>
</tr>
<tr>
<td>Military/ Police health coverage</td>
<td>2.2</td>
</tr>
<tr>
<td>National Medicaid Programs (Jamkesmas) (covered by the Ministry of Health)</td>
<td>76.4</td>
</tr>
<tr>
<td>Workers’ Social Security scheme (JPK Jamsostek)</td>
<td>5.6</td>
</tr>
<tr>
<td>Local government medicaid programs (Jamkesda) (covered by various regional governments)</td>
<td>31.8</td>
</tr>
<tr>
<td>Corporate Insurance (self-insured)</td>
<td>15.4</td>
</tr>
<tr>
<td>Commercial Health Insurance</td>
<td>2.9</td>
</tr>
<tr>
<td>Total</td>
<td>151.5</td>
</tr>
</tbody>
</table>

Source: Center for Health Financing, Ministry of Health of the Republic of Indonesia, 2012

The expansion of population coverage by the NHIC and the unification of the benefit package are conducted in the following stages:

All members of the Civil Servant Health Insurance scheme, the National Medicaid beneficiaries (Jamkesmas), the workers’ Social Security scheme (JPK Jamsostek), family members of the military/police
personnel, and some regional medicaid programs (approximately the sum of $121.6^1$ million people) will be insured by the NHIC as of January 1, 2014;

1. Members of the Civil Servant Health Insurance currently managed by PT (Persero) Askes, will be automatically become members of the NHIC, since PT (Persero) Askes will be transformed into the NHIC.

2. Members/beneficiaries of the National Medicaid Program (Jamkesmas) currently managed by the Ministry of Health will be transferred to and managed by the NHIC. These members will not pay any contribution; instead, they shall receive financial assistance from the Government to contribute as members. The number of this beneficiaries (known as PBI) is proposed to increase to about 96.4 million in 2014.

3. All family members of the Military/the Police of the Republic of Indonesia currently insured by the Ministry of Defense will be transferred to and managed by the NHIC.

4. Members of Workers’ Health Insurance (JPK Jamsostek) currently managed by PT (Persero) Jamsostek shall be transferred to and managed by the NHIC as of January 2014.

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$^1$ This covers about 96.4 million people covered by expanded Jamkesmas; 17.3 million members of the Civil Servant Health Insurance; 5.5 million members of the workers’ Social Security scheme; and 2.5 million members of Regional medicaid programs.
5. In principle, all waged employees (and their family members) are mandated to contribute to the NHIC. However, since many of them are insured by their employers, enforcement to join the NHIC will be conducted gradually up to 2019. Those who are currently insured under self-insurance or private insurance schemes may join the NHIC any time between 2014 and 2019.

6. Members of the current Regional medicaid programs must join the NHIC by the end of 2016.

7. Law enforcement with administrative and public service sanctions will be conducted in a gradual manner. First, law enforcement will be coerced towards employers with large numbers of employees, but with no insurance coverage. Meanwhile, employers that currently provide health insurance through commercial insurance or self-insurance may join the NHIC any time until 2019. After that, all employers of any size must register all of their employees and their family members to the NHIC. Law enforcement will be compelled systematically, starting from employers with more than 100 employees; employers with 50-100 employees, and so forth, until all employers having only one employee (including households), register their employee(s) to the NHIC in 2019.

8. Non-waged/non-salaried workers (often known as informal sector) who obtain income from their own business shall register themselves at any time from 2014 to 2019.

9. By October 2019, there must not be any worker without health coverage by the NHIC.
K. THE ASPECTS OF BENEFIT PACKAGE AND CONTRIBUTION

1. The Benefit Package

By the end of 2012 all stakeholders agreed that the benefit package shall cover all medically necessary services. This means that if a doctor diagnoses a disease that must be treated, the most efficient treatment will be covered by INA Medicare. However, the non-paying members (those whose contribution paid by the Government PBI) will receive accommodation in a third class hospital ward. At the initial stage, the different accommodation classes is perceived necessary to maintain current schemes and to discourage people to depend on the government paying contribution for them... Meanwhile, those who pay contributions have the right to be treated in a first or second-class room, depending on the level of wages of private employees or rank of civil servants. The different class of accommodation is related to the amount of contribution that the Government pays which is at the beginning below the market values. When the Government pays contribution in the amount equal to the average contribution by salaried workers and the majority of public and private hospitals are ready to provide a uniform standard room and boards, equal accommodation will be preferred. At that time, it is expected by 2020, the Government and regional governments do no need to finance operational funds for health centers and government-owned hospitals. All of public health care providers will receive adequate payments by the NHIC to cover the operational costs. Thus, the government’s responsibility will shift from the direct provision and direct financing of services in public health care providers to the payment of contributions for the poor and the low-
income populations. The complete shift to the full demand side subsidy is expected to be achieved by 2019.

2. The Level of Contribution

The level of contributions (in term of nominal IDR for non-salaried workers and the low income and percentage of monthly salary for waged employees) constitutes the key elements for the sustainability, quality of services, impacts on new impoverishment, and improvement of the people’s productivity. If the contribution is determined without a thorough calculation, or merely by consensus, there are possibilities that the NHIC will undable to pay for health care providers adequately that in a later stage will ruin the trust to the NHIC and to the state. This disaster must be prevented by determining adequate contributions which must (1) be sufficient to pay health services in good quality at the appropriate market prices, (2) be sufficient to fund the operations of the NHIC with good quality, (3) have sufficient allocation for the reserve fund to ensure solvency in the occurrence of high unexpected claims, (4) have adequate funds for program development, operational research, or expanding benefit for new treatments. If there is excess fund (surplus) in a particular year the NHIC, will carry over the surplus for the subsequent years. That is the - not for profit principle. If the amount of reserve fund from the accumulation of surpluses becomes too large, sufficient to fund claims for 5 (five) years, then the contribution amount can be reduced or benefit levels could be increased. On the contrary, if it turns out that in the first years the revenue from all contributions is not adequate, the contributions shall be adjusted or increased. Certainly, workers and or employers have the right to
monitor and know about the financial conditions of the NHIC that must be managed in a transparent manner.

All revenues from contributions, investment incomes, and the accumulation of surplus shall be a Trust Fund, which may not be used by the NHIC or by any other party except for paying health care providers for services consumed by all members.

The expert team of the National Social Security Council (DJSN), the University of Indonesia, other Universities, the World Bank, the Askes Team, the Jamsostek Team, and the National Team for Accelerating Poverty Reduction (TNP2K) have conducted actuarial studies on the contribution levels. The National Social Security Council found that the contribution for the low income that the Government must pay is IDR 27,000 per person per month. This level of contribution is still based on the consideration that government-owned hospitals and health centers still receive funds from the governments. Other institutions found that the level of contributions ranges from IDR 19,000 to IDR 28,000 per capita per month.

Meanwhile, the contribution level for salaried workers ranges between 5-6 percent of their monthly wages. The employers propose the appropriate share between workers and employers between 2-3 percent by workers and 3-4 percent. By paying the share, the workers have a stronger power to control the NHIC. The nominal contribution amount for non-salaried workers is calculated to equal the average contribution (of the 5-6%) per person per month for all salaried workers,. As stipulated by the SJSN law,
salaried workers who have more than five persons in his/her family should pay additional contribution. Salaried workers may also insure their parents, parents-in-law, or other family members (sponsored participants) by paying additional one percent of his/her monthly wage per person per month. This contribution shall be borne only the worker since it is his/her preference. The contribution for non-salaried workers is about the average contribution per person per month of all salaried workers. During the transitional period, there will be two contribution levels, namely equal to 100 percent of the average per capita contribution for the second-class room and board and 125 percent for the first class room and board of hospital admission. Every two years, the Presidential regulation will determine the maximum wage (upper limit) for calculation of contribution, as well as the adjusted nominal contribution for non-salaried workers and their family members.

It is considered a fair health insurance system where all people are responsible for paying health care for themselves in a portion of their income. This principle will put relatively the same burden (to pay contribution) for all when they are healthy and productive. Those with smaller income contribute a smaller nominal value and those with higher income contribute in a larger nominal value, but it is about the same percentage of wage/income. There is no factors such as age, gender, or health conditions that determine the contribution. Therefore, there is a cross-subsidy or mutual sharing at the national level between the wealthier and the poorer, between the young and the elderly, and between the healthy and the sick.
L. THE ASPECT OF HEALTH CARE PROVIDERS

The second key to the successful implementation of INA Medicare is the availability of quality health services within a relatively short travel distance. The National Social Security System Law has stipulated that the NHIC shall cobtract and pay public and private health care providers at an agreed prospective price for a region. This provision (agreed prices by the NHIC and the association of health care providers) indicates that payments must be based on market prices whereby private facilities can cover all expenses incurred to provide the medical services, which vary by regions. In order to ensure efficiency, health care providers will be paid at a nominal amount per person per month (capitation) or a nominal amount per diagnosis (DRG, Diagnosis Related Groups). With the stipulation of equal rates for all health care providers in a region, there will be a competition in providing quality of services. Additionally, this system will automatically redistribute health facilities across regions. A region is defined as a market region that may cover several districts within a province or several provinces where the costs in providing services are relatively similar. The price indices developed by the Bureau of Census may be used to define a region for price determination.

Further regulations on health care providers will be developed by the Ministry of Health in line with the operation of the NHIC. Actually, at present, procedures and provisions regarding health service quality, such as hospital accreditation, have being implemented. The service quality improvement process does not have to be finished before the NHIC commence its operation in 2014. Over time, the NHIC will only contract health care providers chosen by the members based on a
credentialing process and satisfaction indices by the members. The free choices of members will encourage health care providers to improve the quality of services in order to attract members. **The key is that the Presidential Regulation must ensure members to have a freedom to choose a primary, a secondary, or a tertiary health care provider.** Objectively, the NHIC shall publish objective quality measures in credentialing and recredentialing health care providers to be contracted.

It is a reality that under the current condition, the distribution and quality of health services have not fulfilled many people’s expectations. In the previous system, every patient paid fees for services. This system resulted in the occurrence of maldistribution of doctors and health facilities. Private doctors, dentists, and hospitals competing to get patients who can afford to pay, mostly in urban areas. Furthermore, since those who can afford to pay health care are located in urban areas, health facilities are also concentrated in urban areas. The INA Medicare regulates that the NHIC shall pay for every health care used by the members, who are almost equal in number between rural and urban areas. In the future, the NHIC will pay health care providers wherever they operate at the market prices. Therefore, there will be natural redistribution of health personnel and facilities to chase the money paid by the NHIC for people who live in rural areas. The key is that the NHIC must pay health care providers at the fair market prices in which private health care providers will be reimbursed to cover their production costs.

There are sufficient numbers of health personnel and health care providers for primary and secondary care in Indonesia. Currently, there are more than 85,000 general practitioners and about 25,000 specialists
available. The numbers of dentists and dental specialists, as well as other health personnel are adequate to meet the demand for health care. The ratio of general practitioners (GP) is adequate for an ideal condition of 1 (one) doctor serving 3,000 people throughout Indonesia. The issue lies in the distribution. The distribution issue would be solved if the payment by the NHIC at the fair market values so that there will be incentive for private health care providers to provide services in underserved areas. To obtain adequate payment, adequate contribution is required.

Currently, Indonesia has more than 2,000 hospitals and nearly 3,000 health centers capable of providing inpatient care. Pursuant to the Hospital Law, health centers that equipped with beds and providing inpatient care will be transformed into community hospitals (type D). All beds in hospitals and health centers as well as in private clinics are combined, there are enough beds to population ratio of 1:1,000. The adequacy of beds can be examined by looking current hospital bed occupancy ratios (BOR) that shows that current hospital beds have not been optimally used.

The average BOR is still approximately about 70 percent. Only in big cities, BORs of some hospitals reach above 80 percent. The average high BOR in big cities has not been the effects of insurance, but it has been the effect of market, social and education level, income of the people, and access.

However, many parties claim that the number of beds still far from sufficient. They main argument is the static ratio of 1 bed per 1,000 persons, which is equal for each city/regency. It is dangerous to build
more beds if the demand for hospitalization has not deveoped yet. The current utilization data indicates the fact that the demand in some regions has not been high enough due to the unavailability of effective health insurance, difficulties in geographical access for some, cultural problems, and inadequate service quality. Therefore, we do not need to rush in to build additional beds in order to achieve the targeted ratio. The demands will increase gradually in line with the expansion of membership. Postponing health insurance expansion for the sole reason of unavailability of sufficient health facilities will violate the right of approximately 60-80 percent of the population who live within less than one hour travel time to health facilities but who have no money to pay for health care they need. The latest assessment (December 2012) by the MoH reveals the total number of beds, combined of all hospitals, clinics, and health centers, has reached 1: 1,000 ratio. Meaning that the concern of shortage of hospital beds is no longer valid.

Lessons learned from developed countries, such as in Germany and the United Kingdom that achieved universal health coverage, indicate that there are never be an equal or ideal distribution of health care providers in all urban and rural areas. So, maldistribution of health care providers occurs every where. However, the level of maldistribution is less serious in developed countries. We should not continue our efforts to improve maldistribution of health care providers but we should be aware that the ideal equal distribution of health care providers will never been achieved. In addition, when those countries started to expand health coverage, the maldistribution of health care providers also occured.

The market mechanism will automatically attract investors to build more health facilities and to look for health personnel to serve the members
(insured) in various regions where adequate services are not yet available. In 2015, the ASEAN Community Agreement will allow foreign doctors to practice in Indonesia. So, shortage of specialists will soon be fulfilled by foreign doctors. The key is, again, adequate payment at the fair market prices to all health care providers.

Pursuant to the Regional Government Law, Regional Governments are obligated to provide health facilities. In cases where the population size is too small and people live in a scattered areas where the private investor is not attracted to build a health facility; then Regional Governments are obligated to provide good health facilities. It is for the shake of their own people. Moreover, regional governments that have thus far been paying contributions for the low income are encouraged to reallocate their funds for building and rehabilitating health facilities. Or, they may pay additional salaries or incentives for health personnel so that the personnel can serve the people in the regions with better quality of services. This approach is much more equitable and effective than the demand by some regional governments to establish their own health insurance scheme.

In the end, because the reality is that there are significant maldistribution of health facilities (including health personnel), it is necessary that the government take the following actions:

1. **Ensuring the Availability and Improving Quality of Health Services**

   a. The Ministry of Health needs to map the health service availability and quality, as well as develop action plans for
health facility development. The plans will include various health personnel, medical equipments, medicines, medical supplies, and other office supplies.

b. The governments (National and regional governments) must provide information on the opportunity for private sector to establish health care facilities for the members of INA Medicare. The private sectors may increase competition on service quality for INA Medicare.

c. The NHIC and the regulations must guarantee the principle of any willing provider (any health facility willing to fulfill credentialing requirement, accept contract, and agree on the payment from the NHIC) shall be contracted. There may not be discrimination against any health facility to be contracted by the NHIC. At the same time, the health facilities must comply with the provisions of laws and regulations enforced by the national and local governments.

2. Setting Standards

a. The Ministry of Health will immediately formulate and apply medical and non-medical quality standards as well as a monitoring mechanism. All compliances to the above standards must be published so that the members can identify health facilities (including medical/dental practitioners) fulfilling the standards and select a facility among them when they need health care.
b. The Ministry of Health in collaboration with the Indonesian Medical Council (KKI, Konsil Kedokteran Indonesia) must apply the competency standards for GP and each medical speciality and monitor the compliances of the standards. The monitoring of the compliances to the standards shall be delegated to regional governments as well as the strict enforcement for non-compliances to protect the members of INA Medicare from receiving poor quality of services.

c. The NHIC must develop and publish credentialing/re-credentialing standards and guidelines for prospective health care providers. This standard must be strictly followed to ensure fair competitions among health care providers and to ensure that members will receive high quality of services.

d. The NHIC shall develop a quality control system, which includes the quality of medical services, non-medical services and other services provided by the contracted health care providers. Additionally, the NHIC must also develop a quality control system for the NHIC to serve the members in selecting health care providers, grievant procedures, and serving other parties to ensure high members’ satisfaction.

M. THE FINANCIAL ASPECTS

The core of INA Medicare is the financial aspect. Therefore, the regulations and procedures related to finance must be completed before the NHIC operates on January 1, 2014. To provide sufficient time for
employees of the NHIC to establish electronic and printed procedures, all regulations related to the financial aspects shall be finished by mid-2013. The most important aspect of finance is **transparency** of fund management and uses. Financial reports and audits must be thoroughly regulated.

Financial management needs to be performed prudently in the context of (i) ensuring the availability of sufficient and sustainable funds (long term solvency requirement); (ii) paying health care providers at the fair market prices; (iii) paying the staffs of the NHIC and procurement of goods and services at reasonable prices; (iv) ensuring efficient funds management and good risk management of the assets and liabilities; (v) sound and generally-accepted recording and reporting of all transactions; (vi) fulfilling a strong internal control system, and (vii) auditability and transparency.

In the preparation of the operations of the NHIC, the following activities must be conducted:

1. **Paying Health Care Providers**

   a. The Ministry of Health, together with DJSN, formulate general policies on payment methods, unit prices, and setting reasonable upper limits of fair market prices of health services in various regions. Price regulation (after reaching agreement between the NHIC and association of health care providers) is required maintain a balance between the Trust Fund and Health Expenditures. Long term financial balannce guarantees liquidity (ability to pay health care providers within 15 days after the
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   b. The NHIC shall allocate 0.5 percent of the total revenue, which constitutes a part of the operational budget of the NHIC for studies on the development of payment schemes, the benefits, fair contributions, and other system strengthenings. Competent public and private research institutions shall be contracted on a fair competitive basis.

2. **Funds Management:**
   a. The Government, together with the DJSN, formulate general policies on the investments of funds with optimal yields and low risks to maintain adequate liquidity and solvability of the NHIC.
   b. The Government and the DJSN review and determine the operational budget of the NHIC that may not exceed 5 percent of the total revenues from contributions.
   c. The Government and the DJSN review and determine annually the minimum technical reserve fund and all surpluses shall be accumulated as technical reserve fund.
   d. The DJSN performs periodical effective monitoring and communication as a part of the supervisory and monitoring function of the financial planning and financial performances.
3. **Financial Accountability**

a. The Ministry of Finance in collaboration with the DJSN and the NHIC develop Guidelines on Financial Recording and Reporting in as the Special Accounting Standards for Social Security. The Financial Regulation of the NHIC must comply with the law of Public Finance and must be easily accessible and understood by the public as a management transparency. One of the important aspects of Not for-Profit Legal Entity is that the surplus of the NHIC, not subject to income tax.

b. The Audit Board of Indonesia (BPK) shall train special personnel and procedures for the supervision and financial audit of the NHIC.

c. The NHIC shall develop a standard financial procedure to ensure that the NHIC is able to present systematic electronic and printed reports to the public periodically (at least every six months).

4. **Internal Control System and Report Auditability**

a. The DJSN and the NHIC shall develop Guidelines on Internal Control System to prevent mismanaging the Trust Fund

b. The NHIC shall conduct special training for employees or candidate employees of the NHIC in order to guarantee accountability and good corporate governance of the Trust Fund.
5. Fiscal Impact of the INA Medicare

a. Analyses of the fiscal impacts is required to understand and program continuity of contribution assistance for the poor and the low income as well as contribution for salaried workers. Experience of the countries that have achieved universal coverage shows that at the maturity level, the total health expenditure ranges from 6 to 11 percent of the Gross Domestic Product (GDP). The United state has not achieved universal coverage but it has been spending more than 17% of its GDP for health due to inefficient commercial health insurance systems. Most of the middle and high income countries have tax ratios above 20 percent of the GDP. Indonesia needs a fiscal study on the planning for health expenditure increase, not to decrease. Indonesia’s health expenditure has never reached 3 percent of its GDP for the last forty years. Meanwhile, the tax to GDP ratio has been also very low, at 12.3 percent. Experience from Thailand shows a positive correlation between universal coverage with high contribution from the government increases tax ratio. The study on fiscal impact must be continuously conducted, as a part of the monitoring of the National Health Account to which the standards and procedures have been published by the World Health Organization.

b. The burden for the country for the low income (PBI) if the Government pay the proposed DJSN contribution of IDR. 27,000 per person per month for 96.4 million people is only 0.3 percent of the GDP. The proposed contribution of IDR.27,000 still takes into account the Government and regional
governments funding for investments and some operational budget of the government health facilities. In the future, such operational budget shall be transferred into demand side subsidy by paying contribution for the low income and possibly all families of non-salaried workers (such is practiced in Thailand). The Government and regional governments are still responsible for fund investment of public health facilities. Fiscal studies at the central and regional levels are required during the transitional process of the allocation of demand side subsidies, health facilities budgeting, and political support for health insurance expansion. The politicians and budget decision makers need to understand that more funds are required to improve service quality for the members and those who have no insurance in the transition period. The Government is actually able but still unwilling to pay contribution for all non-salaried workers (informal sector), as conducted by the Government of Thailand. The fiscal burden for that ranges between 0.5 percent - 1 percent of GDP, depending on the level of contribution. Compared to the waste fuel subsidies that take up to 3% of the GDP it is much more beneficial to the public. The contribution assistant can prevent impoverishment of 150 million people who may go bankrupt due to no insurance coverage.

6. Preparation for the Transformation of PT (Persero) Askes into the NHIC

a. Before the NHIC commences its operations as described above, the Ministry of Finance shall establish the Special Financial Accounting Standards for the NHIC. Best practices from South Korea and the Philippines that have similar independent corporations can be good lessons. In turn, such accounting standards will facilitate improvement of the Indonesian NHA (National Health Account) to fulfill the NHA standards of the WHO and the OECD countries.
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b. The State Minister of State-Owned Enterprises or BUMN and the Ministry of Finance shall produce the Closing Financial Statement of PT (Persero) Askes as of December 31, 2013, based on financial audits by a Public Accounting Firm or the Audit Board (BPK). At the same time, the Financial Statement become the initial balance sheet of the NHIC as per January 1, 2014.

c. In the regulation and stipulation of the balance sheets, the position of the initial capital of the NHIC and changes in the capital structure must be clearly demonstrated.

N. THE ORGANIZATIONAL ASPECTS

The appropriate organizational structures and the adequacy of revenues determine whether how good the members are protected from bankruptcy. By the end of December 2013, the following must be completed: (a) the smooth transformation process from PT (Persero) Askes to the NHIC, (b) the new organization structures of the NHIC to fit the goal of INA Medicare, (c) the new information system is completed; (d) socialization (social marketing), education, and advocacy, have been
continuously performed, and (e) coordination and monitoring by the DJSN shall be effective.

1. Transition Toward the NHIC

The NHIC must be established with good corporate governance as the key to the success of INA-Medicare. Immature preparation will destroy the INA Medicare and destroy the reputation of Indonesia in the International arena PT (Persero) Askes, the DJSN, and the Government shall formulate clear and realistic policies for the transitional period to be followed-up by the Bord of Directors and management of the NHIC.

a. The preparation of the Operation of the NHIC by PT (Persero) Askes

The activities that will be conducted in preparing the operation of the NHIC, among others are:

1) Writing the standard operating system and procedures of the NHIC that constitute a renewal of the existing system toward the new vision and mission of the NHIC as a Public Legal Entity, which is to maximize the benefits to all members.

2) Conducting public education/socialization. At the first stage, to conduct socialization of INA Medicare by prioritizing the middle class before the Government Regulation and Presidential Regulation are issued.
The objective is to obtain inputs for the preparation of the standard operating procedures. The next stage is, after the Government Regulation and Presidential Regulation are issued, conducting social marketing aims at all potential members in accordance with the stages of the population coverage mentioned above.

3) Coordinating with the Ministry of Health for the transfer of the members of (Jamkesmas) to the NHIC. Although all data of Jamkesmas members are actually recorded in the database of PT Askes, a serious attention needs to be paid to the updating process using the Unique Single Identity Numbers (NIK, Nomor Induk Kependudukan) that are assigned by the Ministry of Internal Affairs.

4) Coordinating with PT (Persero) Jamsostek for the transfer of the members of JPK Jamsostek to the NHIC. Conceptually this transfer is simple, it is just changing registration process by the employers and payment of contribution from to the account of PT Jamsostek and to the account the NHIC. However, undesirable deviations must be anticipated.

5) Coordinating with the Ministry of Defense, the National Army in Chief, and the National Police for the transfer of members of armed forces and civil servants within the Ministry of Defense along with their family members to the NHIC.
6) Coordinating with various regional governments that have provided medicaid, either managed by PT Askes or using otherschime, for the transfer of the members to the NIHC.

7) Identifying and renewing contracts with health care providers currently contracted by the Ministry of Health and by PT Jamsostek so that the members may continue to receive care from those health care providers when the NHIC commences its operation.

8) Amending and renewing the By-Laws of PT Askes Indonesia to become the By-Laws of the NHIC by adjusting the rules and targets in accordance with the SJSN Law, the BPJS Law, and this Roadmap.

9) Changing the attributes of Askes and designing new attribute of the NHIC, by a contest for finding a new logo and jargon that are easy to understand and to remember by the members.

10) Developing an information system regarding participants, health care providers, diseases’ patterns, utilization patterns, claims processing, financial reporting, and other necessary indicators for the management. The newly integrated information system must include information regarding contribution receipts, payments, service claims, monitoring of
utilization and service quality, monitoring of members’ satisfaction, epidemiologic profiles, national health account, producing data for research on various aspects of health care, etc.

11) Constructing new branch offices and providing human resources who understand social security systems, the SJSN Law, the BPJS Law, the unique characteristics of health care, and who can fulfill the required competencyies in executing the INA Medicare.

b. Transfer of assets and liabilities, employees, as well as the rights and obligations of PT (Persero) Askes to the NHIC by PT (Persero) Askes based on a legal document.

In the context of this transfer, it is necessary to take the following measures:

1) Appointment of a Public Accounting Firm or the Audit Board to conduct audit and produce:

   a) Closing Financial Statements of PT (Persero) Askes;

   b) Opening Financial Statement of the NHIC; and

   c) Opening Financial Statement of the Health Fund;
2) Validation of the Closing Financial Statements of PT (Persero) Askes by the Minister of State-Owned Enterprises;

3) Validation of the Opening Financial Statements of the NHIC and the Opening Financial Statements of the Health Funds by the Minister of Finance;

c. Appointment of the Supervisory Board and Board of Directors of the NHIC by the President;

For the first time, the Board of Commissioners and Board of Directors of PT Askes shall be appointed to become the Supervisory Board and Board of Directors of the NHIC for a maximum period of 2 (two) years. In the context of such appointment, it is necessary to prepare successors of the members of the Board of Directors and Board of Commissioners who have good knowledge on social health insurance and strong commitment for INA Medicare so that they will ensure good corporate governance of the NHIC. A

The Draft Presidential Decree shall also be immediately prepared, which shall be coordinated with the Ministry of State-Owned Enterprises, the Ministry of Health, and the DJSN.

d. Establishment of PMO (Project Management Office)

The process of transformation from PT Askes to the NHIC requires special attention from all parties managing health
insurance. In order to ensure effective implementation of the transformation, PT (Persero) Askes, together with the Ministry of Health and PT Jamsostek, needs to establish a PMO (Project Management Office). The PMO prepares the procedure and process in order to ensure that the transfer of members (of Jamsostek and Jamkesmas) can take place in time, does not interrupt coverage and stays within the corridor of efficient expenditure. This unit also conducts monitoring of nascent issues in the field, in the context of membership and utilizing health care from previous health care providers.

PT. (Persero) Askes shall establish a PMO as an *ad hoc* unit with the following main duties:

1) Prior to January 1, 2014, the PMO shall ensure that all currently registered members of JPK Jamsostek, Jamkesmas, and Jamkesda, as well as Askes are registered accurately with more complete information in the new information system of the NHIC.

2) Extending the contracts of health care providers that they signed with PT Jamsostek and or the Ministry of Health.

3) After January 1, 2014, PMO staffs will provide technical support for the operations of the NHIC related to the updating process of membership until the maximum period limit of one year when all issues
related to membership and services by the health care providers run smoothly.

2. Organizational Development of the NHIC

Preparation of the organization of the NHIC will be conducted by PT Askes together with the Ministry of Health, the Ministry of Finance, the State Ministry of State-Owned Enterprises, and the DJSN which include the following actions:

a. Developing of the organizational structure of the NHIC, which is consistent with the laws and regulations, as well as an effective and efficient expansion strategy for population coverage.

b. Analyzing of the needs for human resources of various qualifications (accountant, public relation officers, actuary, verificator, administration, information system, health economist/health technology assessment, analyst, etc.) and the strategy to recruit them timely.

c. Arranging competence-based career development for managerial and non-managerial positions with clear functions and responsibility.

d. Planning additional offices (branch offices and sub-branch offices) based on workload, number of members, and geographical conditions.

e. Formulating and developing new organizational culture with the main goal of excellences in serving the members, and ensure high satisfaction to the NHIC services and to the services provided by the health care providers.

f. Formulating human resources requirements, procedures for recruitment and open recruitments of managerial positions based on competence (not bound to the status of the employees of the NHIC).

g. Establishing additional offices staffed with competent human resources.

h. Analyzing and publishing regularly performances of the NHIC which include access and quality measures received by members in various regions, management efficiency, members’ satisfaction, and cost-effectiveness of care provided.

i. Developing indicators and monitoring process of GCG (Good Corporate Governance) of the NHIC as well as monitoring service quality provided by the contracted health care providers. Such monitoring may be conducted by internal and or external reviewers.
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3. Information System Development

An information system is the nervous system of the INA Medicare and therefore it must be designed properly so that the NHIC will be responsive to shortcomings and errors. Furthermore, the INA
Medicare must also be open and transparent, allowing research institutions to use the data available in the NHIC for research and development of the INA Medicare. Therefore, it is necessary that PT Askes to conduct the following steps:

a. Designing the blueprint of the information system that includes human resources, infrastructure, and web based application to allow members obtain information with minimum bureaucracy, timely, and accurate. The use of the Single ID number (NIK) and biometric-identification online provides easy update and communication between members and the NHIC.

b. Formulating and Developing the Business Process of the NHIC which includes the human resources needs, software, hardware, continuity, budget, and procedures for data collection and processes.

c. Ensuring the availability of the INA Medicare Warehouse at the national and regional levels providing information based on demographics, geographics, and health care uses accurately and timely.

d. Interconnecting information system or online connection of PT Askes, health care providers and related institutions to accelerate the cooleting contribution, claim submissions, claim payments, and utilization reviews.
4. Social Marketing, Education, and Advocacy

Investment in social marketing is another key to the success of the INA Medicare due to the low level of understanding and level of education of the population. The NHIC and the government must allocate sizable fund that is more than that of the family planning in the past. The INA Medicare must be understood and supported by all population. Proper social marketing will provide full understanding and awareness to the members’ participants and employers of their rights and obligations. Social marketing is equal to marketing of commercial products. As to commercial products, marketing budget for a new product may reach 30-50 percent of production costs. With adequate marketing, product sales reach the expected target and business achieves the expected profit. Learning from the commercial model, the INA Medicare must conduct adequate social marketing.

To achieve broad understanding and awareness of the INA Medicare, social marketing must be conducted in two big stages:

a. The stage of social marketing to key stakeholders, namely, prominent figures and leaders of labor unions, employers, academicians, activists of non-government organizations, and government officials at the central and regional levels. The development of laws and regulations must take inputs from those groups by through face-to-face workshops, road shows, and publication on certain printed and electronic media, with the target groups of the middle or higher classes.
b. The social marketing to the general public shall be performed after the laws and regulations have been issued, health care providers/personnel have been contracted, standard system and procedures have been completed and tested, as well as printed information is available. Health facilities and health personnel working at health facilities or individual practitioners will be trained to understand various aspects of benefits, including the procedures. This social marketing will be conducted using simple and easily comprehensible language. A success model or testimony constitutes one of the forms that can attract attention of the public such as workers, retailers, farmers, fishermen, and the community in general. In this stage, the echo of one a song or jingle will encourage every person to actively register to be a member.. Slides, posters, short movies, content of movies or TV shows, talk shows, text books, and various printed materials referring to one standard source need to be produced and distributed (placed on a website) in two languages (Indonesian and English). The above information will be used to inform investors, researchers, politicians, and activists of non-government organizations; whose support is critical to the success of universal coverage in Indonesia.

Social marketing and advocacy, until mid-2013, the following activities will be conducted:

a. Developing strategies for social marketing and advocacyies.
b. Producing social marketing and Advocacy materials.
c. Developing organization/team and budget for social marketing and Advocacy.

d. Monitoring and evaluation of social marketing and Advocacy.

5. Coordination, Monitoring, and Reviews

During the process of developing laws and regulations, standard procedures, ensuring availability and quality of health care providers, social marketing, etc., the DJSN and other stakeholders will conduct:

a. Developing Standard operating procedures and Supervision Mechanisms of the NHIC by the DJSN.

b. Formulating Key Performance Indicators of the NHIC.


d. Monitoring and coordinating preparation activities by various ministries and other relevant institutions to ensure consistency with this Roadmap.

e. Supervising and Evaluating of the performance of the NHIC in the preparation and implementation of the INA Medicare.

f. Analysing the Reports of produced by the NHIC.
CONCLUSION

The Roadmap is produced to ensure that all stakeholders act in a coordinated and integrated manner in order to achieve the goal of INA Medicare, which is to eliminate impoverishment of Indonesian when a severe illness occurs. A thorough understanding of all stakeholders regarding the INA Medicae is absolutely required. All stakeholders, including employers and employees, must play active roles in ensuring consistent implementation of this roadmap. In addition, academicians, journalists, professional organizations, and community organizations who are concerned with the future of this nation must also, together with the government and the NHIC, ensure that INA Medicare is implemented in consistent with the laws and regulations. May the Almighty God bless us all in achieving equitable and universal health coverage in Indonesia.
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