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A publication in the German Health Practice Collection

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GERMAN HEALTH PRACTICE COLLECTION

Working together to generate and share learning

The German Health Practice Collection (GHPC) is a joint initiative of the German Federal Ministry for Economic Cooperation and Development (BMZ) and its implementing agencies, the *Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH* and KfW Development Bank (KfW), which are known collectively as German Development Cooperation (GDC). Since 2004 the Collection has involved experts working in German-supported health and social protection programmes in a collaborative knowledge management process, seeking to identify, document and share knowledge generated during the implementation of programmes around the globe.

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Every one or two years GIZ and KfW staff from around the world are invited to submit and jointly discuss proposals for experiences they believe should be documented in detail. Through their active participation in the selection process, they help to turn the Collection into a co-creation whose case studies reflect issues and themes which the community regards as worthwhile.

Guided by this assessment of the proposals' merits, BMZ decides which proposals will be documented. Professional writers are contracted to develop the case studies in cooperation with programme staff and their partner institutions. Prior to publication, independent peer reviewers who are international experts in their fields review the case studies and comment upon the new insights which have been generated.

● ***Front cover photo:*** *Mari Elka Pangestu, Indonesian Minister of Trade, and Bernd Rürup, German social policy and social security expert, at consultations on social standards for the ASEAN economic community in Jakarta in August 2008.*

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Acronyms and abbreviations

AOK	*Allgemeine Ortskrankenkasse* (major public health insurance company), Germany
BAPPENAS	*Badan Perencanaan Pembangunan Nasional* ('Ministry of National Development and Planning') Indonesia
BMZ	Federal Ministry for Economic Cooperation and Development, Germany
BPJS	*Badan Penyelenggara Jaminan Sosial* ('Social Security Carrier'), Indonesia
CEO	Chief Executive Officer
DDD	Doing Development Differently
DJSN	*Dewan Jaminan Sosial Nasional* ('National Social Security Council'), Indonesia
GDC	German Development Cooperation (comprising BMZ, GIZ and KfW)
GDP	Gross Domestic Product
GIZ	*Deutsche Gesellschaft für Internationale Zusammenarbeit GmbH*
GTZ	*Deutsche Gesellschaft für Technische Zusammenarbeit GmbH* (now GIZ)
ILO	International Labour Organization
InWEnt	*Internationale Weiterbildung und Entwicklung GmbH* / Capacity Building International (now part of GIZ)
JKN	*Jaminan Kesehatan Nasional* ('National Health Insurance'), Indonesia
KfW	KfW Development Bank
MIS	Management Information System
MP	Member of Parliament
NHA	National Health Authority (India)
OOP	Out-of-pocket
PM-JAY	*Pradhan Mantri Jan Arogya Yojana* ('Prime Minister's Health Programme for People'), India
QR	Quick Response
RSBY	*Rashtriya Swasthya Bima Yojana* ('National Health Insurance Programme'), India
SDG	Sustainable Development Goal
SECC	Socio-Economic Caste Census (India)
SHA	State Health Agency (India)
SNA	State Nodal Agency (India)
UHC	Universal Health Coverage
UN	United Nations
UNEP	UN Environment Programme
USP	Universal Social Protection
UNDP	United Nations Development Programme
WHO	World Health Organization

Executive Summary

BOX 1. KEY LEARNINGS

This comparative review of GDC's experience in India and Indonesia yields four broad lessons for how German technical cooperation can position itself and what type of support it can deliver to advance social health protection in partner countries:

- **The pursuit of Universal Health Coverage (UHC) is primarily a political, rather than a technical undertaking**. German Development Cooperation (GDC) support to UHC reforms in India and Indonesia has been most effective when the advisors had a deep understanding of the dynamics of the local context and purposefully engaged in the political-administrative reform process with a solution-focused, adaptive, and politically informed approach.

- **Working through well-connected and respected national staff with deep subject-matter expertise yields results**. Indian and Indonesian advisors and team leaders have been central to the effectiveness of GDC's support. They have facilitated change processes and helped to translate and link GDC's international expertise and experiences to local reform processes. Even where inputs from international advisors proved to be critically important, they took care to maintain a low profile and ensured that GDC's work was seen as part of and supportive of the agenda driven by the respective country.

- **The effectiveness of GDC's support was built on long-term in-country commitment, flexibility, responsiveness to partners' needs, and trust**. GDC advisors were respected as 'neutral brokers' who were committed to their partner's UHC agenda. GDC staff were granted insights into many of the core decision-making processes and were allowed to provide technical support to shape both countries' health schemes in pursuit of UHC because the partners trusted them. Short-duration projects and narrowly defined results frameworks could undermine the defining characteristics of what made GDC support to large-scale UHC reforms effective in India and Indonesia: taking a long-term, impact-focused approach and committing to genuinely partner-led processes with flexibility over time and resources.

- **While GDC's work with individual 'champions' has significantly helped to advance UHC efforts in each country, strengthening institutional capacities has proven to be critical to ensure sustainability** of the progress towards UHC. When leading figures transition out of their UHC roles or their political fortunes change, institutional mechanisms must be in place to maintain the reform momentum and manage the social health protection schemes.

THE CHALLENGE: THE COMPLEXITY OF PURSUING UNIVERSAL HEALTH COVERAGE

Health is a human right. Yet nearly half the world's population currently does not have full coverage of essential health services and about 100 million people are pushed into extreme poverty (having to live on US$1.90 or less a day) each year due to healthcare expenditures. In 2005, India and Indonesia, along with other World Health Organization (WHO) member states, subscribed to the goal of Universal Health Coverage (UHC): ensuring that all people have access to healthcare without suffering financial hardship paying for it.

Attaining UHC is a highly complex and lengthy undertaking that raises numerous systemic – and redistributive – questions about how a state intends to fulfil a basic human right of its citizens. Therefore, supporting UHC reforms as a development partner is not merely a technical but also a political task.

German Development Cooperation (GDC)[1] has accompanied India's and Indonesia's efforts to reach UHC since the beginning of their endeavours in this direction. This case study retraces key moments, successes and challenges experienced by the GDC teams supporting the two countries' UHC reforms and seeks to generate insights into how technical cooperation can position itself and what it can deliver to effectively support large-scale, long-term social health protection reforms in partner countries.

THE RESPONSE: FLEXIBLE, LONG-TERM SUPPORT TO LARGE-SCALE SOCIAL HEALTH PROTECTION REFORMS

In India, the government introduced *Rashtriya Swasthya Bima Yojana* (RSBY) in 2008 to provide publicly funded health protection to poor and informal workers and their families. At its peak, the scheme was operational in 25 out of 36 Indian states and union territories and covered 41 million households, or about 135 million individuals. After some political and administrative changes, a more comprehensive national health scheme was launched in September 2018 as part of the *Ayushman Bharat* ('Long Live India') initiative: *Pradhan Mantri Jan Arogya Yojana* (PM-JAY) provides coverage for inpatient care to over 500 million poor and vulnerable beneficiaries. As of December 2019, 110 million individuals had already been verified as eligible and have been issued a card confirming their entitlement to receive benefits under PM-JAY. The second component of *Ayushman Bharat* reflects the government's plan to provide comprehensive primary care, with the planned establishment of 150,000 'Health and Wellness Centres' across India.

In Indonesia, the fragmentation of the country's health and social protection system – catering only to selected groups, such as civil servants and the military – left large parts of the population exposed to the devastating effects of the 1997 Asian financial crisis. It took over 10 years and a delicate political process to arrive at a new social security law that mandated universal coverage for all, the establishment of a National Social Security Council, the transformation of some of Indonesia's most powerful parastatal companies and service providers into public trusts and finally the 2014 launch of *Jaminan Kesehatan Nasional* (JKN), the national social health insurance scheme that aims to cover all 270 million Indonesians. By March 2020, JKN had insured 223 million people, or 83% of the universal coverage target.

In both countries, German-supported advisors stayed engaged for over 10 years and provided flexible technical assistance, as legal frameworks needed to be developed and administrative procedures drafted. Vast amounts of data had to be analysed and management structures set up that could ensure the functionality and operational viability of the new schemes to serve over half a billion users.

WHAT HAS BEEN ACHIEVED

By acting as 'neutral brokers', GDC has enabled processes and platforms that **brought divergent interests together to establish common ground**, and helped its partners find viable, durable solutions to regulatory and operational UHC challenges.

GDC has contributed substantial technical expertise to India's and Indonesia's UHC reforms, grounded in extensive experiential learning. German-supported national advisors have played decisive roles in **contributing knowledge, translating international expertise into the local context**. They have **facilitated change processes as respected conveners and subject matter experts** and helped to design solutions that were technically sound and politically viable.

GDC advisors helped their partners find **viable solutions to regulatory and operational challenges** by committing themselves to partner-led processes – often of unknown duration and uncertain outcome – which they helped to advance as 'honest brokers without a hidden agenda'. While always maintaining their impartiality, they clearly positioned themselves as proponents of the ultimate goal of attaining UHC.

Strengthening partners' institutional capacities has enabled them to take social health protection to scale. In some instances, GDC advisors became integral parts of India's and Indonesia's UHC management and implementation arrangements, in India so much so that they filled key roles in supporting the government to operate the scheme while dedicated institutional capacity was not yet available. GDC then worked closely with the Indian government in setting up the National Health Authority as the responsible body to manage PM-JAY. In Indonesia, dedicated efforts to strengthen institutional capacities were successful for certain actors, empowering the National Social Security Council during a critical phase of the UHC reform process.

[1] GDC comprises the German Federal Ministry for Economic Cooperation and Development (BMZ) and its implementing agencies, the *Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH* and KfW Development Bank (KfW).

Rationale for this case study

In late 2018, a group of experts from the German Federal Ministry for Economic Cooperation and Development (BMZ), the *Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH* and the KFW Development Bank (KFW) came together to discuss the situation in countries where German-supported technical cooperation had contributed to social health protection reforms. The group was particularly interested in learning from the examples of India and Indonesia, both of which had recently undertaken major initiatives to move towards Universal Health Coverage (UHC). German Development Cooperation (GDC) has supported both countries from the early stages of their UHC endeavours.

This case study was commissioned to explore and compare the lessons that can be learned from technical cooperation in accompanying two very different countries on their paths towards UHC. It seeks to answer the question of how technical cooperation can position itself and which ways of working are effective to support large-scale, long-term and complex social health protection reforms in partner countries.

SIX SLEEPLESS MONTHS TO MAKE IT HAPPEN

One September evening in 2018, a small group of senior Indian government officials, development partners and health sector professionals were gathered at a private residence in New Delhi. The atmosphere was joyful as glasses clinked and light-hearted conversation filled the room. The guests' faces beamed with expressions of accomplishment and relief, but they also bore the signs of

→ *National Health Authority CEO Dr Indu Bhushan (centre) lights a ceremonial lamp to open a workshop on national health insurance, together with GIZ principal advisor Dr Nishant Jain (bottom left) and staff members of the NHA.*

countless sleepless nights. For the past half year, this group of individuals had worked together tirelessly and at times frantically, determined to achieve the goal that had been set for them and the people of India. What had seemed impossible at first, given the short timeframe and the immensity of the task, had become a reality. The host of the informal gathering proposed a toast: 'Today, we have launched *Ayushman Bharat, Pradhan Mantri Jan Arogya Yojana* (PM-JAY), India's new national health scheme. Over 500 million people will have better access to healthcare, thanks to your hard work, dedication and professionalism. It is also thanks to GIZ without whose support this would not have been possible' said Dr Indu Bhushan, Chief Executive Officer (CEO) of India's National Health Authority.

Six months earlier, Dr Nishant Jain, programme director of the GIZ-supported Indo-German Social Security Programme[2], had felt a jolt of excitement when he heard the budget speech of India's late finance minister Arun Jaitley on 1st February 2018. Somewhere in the middle of his address, in merely five sentences, the minister announced a grand new National Health Protection Scheme to be funded by the government in its efforts towards attaining UHC. In the course of the 2018/19 fiscal year, he said that the scheme would be established to provide family health coverage worth up to 500,000 rupees for half a billion poor and vulnerable families (Government of India, 2018, p. 11).

News outlets around the world picked up on the momentous promise buried in Jaitley's speech. The same day, the Washington Post reported on the 'potentially transformative upgrade' of India's health system, but also quoted a sceptical economist who predicted 'there's no way this can happen in a year' (Doshi, 2018). Yet Jain felt confident because he had supported a similar effort once before: in 2007 GDC had started working with the Indian government in designing and implementing an earlier health protection scheme, *Rashtriya Swasthya Bima Yojana* (RSBY), at the time dubbed one of the 18 most innovative social security schemes worldwide by the United Nations Development Programme (UNDP) and the International Labour Organization (ILO). Therefore, Jain was determined to enlist GDC support again to make PM-JAY become a reality.

"The Washington Post reported on the 'potentially transformative upgrade' of India's health system, but also quoted a sceptical economist who predicted 'there's no way this can happen in a year'.

62 FORMAL MEETINGS AND INNUMERABLE COFFEE TALKS

GIZ's advisors in Indonesia often felt similarly awed by the challenges but also the opportunities they encountered, albeit over a longer time span. For decades, post-independence Indonesia had grappled with highly fragmented health and social protection schemes that covered only selected segments of the population. When a constitutional amendment in 1999 established the right to healthcare and social security for all, Paul Rueckert, German technical cooperation's then principal advisor for health, saw an opening. While many regarded the constitutional change as a lofty, distant promise that would take years to materialise, Dr Rueckert began working with a small number of Indonesian experts who had started to develop ideas on how social health protection could become a reality. Finally, in 2002, a further amendment to the constitution mandated the state to introduce a social security system, creating the political space to begin working in earnest towards a national social health protection scheme.

As this was new territory for stakeholders in Indonesia and one of the first ventures into national health insurance for GDC at the time, a sense of exhilaration often filled those involved. Rueckert recalls having to meet many of his counterparts in the early hours of the morning, usually around 6 AM, to brainstorm options for what a national health insurance scheme could be like. Then everyone had to go back to their 'day jobs'. Their work culminated in the passing of Indonesia's landmark social security law of 2004, providing the legal grounds for establishing the National Social Security Council (*Dewan Jaminan Sosial Nasional*, DJSN) and laying the foundations for the 2011 social security carrier law that did away with the fragmentation of Indonesia's social protection landscape. The 2011 legislation also envisaged the creation of one coherent national health insurance scheme by 2014. However, it had not been decided *how* this transformation should be organised.

Cut Sri Rozanna (henceforth referred to as Ibu Aya, as her colleagues and counterparts call her), current principal advisor of the GIZ-supported social protection project in Indonesia, played a key role in preparing the country's strategic 'Roadmap' towards national health insurance. The process of developing the Roadmap provided a platform for stakeholders from the different government ministries and agencies who were managing the existing social security schemes (all with strong vested interests in the status quo) to exchange ideas and concerns and to reach a consensus about the makeup of the new system.

[2] GIZ implements its programmes and projects in India and Indonesia on behalf of BMZ.

→ *Dr Chazali Situmorang, then Chairman of Indonesia's National Social Security Council, at the launch of the 'Roadmap' towards national health insurance, 2012.*

To come to an agreement, Ibu Aya recalls that it took her and the team of experts who drafted the roadmap together with DJSN a series of 62 formal meetings plus countless 'coffee talks' – as the informal off-site gatherings are called that allow sensitive issues to be discussed frankly and directly while avoiding the formalities of bureaucratic proceedings.

The Roadmap was finalised in 2012, jointly launched by six ministers, and constituted a major milestone in operationalising the previous legal commitments to universal social health protection. The document charted the necessary steps that had to be taken to realise the launch of Indonesia's national health insurance *Jaminan Kesehatan Nasional* (JKN) in 2014, signifying a big leap forward towards UHC.

A *Lancet* review of the evolution of social health protection in Indonesia summarises the experience: 'In Indonesia, the pathway towards UHC was marked by a combination of political opportunism, local experimentation, compromise, and sheer coincidence' (Agustina et al., 2019).

HOW CAN TECHNICAL COOPERATION ADD VALUE TO COMPLEX SOCIAL HEALTH PROTECTION REFORMS?

The progress made by India and Indonesia towards UHC is spectacular. Two of the world's largest and most populous nations took on the challenge of providing social health protection for hundreds of millions of people in record time. They could partly build on existing schemes but had to develop many components from scratch. In both countries, legal frameworks needed to be elaborated and administrative procedures drafted, vast amounts of data had to be analysed, and management structures set up that could ensure the operational viability of the new schemes to serve up to half a billion users.

Germany has supported India's and Indonesia's efforts towards UHC from the outset, cognisant that the pursuit of UHC is as much a political as a technical issue (Kirton & Kickbusch, 2019). GDC advisors in both countries understood that sustainable social health protection systems cannot be set up 'from the outside' but emerge from local initiative, ownership and technical leadership.

This case study examines the experiences of GDC teams in India and Indonesia as they supported their partners in advancing the UHC ambitions of their countries. Neither example is a perfect success story, but by retracing key moments in their trajectories the study seeks to generate insights into where and how technical cooperation can make a difference, given the complexity and non-linearity of large-scale social health protection reforms. Therefore, this case study takes an inductive approach to learning from implementation. Through the lens of a simplified cyclical model of public policy management, the study critically reviews the contributions and challenges of German technical cooperation at each stage of the UHC reform process.

In both countries, the mode of engagement of the German-supported advisors often resembled a 'smart implementation' approach. 'Smart implementation', first used by German technical cooperation around 2009 (Ernsthofer & Stockmayer, 2009; Frenken & Müller, 2010) is closely aligned with the Doing Development Differently agenda that has emerged in the international development field since 2010 (DDD Manifesto, 2014: see Box 2).

Smart implementation acknowledges that development initiatives unfold in complex environments and that programmes and projects need to take complexity into account, fundamentally acknowledging the non-linearity of development. To be successful, they must be problem-driven, adaptive, and politically informed, responding to the dynamics and conditions of local contexts (Andrews et al., 2017). GIZ thus encourages partners and advisors to take joint responsibility for programme implementation, adapting management based on iterative learning loops and developing incremental approaches and instruments instead of ready-made solutions that are 'transplanted' as 'best practices' from elsewhere. Smart implementation also means that, as partners and advisors pursue their goals incrementally, milestones and results may differ from what the original programme design had envisaged (Kirsch et al., 2017), an issue that can sometimes lead to tensions between the technical implementing agency (GIZ) and the commissioning institution (BMZ).

CASE STUDY METHODOLOGY AND STRUCTURE

This paper pursues a qualitative, project implementation case study approach, applying a simplified policy cycle model (cf. chapter on 'Supporting large-scale social health protection reforms: learning from implementation'). The study is based on 28 in-depth key informant interviews in India and Indonesia and a thematic review of literature on UHC and social health protection mechanisms in both countries, as well as a review of project documentation.

The case study is structured as follows. The next chapter provides an overview of the UHC concept: what it is, how countries can make progress towards UHC and how it is measured. The following chapter reviews the steps taken by India and Indonesia to attain UHC and where they currently stand. The next chapter is the centrepiece of the case study: it retraces the implementation process of the large-scale social health protection reforms in India and Indonesia through the lens of a simplified policy cycle, identifying where and how technical cooperation was able to add value to the partner-led UHC endeavours. A brief final chapter outlines the two countries' remaining challenges on the path to UHC and GDC's potential role in this journey. The study wraps up with a peer review by two independent experts in the domain of social health protection.

BOX 2. THE DOING DEVELOPMENT DIFFERENTLY (DDD) MANIFESTO

An emerging community of development practitioners and observers found that development initiatives that achieve real results usually involve many players – governments, civil society, international agencies and the private sector – working together to deliver real progress in complex situations and despite strong resistance.

In practice, successful initiatives reflect common principles for more effective development cooperation in complex settings:

- Focus on solving local problems that are debated, defined and refined by local people in an ongoing process.
- Legitimise reform at all levels (political, managerial, social), building ownership and momentum throughout the process to be 'locally owned' in reality (not just on paper).
- Work through local 'convenors' who mobilise all those with a stake in progress (in both formal and informal coalitions and teams) to tackle common problems and introduce relevant change.
- Blend design and implementation through rapid cycles of planning, action, reflection and revision (drawing on local knowledge, feedback and energy) to foster learning from both success and failure.
- Manage risks by making 'small bets', pursuing activities with promise and dropping others.
- Foster real results – real solutions to real problems that have real impact: build trust, empower people and promote sustainability.

(DDD Manifesto, 2014)

Universal Health Coverage: definition, determinants and progress at global level

People in most countries rate health as one of their highest priorities, second only to economic concerns such as low incomes, unemployment or not being able to maintain one's living standard (Brodie et al., 2007). For many, healthcare is – even before poverty and education – the primary reason to become politically active (Pew Research Center, 2018). It is therefore not surprising that health frequently becomes a political issue as governments try to meet the expectations of their constituents. In 2005, World Health Organization (WHO) member states committed to develop their health financing systems so that all people would have access to health services and not suffer financial hardship paying for them (WHO, 2005), a principle that later culminated in the globally accepted goal of UHC (WHO, 2010; UN General Assembly, 2015).

> About 100 million people worldwide are pushed into extreme poverty each year due to catastrophic health expenditures.

The relevance and urgency of UHC has been extensively researched and widely publicised (for references see WHO, 2014): while nearly half the world's population currently does not have full coverage of essential health services, each year about 100 million people are still being pushed into extreme poverty (having to live on US$1.90 or less a day) because of their healthcare costs (WHO, 2019f). More than 800 million people spend at least 10% of their household budgets to pay for health-related expenses (Ibid.). Consequently, all UN member states have included UHC among their Sustainable Development Goals (SDG) and have committed to try to achieve universal coverage by 2030. UHC forms an integral building block of Universal Social Protection (USP), that aims to cover all people for all risks (Ulrichs & White-Kaba, 2019).

WHAT IS UHC?

For a time, policy-makers, practitioners and academics did not agree on a common definition of what constitutes UHC. Disagreements existed, for example, on which services should be included in the benefit package and which population groups should be covered. Countless concepts were in use (Stuckler et al., 2010). Despite the initial conceptual differences, WHO's aspirational and comprehensive definition has eventually become widely accepted (WHO, 2010) (Box 3).

BOX 3. CORE CONCEPTS OF UHC

'Universal health coverage (UHC) means that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship' (WHO, 2019g).

UHC does not mean that coverage is necessarily free for everyone and for all possible health interventions, regardless of the cost. No country could maintain a system that offers all services without any user contributions on a sustainable basis.

This definition of UHC embodies three related objectives:

1. Equity in access to health services – everyone who needs services should get them, not only those who can pay for them;
2. The quality of health services should be good enough to improve the health of those receiving services; and
3. People should be protected against financial risk, ensuring that the cost of using services does not put people at risk of financial harm.

The WHO 'Cube diagram' (Figure 1) has become a globally recognised, simplified visual representation of health policy choices: the services covered, the population covered, and the proportion of costs covered. Pursuing UHC can be thought of as 'filling the Cube', i.e. increasing the proportion of the population that is covered, expanding the range of available services and raising the proportion of the cost covered.[3]

> UHC does not mean that coverage is free for everyone and for all possible health interventions.

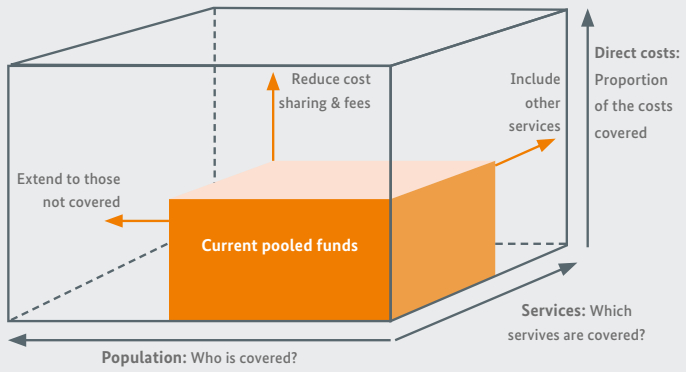
Pursuing UHC requires strengthening several health system functions, as discussed in the next sub-section. Since resources are finite, governments' decisions on how to move towards UHC inevitably involve trade-offs, for example, whether to cover a broader range of services or a larger proportion of the population, or whether to pay for a higher share of the health service costs while narrowing the eligibility criteria. Therefore, each country's strategy to achieve UHC is unique, based on its context, means and political preferences.

HOW DO COUNTRIES MAKE PROGRESS TOWARDS UHC?

UHC is centrally but not exclusively concerned with financing. Health system financing for UHC includes at least three critical elements: revenue collection, pooling of resources and purchasing of services (WHO, 2007). The availability of resources is a fundamental prerequisite for moving towards UHC: without financing and efficient allocation, coverage cannot be expanded – or it would come at a prohibitive cost to the users. Therefore, governments need to reduce out-of-pocket payments and ensure the efficient and equitable use of resources. On the other hand, no amount of money can deliver quality service coverage if skilled health workers are not available or facilities are not within geographical reach of the population.

All functions of the health system must be strengthened for attaining UHC (WHO, 2014). In addition to financing, the four key functions include health service delivery, development of human (the health workforce) and physical (health facilities) resources, and what WHO calls 'stewardship': setting and enforcing rules and providing strategic direction for all actors involved (WHO, 2000; WHO, 2006; Campbell et al., 2013).

FIGURE 1. THREE DIMENSIONS TO CONSIDER WHEN MOVING TOWARDS UHC (THE WHO 'CUBE') (WHO, 2010)



Adapted from WHO (2010)

Progress towards UHC is also subject to political economy dynamics, just as in any other public policy domain. This is of particular interest to this case study because the effectiveness of technical cooperation in support of UHC reforms depends on the extent to which political economy influences are considered and built into the programme or project design. The political economy of UHC has been studied from a variety of disciplines, including sociology, political sciences and public health. Its determinants of UHC can be broadly grouped into four categories (Stuckler et al., 2010):

- Social democratic / left-labour coalitions: Left-leaning political decision-makers tend to prioritise greater redistribution of wealth and social protection, including healthcare. A related tendency is that policy-makers expand UHC as an antidote to social discontent arising from high levels of social inequality (Navarro, 1989).

- Political regimes and social cohesion: Differences in political regime types – for example, parliamentary democracy, congressional democracy, presidential governance, dictatorship, etc. – influence policy outcomes and can lead to different health protection policy preferences. The political science literature also suggests that the successful implementation of social redistributive policies significantly depends on a society's degree of ethnic fractionalisation, geographic factors of proximity, and the ability to form labour unions. Redistributive public policies are less likely to occur in societies that are divided on ethnic or linguistic lines, or that are characterised by high levels of social inequality (Alesina & Glaeser, 2005; Steele, 2016).

[3] The WHO Cube is typically said to depict national averages and may therefore mask disparities between population groups. Alternative visualisations – such as the 'step pyramid' (Roberts et al., 2015) – have been proposed to represent coverage, disaggregated by relevant dimensions, for example, income.

- Starting point / initial health system design: Another strand of research argues that the initial setup of a country's health system influences its evolution over time. For example, providers in a system that relies on out-of-pocket payments develop vested interests in the status quo and may resist efforts to change the system towards a greater degree of public payment (Bump, 2015).

- Political windows of opportunity: This perspective highlights the role of exogenous shocks – positive or negative – that create opportunities for major change initiatives in the political process, which otherwise evolves at its usual very slow pace. The windows of opportunity can be opened, for example, by economic crisis or, conversely, the 'honeymoon' period of a newly elected leader who can advance controversial proposals based on his or her newly gained political capital (Fishback et al., 2007).

> Universal Health Coverage is first and foremost a political choice which transcends the technical issues to be solved.

UHC is fittingly regarded as a political choice, rather than simply a technical issue to be solved (WHO, 2010; WHO, 2019e; Kirton & Kickbusch, 2019). Governments have to make policy and investment choices along the dimensions of the Cube, deciding which services are covered, who is covered, and the proportion of the costs that are covered.

Attaining *universal* health coverage also requires tackling *all* barriers to coverage. Many of these barriers are non-financial – including political, legal, geographic and cultural barriers – and are not necessarily best addressed through financial means (Frenz & Vega, 2010; UNICEF, 2012; Thiede & Koltermann, 2013; WHO, 2006). As the overall objective is to improve the health of people, and not only health services, UHC requires approaches that go beyond the health sector. Countries must address the broader determinants of health, including social determinants such as education, employment, housing, and environment. Government's pursuit of UHC must consider these additional dimensions (Commission on Social Determinants of Health, 2008; World Conference on Social Determinants of Health, 2011; Leppo et al., 2013).

HOW IS UHC MEASURED AND WHERE DO COUNTRIES STAND GLOBALLY?

While data on health services and costs have been collected for some time, it was not until July 2017 that the United Nations (UN) adopted specific indicators for measuring progress on UHC, as part of the Sustainable Development Goals (SDG) indicator framework. WHO and the World Bank now lead the tracking of UHC (Box 4).

BOX 4. HOW IS UHC MEASURED?

Achieving UHC is grouped as Target 3.8 under SDG 3 –'Ensuring healthy lives and promoting well-being for all at all ages'. UHC is measured using two indicators:

Indicator 3.8.1: Coverage of essential health services. The UHC service coverage index is a single indicator, ranging from 0 to 100, that is computed based on tracer indicators (some of which are proxies of service coverage) to monitor coverage of essential health services. Essential health services are services that all countries, regardless of their demographic, epidemiological or economic profile, are expected to provide.

Indicator 3.8.2: Proportion of a country's population with catastrophic spending on health, defined as large household expenditure on health as a share of household total consumption or income. The incidence of catastrophic spending on health is reported on the basis of out-of-pocket (OOP) expenditures as a proportion of total household income or consumption. The idea is that spending a large fraction of the household budget on healthcare must be at the expense of the consumption of other goods and services, such as basic necessities or children's education. The intensity of catastrophic spending is measured by using two thresholds: OOP exceeding 10% of total household income or consumption, and OOP exceeding 25%.

Both indicators must be measured together to obtain a clear picture of those who are unable to access healthcare and those who face financial hardship due to spending on healthcare. To capture the equity dimension, the SDG goal indicators are to be disaggregated by income, sex, age, ethnicity, disability, geographical location and migratory status, as applicable and where data is available (WHO/World Bank, 2017).

The latest global monitoring report shows that the coverage of essential health services (indicator 3.8.1), as measured by the UHC service coverage index, has improved (WHO, 2019e). The global average increased from 45% in 2000 to 66% in 2017. Progress has been greatest in lower income countries, mainly driven by interventions for infectious diseases and for reproductive, maternal, newborn and child health services. However, socioeconomic factors exert a major influence on access to health services and ultimately health outcomes. Poor people have lower coverage even for basic services such as immunisation and antenatal care. For these basic services, rural areas generally have lower coverage than urban areas. Moreover, progress appears to have slowed and future gains in health system strengthening are projected to be partly offset by population growth (Ibid.). Therefore, progress in all countries must accelerate, with coverage having to double to reach the SDG target of UHC for all by 2030.

Unfortunately, financial protection has evolved in the opposite direction. The gains in service coverage have come at a major cost to individuals and their families. All regions except North America saw increases in the number of people and percentage of the population with catastrophic health expenditure (indicator 3.8.2) between 2000 and 2015 (WHO/World Bank, 2019). Globally, the proportion of the population with out-of-pocket spending of more than 10% of their household budget rose from 9.4% to 12.7%, and those with OOP spending exceeding 25% jumped from 1.7% to 2.9% of the global population. The share of the population impoverished by out-of-pocket health expenses grew by nearly 40%, from 1.8% in 2000 to 2.5% in 2015 – more than 200 million people in the most recent estimate (WHO, 2019e). The latest Global Monitoring Report on Financial Protection in Health indicated that more analysis is needed to understand the types of health systems that drive financial hardship from OOP health spending. Research suggests that in the South-East Asia region medicine accounts for the largest share of OOP health expenditure among people with any OOP health spending, and among the poorest people (WHO/World Bank, 2019).

This brief global overview illustrates that progressing towards UHC is a difficult task. The world over, but particularly in lower- and lower middle-income countries, constraints in basic infrastructure, human resource gaps, service quality and limited trust in health practitioners and medical authorities remain barriers to achieving UHC (WHO, 2019e). The next chapter outlines the measures taken by India and Indonesia in their pursuit of UHC.

Two countries' journeys towards Universal Health Coverage

In recent years, both India and Indonesia have undertaken major initiatives towards UHC with technical support from GDC. As the following section will show, each country has taken a different approach: while India focused its first efforts on extending social health protection to the poor as part of its 'inclusive growth' strategy, Indonesia conceived of health protection as part of the government's comprehensive social protection mandate and therefore launched a single-payer national health insurance scheme for the entire Indonesian population.

INDIA'S TWO BIG STRIDES: LEARNING FROM RSBY INFORMS THE LAUNCH OF PM-JAY

In post-independence India, the government has historically spent little – around one per cent of Gross Domestic Product (GDP) annually – on health (WHO, 2019b). Many public health facilities have thus been left ill-equipped to meet the health needs of the population. Until 2007, the year of the launch of the RSBY national health protection scheme, the OOP share of total health expenditure stood at or above a staggering 70%, one of the highest rates in the world (La Forgia & Nagpal, 2012). OOP are direct payments made by individuals to healthcare providers at the time of service and are part of the health financing system in all countries that rely on user fees and co-payments to mobilise revenue. In poor settings where healthcare providers tend to be under-resourced, user fees represent a major source of revenue for health workers. However, unregulated direct charges often constitute a major barrier to accessing necessary healthcare.

Although numerous government, private, and community-based insurance schemes have long coexisted and occasionally merged with each other (Ahlin et al., 2016), enrolment levels have generally been low. In 2005/06, only five per cent of Indian households had at least one member covered by a health scheme or health insurance, with stark differences between income groups. While 16% of the richest quintile had some insurance coverage, only 0.1% to 0.7% of the bottom 40% of the population had a household member in a health scheme – not more than 28 million out of over 400 million people (IIPS & Macro International, 2007, p. 435). It is unsurprising that every year, catastrophic health expenses have pushed up to eight per cent of India's population into poverty (Kumar et al., 2015; Pandey et al., 2018). A *Lancet* review concluded that 'individuals with the greatest need for healthcare have the greatest difficulty in accessing health services and are least likely to have their health needs met' (Balarajan et al., 2011). India's widely admired steady and high economic growth rates did not translate into better healthcare for the majority of the population.[4]

In 2007, Prime Minister Manmohan Singh announced that his government intended to increase public spending on health, education, agriculture and rural development to pursue a vision of 'inclusive growth'. To implement this vision, three new initiatives were launched to strengthen social protection and extend social health insurance coverage to hundreds of millions of people living in poverty (Birdsall & Adams, 2016). One of these schemes was RSBY (*Rashtriya Swasthya Bima Yojana*), or 'National Health Insurance Programme', which aimed to provide social health protection to 65 million households which lived below the poverty line (Karan et al., 2017). At its peak, the scheme was operational in 25 out of 36 Indian states and union territories and covered 41 million households, or about 135 million individuals (National Health Authority, 2019a), corresponding to 63% of its coverage target.

[4] Despite the overall challenging conditions, India has had significant successes in its health sector: The National Rural Health Mission was launched in 2005 as a supply-side strengthening programme and provided flexible funding for health to Indian states. It was later merged with the National Urban Health Mission into the National Health Mission which played a critical role in achieving the health-related Millennium Development Goals 4, 5 and 6 and contributed to a significant (20-40%) reduction in the burden of diseases affecting mothers and new-borns, the eradication of polio and fighting communicable diseases.

The introduction of RSBY meant a significant step towards UHC, but the scheme experienced some administrative and political setbacks which will be discussed in the next chapter, which retraces the implementation process. The health ministry[5] prepared and released a comprehensive National Health Policy in 2017 that firmly committed the government to 'progressively achieve Universal Health Coverage' (Government of India, 2017)[6] and paved the way for the launch of the national social health protection scheme PM-JAY in September 2018.

PM-JAY aims to cover the 'bottom 40%' of India's population (National Health Authority, 2019b), i.e. approximately 500 million poor and vulnerable individuals, making it the world's largest fully government-funded health protection scheme. Eligibility for PM-JAY is based on the deprivation and occupational criteria of the Socio-Economic Caste Census (SECC) 2011 (Ministry of Rural Development, 2011), or the enrolment in the previous RSBY scheme.

PM-JAY is part of the two-pronged *Ayushman Bharat* initiative: a major investment in delivering comprehensive primary healthcare through so-called 'Health and Wellness Centres' is intended to expand access to primary care, while PM-JAY covers secondary and tertiary healthcare-related costs of up to 500,000 Indian rupees (about €6,300) per family per year.

As PM-JAY is an entitlement-based scheme, beneficiaries do not need to enrol but there is an eligibility verification process. Upon their first contact with the system, e.g. when seeking treatment at a hospital, an agent checks their eligibility vis-à-vis a master database and a confirmation of their entitlement is handed to the beneficiaries – in most cases a computer printout that includes a Quick Response (QR) code and a PM-JAY identification card with the name, gender, year of birth and photograph of the beneficiary.

India's Minister of Health and Family Welfare, Harsh Vardhan (left) and State Minister Ashwini Kumar Choubey (centre) listen to a poster presentation on health insurance in India by GIZ principal advisor Dr Nishant Jain (right foreground) at a conference in Delhi, 2019.

[5] Full name: Ministry of Health and Family Welfare.

[6] A holistic vision for UHC in India was first outlined by a High-Level Expert Group convened by the Planning Commission of India in 2011 (Reddy et al., 2011).

As of December 2019, 110 million confirmations had been issued. In total, 6.5 million persons used PM-JAY to get treatment between its launch in September 2018 and December 2019 (National Health Authority, 2019c; Press Information Bureau, 2019; GIZ India, 2019). Table 1 (below) provides an overview of PM-JAY key features in comparison to Indonesia's JKN, their current coverage status and their priorities for expansion in relation to the WHO Cube.

INDONESIA TACKLES FRAGMENTATION AND EXPANDS COVERAGE

Although Indonesia had already established a network of community health centres (*puskesmas*) in every subdistrict by 1970 and gradually expanded the range of services provided, accessibility and affordability remained starkly uneven. Therefore, most health indicators have shown persistent gaps between wealthier and poorer people, as well as between population groups by geography, religion, and language spoken (Dartanto & Otsubo, 2016; UNDP/UNEP, 2015; Wiseman et al., 2018). Health insurance systems existed at the time but covered mostly government and military personnel, a legacy from the colonial past (Agustina et al., 2019). For decades, the out-of-pocket share of total health expenditure remained consistently over 40% in Indonesia (Harimurti et al., 2013) and gradually rose to over 55% in 2010/11, more than double the South-East Asia regional average (WHO, 2019a).

In 1997, the Asian financial crisis severely hit Indonesia: peak inflation reached 78%. At the same time, an El Niño event caused one of Indonesia's worst droughts on record and, combined with the loss in purchasing power, sent food prices spiralling by over 80%. The proportion of poor households surged from 11% in 1996 to 20% in 1999, pushing an additional 19 to 20 million people into poverty (Ramesh, 2009; World Bank, 2000).

The repercussions of the crisis opened a political window of opportunity and triggered far-reaching changes, including the resignation of military leader and then president Suharto, widely regarded as a dictator, after 31 years in office. Having experienced the consequences of limited or no social protection cover during the crisis – less than 20% of Indonesia's population were protected by health insurance at the time (Harimurti et al., 2013) – social security reform became an issue of public interest and debate. Social security for all was finally made a political priority under the new social-democratic leadership from 2001 onwards (Agustina et al., 2019).

In 2004, Indonesia adopted a social security law that, as part of a comprehensive social security architecture, required the government to establish a National Social Security Council within five years and enshrined the goal of universal health coverage (Republic of Indonesia, 2004). This legislation laid the foundations for the transformation of the country's fragmented health insurance landscape into a single-payer system through the launch of the national health insurance scheme, JKN, in 2014 – with the explicit goal of achieving UHC for the entire population by 2019.

Immediately following the launch, JKN covered 117 million people, or 46% of the total population. Most participants were transferred from the previous social health insurance and medical schemes. Within only five years, coverage reached 221 million people, or 83% of the universal coverage target, as of September 2019 (DJSN, 2019), making it the largest contribution-financed social health insurance worldwide. Participation is mandatory for all Indonesian residents and contributions must be automatically deducted from formal employment payrolls. However, participation has been low for informal sector workers who do not live in poverty and who would have to self-enrol and pay the insurance premium. Research has indicated that the insurance premium is not the primary impediment, but rather a limited understanding of health insurance and the poor availability of services (Dartanto et al., 2016).

HOW DO INDIA AND INDONESIA MEASURE UP AGAINST THE SDG INDICATORS ON UHC?

By convention, the progress of the two countries towards UHC is measured using the UN's SDG indicator data on service coverage (SDG indicator 3.8.1) and catastrophic health spending (SDG indicator 3.8.2), as discussed above (Box 4). Table 2 provides an overview of where India and Indonesia stand, vis-à-vis each other and in the region.

When reviewing the SDG UHC indicator data in Table 2, it is important to bear in mind that robust data on most health indicators are only collected periodically. The latest available data, respectively, have been collected *after* Indonesia introduced its major national social health insurance, JKN, in 2014, but *before* India launched its social health protection scheme, PM-JAY, in 2018. Therefore the contributions of these schemes to the UHC status as represented by the SDG indicators may not yet have been captured; thus the data presented in Table 2 can be considered to be a baseline benchmark which PM-JAY and JKN will help to improve. Moreover, UHC is the result of a holistic health system effort, not individual social health protection schemes such as PM-JAY and JKN, although their contributions may be sizeable.

TABLE 1. INDIA'S AND INDONESIA'S MAIN SOCIAL HEALTH INSURANCE SCHEMES: OVERVIEW OF KEY FEATURES VIS-À-VIS THE WHO CUBE

		INDIA (PM-JAY, SINCE 2018)[7]	INDONESIA (JKN, SINCE 2014)[8]
A. OVERVIEW OF KEY FEATURES:			
Eligibility / enrolment		Entitlement-based: deprivation and occupational criteria from SECC 2011, plus those previously enrolled under RSBY; states can expand the scheme to cover more categories	Mandatory enrolment by 1 Jan 2014 for all Indonesian residents
Funding source		Fully government-funded through general taxation	Contribution-funded. Employees pay approx. 5% of payroll salary. Government pays the contributions for the poorest 90 million people as of 2019 (33% of total population; the 2012 roadmap had anticipated 97 million poor)
Level of care		Inpatient care (all of secondary and most of tertiary care)	Primary, secondary and tertiary
B. CURRENT STATUS AND PRIORITIES FOR EXPANSION VIS-À-VIS THE WHO CUBE:			
Population covered	Current status	Approx. 500 million people or 40% of the total population; An additional more than 100 million are covered through expansion by states.	221 million JKN members (82% of target, Sep. 2019)
	Priorities for expansion	Include persons that are not yet covered by any insurance scheme; link PM-JAY with existing schemes for the formal sector (for example, Employees' State Insurance Scheme, other schemes for certain employee groups, and schemes at state level)	Full coverage of the entire population of approx. 270 million people (100%)
Services covered	Current status	All inpatient secondary and most tertiary care services with a short exclusion list; prices for 1393 conditions have been fixed in advance	'All medically necessary' procedures are covered; an exclusion list applies (e.g. prosthetic dental care or alternative therapies such as acupuncture).
	Priorities for expansion	Link primary care, including Health and Wellness Centres, with PM-JAY; introduce a referral system to achieve a continuum of care	Increase service preparedness across all health facility types to ensure effective service delivery at the point of care (in 2017, only 67% of community health centres passed the service preparedness test)
Proportion of costs covered	Current status	Up to 500,000 rupees (about €6,300) per family per year for inpatient care; this amount is sufficient for most of the inpatient care costs	100% of all medically necessary service cost (no upper limit)
	Priorities for expansion	Cover conditions which require more than 500,000 rupees per family per year; also cover costs for outpatient care	Reduce out-of-pocket expenditure as percentage of current health expenditure which still stands at 48% (2015)

[7] Data sources for India: On insurance background and enrolment (National Health Authority, 2019c); service coverage (WHO, 2019e); priorities for expansion (GIZ India, 2019).

[8] Data sources for Indonesia: On insurance background and enrolment (Republic of Indonesia, 2012; Mahendradhata et al., 2017; DJSN, 2019); service coverage (WHO, 2019e); OOP expenditure (WHO, 2019d); priorities for expansion (Agustina et al., 2019); service preparedness statistics (Directorate General of Health Services, 2017).

The figures in Table 2 mirror the global trend that service coverage has improved in both countries while financial protection deteriorated, even in Indonesia after the introduction of JKN. The UHC service coverage index in 2017 stands at 55 points for India[9] (or 55% as these are 55 out of 100 index points) and 57 points for Indonesia, signalling that both countries still have some ways to go to attain UHC. Indicative of the weakening of financial protection coverage in step with the global and South-East Asia regional direction, the level of catastrophic health expenditure has increased in both countries. Additionally, India shows considerable disparities between states and union territories (cf. Pandey et al., 2018). In Indonesia the proportion of the population with OOP spending exceeding 25% of total household income or expenditure has stagnated at low levels.

As both countries have gradually expanded health service coverage to larger parts of the population, the data show that progress has been relatively slow, but steady. With the introduction of major social health protection schemes, RSBY and PM-JAY in India and JKN in Indonesia, the two countries have also taken significant steps in trying to improve financial protection and moving towards UHC.

The following chapter reviews the role of GDC in supporting India and Indonesia in undertaking these highly complex, long-term social health protection reforms.

TABLE 2. INDIA'S AND INDONESIA'S PROGRESS ON UHC AS MEASURED BY THE SDG INDICATORS (WHO, 2019e)

SDG indicator, first/last available data point[10]	SDG 3.8.1: UHC service coverage index (range: 0-100)		SDG 3.8.2: CATASTROPHIC HEALTH EXPENDITURE			
			Total population with household expenditures on health greater than 10% of total household expenditure or income (%)		Total population with household expenditures on health greater than 25% of total household expenditure or income (%)	
	T_0	T_1	T_0	T_1	T_0	T_1
India	52 (2015)	55 (2017)	13.39 (2004)	17.33 (2011)	2.18 (2004)	3.9 (2011)
Indonesia	53 (2015)	57 (2017)	2.56 (2001)	3.61 (2015)	0.42 (2001)	0.41 (2015)
South-East Asia Region	46 (2010)	61 (2019)	10.71 (2000)	12.82 (2010)	1.96 (2000)	2.85 (2010)

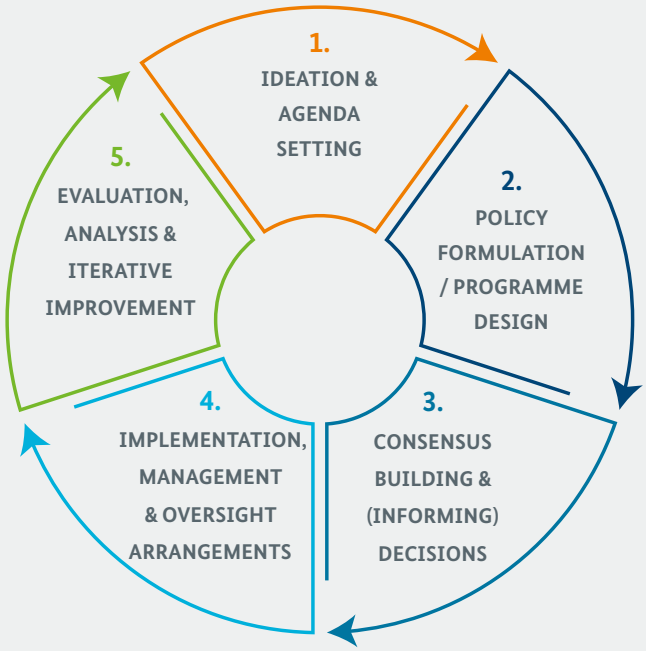
[9] In 2018, India's government think tank, NITI Aayog, together with the UN in India, published a 'SDG India Index Baseline Report' with the aim of localising the SDG indicators and assessing the states' and union territories' progress on the SDGs (NITI Aayog/UN, 2018).

[10] The earliest and latest available data for India and Indonesia are from different time periods, therefore the earliest (T0) and latest (T1) data point is provided for each country to show change over time.

Supporting large-scale social health protection reforms: learning from implementation

Instead of concentrating on individual UHC issues related to health financing or service delivery, we take a process-oriented approach and review the experiences of GDC teams through the lens of a simplified model of the policy cycle (Figure 2). Cyclical models have been widely used in the political science and international development literature, although it is important to reiterate the fundamental insight of smart implementation that events on the ground rarely unfold in a neatly cyclical process.[11] This chapter traces the policy reform and implementation process in each country through the cycle to identify where and how technical cooperation was able to add value to the partner-led UHC processes – subject to the political economy dynamics outlined above, as the study will show. The chapter is structured following the five policy cycle stages and, for each stage, examines the implementation experience in India and Indonesia.

FIGURE 2. A SIMPLIFIED POLICY CYCLE (LASSWELL, 1956; UNDG, 2011)



1. SUPPORTING IDEATION AND INFORMING AGENDA SETTING

In the policy cycle, reform processes typically begin with individuals or institutions identifying a problem area that requires government attention, or recognising that the status quo can be improved with new ideas that inform a programmatic or policy change. Sufficient momentum is required for an issue to surface on the political agenda and to gain traction with decision-makers, either by having broad public support or a champion from within the system.

In India and Indonesia, German-supported advisors contributed significantly to advancing the social health protection reforms by investing in individuals and processes that generated ideas for 'what could be' and by helping local change agents build support for their transformational proposals, as will be discussed below.

[11] Therefore, some of the learnings from implementation may apply to more than one stage in the policy cycle. In the context of international development, project management cycles have been associated with 'donor-driven' or otherwise externally determined processes, with limited or only token local participation (Flint & Natrup, 2019). The policy reform processes in India and Indonesia reviewed in this case study were fully locally initiated and locally led; we use the cyclical model only as an analytical device to structure the discussion.

Shaping social health protection in India from the start – and the restart

India's first major German-supported venture into social health protection began without GDC involvement. The concept of RSBY was initiated in 2007 under the leadership of Anil Swarup, then Director General and Joint Secretary in the labour ministry[12], with support from national experts and agencies, the ILO and the World Bank. RSBY was housed in a department within the labour ministry because informal sector workers and their families constituted the majority of its target group. With India being a federation and health the responsibility of the states and union territories, the central government provided the overall regulatory framework and 75% of the budget, but the states decided whether and how to implement the scheme for their citizens.

Gujarat was one of the first few states to take on RSBY. When they received the RSBY implementation guideline from the labour ministry at the end of 2007, they had many questions and reached out to Nishant Jain, principal advisor of the GIZ-supported health programme, for technical support. They had heard that Jain had earned his doctoral degree in health financing and health insurance from the renowned Indian Institute of Management, and knew that he was one of only a handful of experts on the subject in India at the time. Jain not only helped Gujarat's administration to interpret and use the central RSBY guidelines; he also identified a number of areas for improvement in the guidelines that needed to be addressed by the labour ministry to make the scheme more effective. Jain subsequently sent a series of ideas to the labour ministry which marked the beginning of a dialogue between GIZ and the institution.

Anil Swarup who led RSBY recognised that the GIZ advisor offered concrete proposals for fine-tuning the scheme, based on practical insights from state-level implementation. Swarup therefore asked GDC to provide more systematic support to RSBY. Although GDC did not have an active project – and therefore resources – with the labour ministry at the time, Jain managed to reorient some funds within GIZ's ongoing collaboration with the health ministry towards RSBY work.[13] This was possible because health insurance was one of the main components of the GIZ-supported health project in India. GDC continued supporting the labour ministry informally until 2010, when the collaboration was formalised with a new project agreement at the request of the labour ministry. Beginning with the new project in 2011, GDC's support to RSBY was scaled up under the leadership of GIZ's Rolf Schmachtenberg. GDC worked closely with the team at the labour ministry to refine the design of RSBY, support its expansion to more states and strengthen the effectiveness of the programme.

In the meantime, several more states wishing to implement RSBY requested GDC's and Jain's support. Thus started a fruitful process of incrementally improving the scheme as it was rolled out, with Jain and the small GDC team that he had formed taking learnings from one state and generating ideas for how to tweak the RSBY scheme so the concept could be adapted and better implemented in the next state. In a book, Swarup later wrote about Jain's role in this formative period of RSBY: 'He was the one who kept the momentum going, shuttling from one state capital to the other, trying to find solutions to problems (...). Much of the success of the scheme after its launch can be attributed to the small team of GIZ that became an intrinsic part of [the] RSBY movement'[14] (Swarup, 2019).

> 'GIZ's principal advisor was the one who kept the momentum going, shuttling from one state capital to the other, trying to find solutions to problems.' (Anil Swarup, India)

Despite the considerable successes of expanding social health protection through RSBY – the scheme was operational in 25 states out of 28 at its peak (National Health Authority, 2019a) – several fault lines in the scheme's setup emerged within five years of its implementation. The bureaucracy of the labour ministry was ill-equipped to manage a health protection programme for hundreds of millions of people. Within the ministry and in the overall government hierarchy, RSBY had a relatively low standing, so that its continued existence hinged decisively on the leadership of Anil Swarup and his ability to defend the scheme against competing government priorities. The cohesiveness of RSBY's implementation across different strong states proved to be a delicate balancing act and was facilitated by the work of Jain and his GIZ team who bridged the gap between the national and the state level. Although challenging at times, the empowerment of the state level was one of the major successes of RSBY. It provided states with first-hand experience in running a health protection scheme and later motivated many of them to expand RSBY or to launch their own schemes.

[12] Full name: Ministry of Labour and Employment.

[13] With the approval of then programme director Hans Steinmann.

[14] In an anecdote exemplary of Jain's commitment, Swarup also reminisces that 'none of us could believe it when he showed up a couple of days before his wedding at a state-level workshop and volunteered to make a presentation.

GIZ advisor Susanne Ziegler in conversation with community members in Bihar.

In 2014, several unfortunate events coincided that eventually had a significant negative impact on the performance of RSBY. When Swarup was promoted and was transferred to another ministry, the scheme had lost its most powerful proponent within the labour ministry. Even though his successor, Rajeev Sadanandan, tried his best to maintain the momentum for RSBY, the highest-level leadership in the labour ministry withdrew their support for the scheme. As a consequence, the states no longer received adequate RSBY implementation support from the national level and therefore either discontinued RSBY or launched their own health protection schemes. At the same time, GIZ's 2011-2014 project agreement with the labour ministry on RSBY ended; it took almost one year for the new agreement to be signed between GIZ and the Government of India. Due to this multitude of issues, the performance of RSBY dropped considerably: only 19 states continued with the scheme in 2015.

The GDC team's experience with RSBY yielded several learnings that informed GDC's strategic positioning in support of India's UHC initiatives going forward, including how they would contribute to the design of future UHC efforts as providers of unique insights and ideas. This will be discussed in the next section concerning the policy formulation stage of the policy cycle.

Forming a 'critical mass' for social health insurance in Indonesia

Indonesia's gaps in social protection, and particularly in health, had become evident during the 1997 Asian financial crisis. It had left most poor households exposed (cf. previous chapter) and gave rise to calls for greater solidarity in society generally and for public social security specifically. From 2001 on, the country's new social-democratic leadership made social security reform a government priority, recognising the need to address the mounting popular discontent. However, there was considerable uncertainty about how to proceed.

In this context, as early as 1998, the InWEnt[15] corporation began offering short courses on health insurance and organised study tours to Germany for selected government officials and academics from Indonesia; the participants also received in-depth briefings of how German public health insurance providers such as AOK (*Allgemeine Ortskrankenkasse*) worked.

At the same time, a collaboration emerged between Paul Rueckert, then GIZ's principal advisor in Jakarta, and Dr Hasbullah Thabrany, a charismatic and politically active health economics academic who had invited Rueckert to give a presentation at one of his public lectures at Universitas Indonesia in Jakarta. Thabrany was a passionate, vocal advocate for social health insurance and wrote prolifically about the merits of UHC. His research and opinion pieces regularly appeared in national newspapers and were picked up internationally, e.g. by the Washington Post (Emont, 2016).

In 2004, GDC, at the initiative of BMZ and together with the ILO and WHO, formed a Consortium on Social Health Protection which was active in multiple countries. In Indonesia, the Consortium organised a series of conferences and public workshops on social health insurance with Thabrany, drawing large and diverse audiences across the country. In collaboration with the Ministry of Health, Rueckert and the academic put together international study tours for Members of Parliament (MPs) who were part of the Commission on Health. Pursuing a 'seeing is believing' strategy, the exposure visits were designed to give the MPs an overview of how other countries – the Philippines, Korea, Japan and Germany – had organised their social health protection systems. The MPs could compare the different pathways to UHC that these countries had taken and form their own opinions as to what would be practical in Indonesia. Gradually, more and more policy-makers were convinced that universal social health protection was desirable and possible for Indonesia to implement.

[15] Capacity Building International, Germany (*Internationale Weiterbildung und Entwicklung*, InWEnt), was an independent corporation before being merged with GTZ and others into GIZ in 2011. InWEnt was formed in 2002 as a merger of the *Deutsche Stiftung für internationale Entwicklung* (DSE) and the *Carl-Duisberg-Gesellschaft e.V.* (CDG). The trainings for stakeholders in Indonesia in the late 1990s may have been organised by one of InWEnt's founding organisations but were referred to as 'InWEnt' contributions.

GDC continued to support the efforts of Thabrany, who worked with the Parliamentary Commission on Health to help prepare the legislation that would make social health insurance a government mandate. Importantly, GDC and Thabrany could rely on the help of a number of the former InWEnt trainees who, in the meantime, had moved to key positions across the government, including the Ministry of Health and the then Coordinating Ministry for People's Welfare. With their backing, voices in support of UHC spoke out from different corners of the government administration and political spectrum. 'After three years of debate and a purported 56 versions of the bill' (Agustina et al., 2019), all interest groups agreed on the content of the social security law.

The bill that was adopted by Parliament in 2004 envisaged a comprehensive social protection system with UHC as one component. The law also required the government to establish a National Social Security Council within five years (Republic of Indonesia, 2004).

Thabrany later characterised the contribution of GDC as 'crucial in helping to build a *critical mass* in support of social health protection'. From the beginning, Rueckert appreciated that building public and political support for UHC and for translating political will into legislation was a sensitive process that could only be locally owned and driven. Insisting on GDC visibility could have been counterproductive. Instead, Rueckert focused GDC's technical cooperation on providing financial and intellectual support to the work and advocacy of a local activist, Thabrany, and the reform process he had helped to set in motion. The strategy of aligning GDC's technical cooperation with a single champion and driving force behind the UHC reform process, while successful, was not without risk, as India's experience with Anil Swarup – reviewed above – illustrates.

Professor Dr Hasbullah Thabrany, a key advisor in Indonesia's UHC reform process.

IDEATION AND AGENDA SETTING: KEY LEARNINGS FROM IMPLEMENTATION (1)

- By harnessing GDC's technical capacity and financial resources in support of local champions (Swarup in India, Thabrany in Indonesia) and supporting their UHC reform efforts without forcing GDC visibility, German-supported advisors helped their partners to advance locally initiated, owned and driven social health protection agendas. GDC's in-country advisors showed remarkable intuition in identifying and gauging which individuals were the most promising to support.

- The experiences from both countries demonstrate that UHC reforms are deeply political. It presents a risk for technical cooperation to be closely tied to processes that stand or fall with the success or failure, or the absence or presence of individual champions. When these fail (which they did *not* in Indonesia) or leave (which they *did* in India), the progress made is jeopardised. Therefore, in addition to working with champions, a broader institutional anchoring of technical cooperation processes is a viable strategy for hedging risk and increasing the chances for UHC reforms to take hold.[16] GDC subsequently followed this path in both countries.

- The promise and peril of 'betting on champions' also applies to GDC internally. For example, had GIZ's Jain, well-connected in India's health sector and with deep subject matter expertise, left the organisation before the launch of PM-JAY, GIZ's role in RSBY and PM-JAY would presumably have been very different. Therefore, it is important for the relevance and sustainability of technical cooperation projects that the 'champions' work in the context of a formally established, broader collaboration between GDC and its partner institution(s) that rests on more than one or two advisors' shoulders. At the same time, the role of individuals with the right technical expertise, level of access and soft skills to establish and maintain trusted relationships with the partners should not be discounted.

[16] One might argue that, when the political 'tide' has turned for or against an issue, there is little that technical cooperation can do. In Indonesia, a social security law might have eventually been passed, whether or not a charismatic leader such as Thabrany pushed it – although it could have taken considerably longer or taken a different shape. One can only speculate, had GDC and others in India worked sooner towards a broader institutional anchoring of social health protection beyond the Ministry of Labour, whether RSBY could have been sustained.

Dr Indu Bhushan, CEO of India's National Health Authority.

2. PROVIDING INSIGHTS FOR POLICY FORMULATION AND PROGRAMME DESIGN

In the second stage of the policy cycle, once an issue or idea has made it onto the policy agenda, options need to be generated and elaborated for addressing the issue or operationalising the idea.

An independent institution to manage India's PM-JAY

With India's change in government at the national level in 2014, it was felt that a health protection scheme should be housed in the health ministry. Therefore, responsibility for RSBY was shifted from the labour ministry to the health ministry in 2015. However, the health ministry had practically no prior involvement with RSBY and limited expertise to revive it. As Jain describes this transition period, 'all the files on RSBY were transferred from the labour ministry to the health ministry, but the knowledge was not transferred with the papers.'

Fortunately, the GIZ team under the leadership of the programme director at the time Helmut Hauschild, with Jain in the technical lead role, was able to contribute the institutional memory and could also draw on their tacit knowledge from six years of in-depth engagement with RSBY from design to implementation. The GIZ team shared their learnings with key staff in the health ministry. Jointly, they pondered options for how an improved national health protection scheme could be designed, to be ready should the political opportunity arise. One of their main proposals was that a successful scheme would require an independent body to manage it, removed from the day-to-day dynamics of a ministerial bureaucracy.

The day after finance minister Jaitley's consequential budget speech that announced PM-JAY in February 2018, the GDC team in India got to work. A team led by the health ministry, with support from GDC and other development partners, including ILO and the World Bank, designed virtually all aspects of the new social health protection scheme within six months – from the legal framework, institutional setup and organisational structure to the eligibility criteria, service benefit packages and models for costing the scheme. When PM-JAY was launched in September 2018, it was under the oversight and management of the newly established National Health Agency, a body created by Cabinet decision, vested with full functional autonomy though organisationally an 'attached office' of the health ministry. In January 2019, the National Health Agency was converted into the National Health Authority (NHA). State Health Agencies (SHA) were set up in participating states, or existing State Nodal Agencies (SNA) that had been created to run RSBY were converted into SHA, to ensure a more stringent management of the scheme at sub-national level while leaving the state's operational autonomy intact. PM-JAY not only subsumed RSBY, the states were also provided with considerable flexibility to converge their existing schemes with PM-JAY. As of December 2019, 25 out of 28 states and 8 out of 9 union territories had rolled out PM-JAY (National Health Authority, 2019a; GIZ India, 2019).

Ten years, two laws and one roadmap to design JKN in Indonesia

Following the Asian financial crisis, the Indonesian government had come to consider social health protection, not as an end in itself, but as a part of comprehensive social protection and a means to reduce poverty. GIZ's principal advisor from 2004, Franz von Roenne, recognised the government's strategic intent and decided to realign the thrust of GDC's programmatic support from the Ministry of Health towards the social protection side of Indonesia's governance architecture. In 2008, as part of this initiative, GDC facilitated a visit by Dr Bernd Rürup (see cover photo), a German social policy and social security expert. Dr Rürup provided insights into how Germany reformed its social security system and how political momentum for reforms could be maintained.

The GDC strategy of supporting social security reforms was further pursued by Alfred Hannig, who led GDC's project support to the Coordinating Ministry for People's Welfare, and was eventually formalised starting in 2009, when GDC's social protection project under principal advisor Johanna Knöss worked with the Ministry of National Development and Planning (BAPPENAS) as one of its main counterparts: this ministry's cross-sectoral role was key for tackling UHC reforms holistically.

The obvious first and pivotal task was to support the Indonesian partners in establishing the National Social Security Council, as envisaged in the 2004 social security law, to provide the overall policy framework and oversight over a coherent social security system for the country while reporting directly to the President. GDC brought on board a former executive at Poland's National Health Insurance Fund who had successfully merged 17 independent regional health insurance authorities into a single entity. This international advisor knew how to navigate the complex politics of reforming a fragmented social health protection system. In his experience, it was 'all about regulation, so you need the best lawyer', therefore he recruited two more Indonesian resource persons – a legal scholar and former Secretary General of the Constitutional Court and a well-connected official from the Ministry of Health.

For the next five years, the German-supported experts engaged all relevant institutions in a participatory process to prepare the regulations and administrative arrangements to establish DJSN as an organisational body. Among their main concerns was to ensure a strong positioning and effective functioning of the Council so it could fulfil its mandate of developing a robust policy framework for social health insurance for all Indonesians. In 2009, it assumed its duties as a 15-member council, with six members from government (Ministries of Health, Defence, Finance, Labour and Social Affairs), five experts, two members from employers' organisations and two from workers' organisations.

The Council subsequently delivered on its mandate and developed the policy framework, as will be discussed in the following section. GIZ's Ibu Aya later supported the Council in elaborating the 2012 Roadmap toward national health insurance, facilitating a delicate, months-long process in which council members and a team of 13 GDC-supported consultants, including Thabrany, operationalised the policy framework by working out all the details for the JKN health insurance, including who would be covered, which services would be covered and how high the different insurance premium levels would need to be.

Ahmad Ansyori, a member of Indonesia's National Social Security Council (DJSN) from 2014 to 2019, at a consultation meeting on the national health insurance JKN.

3. CREATING SAFE SPACES FOR CONSENSUS BUILDING AND BROKERING DIFFICULT DECISIONS

At the third stage of the policy cycle, consensus must be built to reach policy decisions. Formulating policy and programme design options and deciding on the 'rules of the game' involve balancing competing interests and forging compromise around politically sensitive issues. When those with conflicting views can be included in the decision-making process and reach an agreement through reasonable discussion, their policy solutions tend to be durable (Gutmann & Thompson, 2010). However, when vested interests are left unaccounted for, they can stall progress or derail a reform endeavour.

Working as a neutral broker to help keep India's RSBY and PM-JAY in balance

The GDC team in India drew on two resources that put it in a unique position in the country's health sector: the learnings from years of designing and implementing all aspects of social health protection, and a deep understanding of how the system works at the national and the state levels. Under RSBY, despite being formally associated with

POLICY FORMULATION AND PROGRAMME DESIGN: KEY LEARNINGS FROM IMPLEMENTATION (2)

- GDC was highly effective as a bearer of institutional memory and contributor of practical learnings from implementation, assisting partners in optimising their system designs, as well as helping to identify and engage seasoned external experts with outstanding skills whose experience and technical inputs proved to be pivotal on several occasions.
- GDC was also able to provide detailed technical inputs in multi-stakeholder, multi-year processes of developing the regulations, administrative procedures and operational 'nuts and bolts' of India's and Indonesia's social health protection systems, something it was only able to do thanks to its long-term engagement and the technical expertise of the in-country teams.

the government, GDC was respected as a 'neutral broker' who, based on their holistic understanding of social health protection, primarily pursued the interest of the scheme, rather than siding with a particular actor. Jain and his team were fully aligned with Swarup's 'business model approach' and understood that the efficiency of RSBY hinged on a balanced, 'healthy conflict of interests' (as Jain puts it) between the three main sides: the central and state governments as the funder, the insurance companies as the payers, managers and claims processors, and the hospitals as the service providers.

Acutely aware of the political economy dynamics between the three actors, GDC sought to maintain an equilibrium between all three as part of their support to each individually while acknowledging the primacy of the government's vision of providing better health protection for the poor and vulnerable. A 'controlled conflict' was most likely to secure a satisfactory outcome for the health service users by ensuring that the specific interests of each side kept the others in check:

- The government did not want to overpay for social health protection and therefore set financial coverage limits and rules for insurance claims processing, as well as encouraging efficient use of resources among service providers.

- The insurance companies – interested in generating profit – had to work within the financial boundaries set by the government; as their margin depended on how many beneficiaries they could enrol and how efficiently they processed claims, they had an incentive to extend coverage to more people and to install reliable systems for detecting fraudulent insurance claims from hospitals.

- The health service providers, while being scrutinised to ensure correct claims management, could count on a reliable stream of revenue from treating RSBY beneficiaries; at the same time, their feedback on the adequacy of the reimbursement rates for each service package gave the government and the insurance companies an indication of whether their benefit package cost estimates were too high or too low.

GDC still fulfils its neutral broker role under PM-JAY although the system has changed towards greater flexibility: the states and union territories can now choose between an insurance model (working with private insurance companies to purchase health services), a trust model (a state-owned agency purchasing services directly), and a mixed model (one part handled by insurance companies and another by a state agency) (National Health Authority, 2019a). By giving the states the freedom of choice, PM-JAY not only mirrors India's federalism, by which health is constitutionally within the states' purview, the flexibility of PM-JAY ensures that states can choose the mode of implementation that is most appropriate for their context. Research on the effectiveness and efficiency of the three models based on data from the states and union territories that implement PM-JAY has not yet been published. However, key informants interviewed for this case study suggested that states pursuing the insurance model or the mixed model have experienced a more efficient management of the scheme, although many states appear to fare well also following the trust model.

Providing a platform and moderating a process for transforming Indonesia's most powerful parastatals

While Indonesia's National Social Security Council was still being established, the team of German-supported experts also pondered on how they could address the existing fragmentation of the health and social security system, a challenging starting point for moving towards more equitable social health protection. Four major schemes not only catered to separate segments of society, they were set up as parastatal companies – among the country's biggest – and represented powerful interests, among them: civil servants, the military and police, and private sector employees. The GDC group of advisors recognised that a social health insurance scheme would not be financially viable or operationally efficient if these existing schemes were not integrated into it. A transformation and merger of the four schemes were required (Bender & Knöss, 2008; Knöss & Sumadi, 2009).

The two Indonesian advisors engaged by GDC in 2004 — the legal expert and the former health sector official — initiated and tactfully steered a participatory process that brought together the parastatals and the ministries represented in DJSN. The advisor duo benefited from the guidance of the Polish international advisor whose expertise in public health insurance mergers was crucial although he kept a low profile to not disrupt the locally led process. The GDC team prepared international study tours, including to Germany, numerous working meetings and a series of consultations, also with Parliament. This approach afforded the diverse group of government and parastatal actors a 'safe space' to deliberate and focus on 'what was best for Indonesia'. They eventually came to an agreement and formulated their consensus in the draft bill that was adopted by Parliament in 2011 as the seminal Social Security Carrier Law or 'BPJS Law' (Republic of Indonesia, 2011). While the law did not go into details, it stipulated the transformation of *Askes*, the parastatal company catering to civil servants, into the single-payer *Badan Penyelenggara Jaminan Sosial Kesehatan* (BPJS Health, or 'Social Security Carrier for Health'), operating as a public trust to manage the national social health insurance, JKN. *Jamsostek*, the parastatal serving private sector employees, was transformed into BPJS *Ketenagakerjaan* (Labour), also a public trust that combined the administration of occupational accident, old-age risk, pension and death benefits.

The Deputy Minister in the Coordinating Ministry for People's Welfare later explicitly acknowledged the pivotal role of the German-supported experts in forging a stable consensus among the Indonesian key institutions towards a single-payer national social health insurance model (Setiana, 2009).

Since the 2011 Social Security Law did not specify *how* the different schemes were to be transformed, considerable work was left to be done and conflicting positions needed to be reconciled before JKN could be launched. The process of developing the 2012 Roadmap towards national health insurance was not only a means to arrive at the administrative details of JKN: the Roadmap was fundamentally a vehicle to craft a compromise among the government institutions and other stakeholders represented in the Council, including the powerful labour unions and the representatives of the parastatal companies who had to give up considerable power and privilege. GDC hired 13 subject matter experts to support the Roadmap development and deployed Ibu Aya to help the Council facilitate the difficult drafting process. Unanimously described as an 'expert communicator' and 'tireless process manager with attention to detail', Ibu Aya assumed the role of 'honest broker' who created a professional and collegial atmosphere for the different interests to come together and gradually find common ground. While Ibu Aya was GIZ staff and provided support on behalf of GDC, everyone involved in the drafting appreciated that GDC 'did not try to interfere in the substantive decisions' that had to be worked out among the Indonesian stakeholders. The 2012 Roadmap is considered an important prerequisite for the successful, detailed design and launch of JKN in 2014. The President's recognition of the Roadmap as a strategic document to guide the transformation of Indonesia's social health protection schemes also helped to increase the line ministries' acceptance of the Council's steering and coordinating the reform process.

Dr Mundiharno (left), Director of Development Planning and Risk Management at BPJS Kesehatan in a meeting with GIZ principal advisor Ibu Aya (centre) and her team member Anna Farida Hairani.

4. INFORMING AND CAPACITATING IMPLEMENTATION, MANAGEMENT AND OVERSIGHT

The previous sections have illustrated that GDC, through its national and international advisors, has made tangible contributions to the conceptualisation, regulation and detailed design of the social health protection schemes in India and Indonesia. GDC's support also extended to the implementation phase, the fourth stage of the policy cycle.

Demand-driven capacity development and implementation support for RSBY and PM-JAY

In India, the GDC team has sought to bolster the implementation of RSBY and PM-JAY through numerous demand-driven interventions, for example, by embedding technical consultants in NHA, the body that oversees PM-JAY, to support its organisational development or to devise specifications for the information technology (IT) and management information systems (MIS).

CONSENSUS BUILDING AND DECISION-MAKING: KEY LEARNINGS FROM IMPLEMENTATION (3)

- GDC was instrumental in helping its partners reach stable compromise solutions to sensitive UHC design questions by letting highly skilled and well-connected national staff manage dialogue processes and create safe spaces for stakeholders with divergent interests to deliberate freely and find consensus.
- GDC's ability to act as a trusted convener, neutral broker and advocate for the common goal of UHC was made possible (a) by its approach of working with and through national staff and local champions, (b) because it was not seen to be pushing its own agenda, and (c) because it was not perceived as a 'threatening' actor with a big budget that would bend decisions in its preferred direction.
- International GDC advisors were able to make significant technical contributions and provide strategically important guidance, an approach which succeeded because they did not force GDC technical inputs or visibility on their partners.

NHA Chief Executive Officer Dr Indu Bhushant, GIZ's Dr Nishant Jain and their teams during a workshop on benefits package design

Since the Indian states fulfil important functions in running the social health protection schemes, GDC had experimented with a 'young professionals' programme under RSBY, deploying students having recently completed their master's degree as consultants to the state nodal agencies where they actively supported the implementation of RSBY for up to one year. If the states found these consultants to add value, they were encouraged to hire them full time – which a minority did while others did not find the budgetary resources to take on extra staff. Under PM-JAY, the GDC team recast their support to the states into a 'professionals programme', providing demand-driven implementation support to State Health Agencies (SHA) with more experienced consultants for a period of 1-2 years. Again, the SHAs are encouraged to take over the consultants where longer-term assistance is required. In 2019, GDC deployed more than 60 such professionals to different states. At the national level, several GDC staff members have been embedded in the NHA and work as a part of its team. GDC also regularly responds to a wide range of short-term technical assistance requests from NHA.

The GDC team has become such an integral part of NHA and the running of PM-JAY that some development partners who were interviewed for this case study, while appreciating GDC's flexible support in the setup phase of PM-JAY, cautioned against the risk of 'substitution instead of enablement'. They suggested that the time was ripe for a transition: instead of doing it themselves, GDC should empower NHA to strengthen the management and implementation capacities for PM-JAY at the national and state levels. GDC has already taken a significant step in this direction by supporting NHA to adopt 'Capacity Building Guidelines' (National Health Authority, 2019d). One of the guidelines' main objectives is institutional capacity strengthening at the national and state levels.

The changing role of Indonesia's National Social Security Council

In Indonesia, GDC supported the National Social Security Council in regulating and operationalising the transition from a fragmented health and social security system to the establishment of a single-payer social health insurance, JKN. While GDC's assistance in the Council's formative period focused on strengthening the institutional body itself, through organisational development services the German-supported advisors later transitioned to more implementation-focused assistance. For example, the Council and GDC recognised that public expectations had soared following the launch of JKN: people seemed to await an overnight transformation of health services that had been underfinanced for decades. Therefore, GDC worked with the Council to monitor public perceptions and the media coverage about JKN and BPJS Health, the health insurance administrator, and designed strategic communication products to inform the public about JKN and to manage expectations. GDC also engaged an Indonesian expert to help develop an implementation monitoring system for JKN with an interactive online dashboard (DJSN, 2019). The web-based system provides geographically disaggregated data on the progress of enrolment, premium payments, empanelled service providers, and many other variables to help the Council oversee the implementation of JKN.

The Council's oversight role has undergone significant changes over time. It is a composite body: its 15 members are appointed by and directly responsible to Indonesia's president. They come from different government and non-governmental institutions and are appointed for five-year terms. They are supported only by a small secretariat housed in the Ministry for Human Development and Culture (previously the Coordinating Ministry for People's Welfare), but not backed by a ministerial bureaucracy. Therefore, the extent to which the Council can fulfil its regulatory and oversight role depends on the commitment of its members and their clout in the government administration and the health system. During its first term, from 2009 until 2014, when the Council had the defining task of establishing the ground rules and procedures for JKN, it was mostly composed of 'heavyweights' such as Dr Chazali Situmorang (former Deputy Minister of the Coordinating Ministry of Human Development and Culture), highly regarded in their own organisations and with access to key decision-makers in the administration.

From 2014 on, beginning with its second term and a different membership, the Council's influence and visibility gradually seemed to wane. Once the all-important task of making BPJS operational had been accomplished, the health insurance administrator (the transformed parastatal company) quickly became a powerful institution in its own right and began tracking its own progress.

Today, the Council depends on data from BPJS Health to populate its JKN monitoring dashboard, but gets access to the data with up to three months delay. Senior government leaders interviewed for this case study did not see DJSN assert itself or effectively fulfil its oversight role since around 2016: some raise questions about the Council's added value and justification.

What is perceived as the Council's quiet demise has coincided with the end of GDC's support to it. Although GDC's social security project was formally active until the end of 2018, the focus during its final two years shifted from policy advice to the development of the JKN implementation monitoring system. The narrow focus of GDC's commission on monitoring support may have limited its ability to assist the Council in more substantively fulfilling its coordination and oversight role.

5. CONDUCTING ANALYSES AND EVALUATIONS FOR ITERATIVE IMPROVEMENT

Evidence-informed policy-making and programme management depend on timely analyses and evaluations to assess progress and to guide course corrections, where needed – the fifth and final stage of the policy cycle.

In both countries, GDC conducted or supported policy-relevant research and analyses, some of which provided strategic insights for the countries' respective UHC reforms. Well timed, the German-supported study on 'Options for Social Protection Reform in Indonesia' (Bender et al., 2008) was released during the decisive stages of drafting the social security carrier law and provided a robust problem analysis as well as concrete reform scenarios – including the merger of the parastatal companies and their transformation into public trusts. One year after the launch of JKN, GDC technically and financially enabled an analysis of the financial sustainability of the scheme and the incidence and effects of out-of-pocket payments under JKN (Hidayat et al., 2015a; Hidayat et al., 2015b).

In India, an evaluation of RSBY supported by GDC found that RSBY's coverage limit of five people per family was not realistic for the often larger family sizes of India's poor, resulting in the exclusion especially of women and the elderly. The assessment also showed that the coverage cap of 30,000 rupees per year was insufficient to cover people's medical needs for costlier treatments. The family size limit was subsequently removed from PM-JAY and the coverage amount increased to 500,000 rupees annually.

GDC also produced several smaller thematic studies and evidence syntheses, for example, on the empowering effect that RSBY had for women (Cerceau et al., 2017) and the challenges of keeping the database of eligible PM-JAY beneficiaries up-to-date (Schaberg & Ziegler, 2019). GDC has commissioned an international research consortium[17] with documenting the implementation processes and assessing the short-term impact of PM-JAY, aiming to inform the future direction of the scheme. As part of this research, a baseline study was conducted just before the launch of PM-JAY, a second round of data collection was planned for late 2019, and first results are expected in 2020.

> GDC has accumulated a vast body of institutional memory and practical learnings in India and Indonesia.

GDC has accumulated a vast body of institutional memory and practical learnings in India and Indonesia and has made some of it accessible through grey literature publications (e.g. Jain, 2010; Silberhorn, 2015; Birdsall & Adams, 2016; Cerceau et al., 2017). There is room to increase efforts to document tacit, strategic management insights that may not be suitable for external publication but that are important for maintaining GDC's effectiveness and relevance as a complexity-aware, politically informed development partner.

IMPLEMENTATION, MANAGEMENT AND OVERSIGHT: KEY LEARNINGS FROM IMPLEMENTATION (4)

- GDC has effectively strengthened the implementation, management and oversight of UHC initiatives in India and Indonesia through direct technical assistance and organisational capacity development activities.
- The experiences from both countries indicate that implementation assistance and management support must be geared towards strengthening institutional capacities and relationships and must take care not to be tied (exclusively) to the fortunes of politically appointed individuals who only temporarily fulfil their role. Otherwise, GDC assistance risks substituting itself for local capacity or, where local capacity has been developed, it risks losing it 'overnight' when those who embody the capacity move elsewhere.

[17] The consortium is led by the Heidelberg Institute of Global Health (Faculty of Medicine, Heidelberg University) and includes the German Development Institute / *Deutsches Institut für Entwicklungspolitik* (DIE), City University of London, IQVIA (India) and Nielsen (India).

The Indian GDC team has retained virtually all of its knowledge, in spite of two programme director rotations, thanks largely to GIZ's Nishant Jain and other national team members who have stayed with the organisation since the beginnings of RSBY in 2007. In Indonesia, the principal advisors have changed frequently and there is a tangible risk of valuable learnings' being lost.

Cross-cutting insights: the importance of trust, flexibility and localised knowledge

Reflecting across the experiences and contributions of GDC to the partner-led UHC reform processes in India and Indonesia, several additional learnings emerge.

GDC was granted the opportunity to contribute to many of the core decision-making processes and was allowed to help shape the social health protection schemes in both countries because the partners trusted GDC. This trust had emerged from (a) GDC's long-term commitment to the UHC agenda (over 10 years in each country) even in difficult times – for instance, not giving up on UHC although RSBY had suffered a major setback – and over thorny political issues, such as suggesting a merger of some of Indonesia's most powerful parastatal companies; (b) GDC's broad and deep technical expertise that was grounded in implementation experience and mostly delivered through national staff; and (c) the conscious efforts of the GDC advisors to build relationships with their counterparts as equals and to demonstrate their unwavering support for locally-defined instead of donor-driven priorities.

> The key to effectiveness was GDC's long-term, flexible and impact-focused approach, committing its technical assistance to genuinely partner-led processes.

The last strategy, supporting *partner*-led processes, required considerable flexibility on the part of GDC – in two directions. First, country teams needed to be able to respond to partner needs and demands even if these came at short notice, from unanticipated geographic areas or different institutions, or on a subject area that was 'not in the partner agreement'.[18] Secondly, since the partners' requests did not necessarily align with the project results framework – typically spanning four to five years – that GIZ had agreed upon with its client BMZ, the GIZ advisors needed to be flexible in how they communicated their activities, how they advocated for support with their financier, and how they reported on results. Some indicators had purposely been defined in relatively broad terms to ensure that a wide range of activities could be captured, as long as they pursued the same objective.

More recently, the emergence of narrowly defined results frameworks and short-duration GDC projects (e.g. no longer than two to three years, possibly with limited funding) call into question the defining characteristics of what made GDC support effective in India and Indonesia: taking a long-term, impact-focused approach to UHC reforms and committing to genuinely partner-led processes with flexibility over time and resources.

The experiences of GDC in supporting India's and Indonesia's social health protection reforms further illustrate the importance of balancing international with local expertise. The majority of the key informants who participated in this case study referred, at some point, to GDC's ability to make Germany's vast health insurance legacy accessible and practically usable for the partner countries (Bismarck was mentioned in nearly every second interview). GDC did bring its international expertise to bear – by organising study visits, offering short training courses or by bringing German and international experts to India and Indonesia. However, there can be no doubt that these technical inputs were effective because they were ultimately delivered through or moderated by skilled and trusted national advisers and partners who spearheaded the support for reform processes locally.

EVALUATION, ANALYSIS, IMPROVEMENT: KEY LEARNINGS FROM IMPLEMENTATION (5)

- GDC assisted its partners in establishing monitoring and evaluation systems and supported or conducted selected high-impact analyses that, when provided at the right time, helped to improve the design or management of India's and Indonesia's UHC schemes. However, GDC's main strength was to contribute insights from experiential learning in the daily practice of technical cooperation.

- It may be worth considering for GDC in India and Indonesia to periodically capture their institutional memory and implementation learnings, or risk losing this knowledge that currently rests almost exclusively with the advisors. Documenting their tacit knowledge would ensure that future technical cooperation can function effectively in the two countries, while the insights may be relevant to GDC teams working on similar challenges elsewhere.

[18] GDC advisors have occasionally denied requests for support when they thought others were better placed to respond or when responding would have jeopardised their impartiality (like printing UHC information posters that resembled campaign ads shortly before an election). Most partner requests were about additional technical support which GDC typically and readily met by hiring additional consultants or deploying its own advisers.

What's next for India and Indonesia – and for GDC – on the road to UHC?

India and Indonesia have taken great strides towards UHC by extending social health protection to hundreds of millions of people in just a few years. Now both countries face similar challenges: they need to extend coverage to those who are eligible but who have been left out – whether it is because they do not want to participate, cannot afford to, or are not even aware of their eligibility. For both countries, this means finding ways to include the better-off in the social health protection schemes to ensure a more balanced risk pooling – a politically difficult task because these richer groups would rather purchase private insurance.

The teams in India and Indonesia are also concerned about the financial sustainability of PM-JAY and JKN: each lays a considerable weight on its government's annual budget. Moreover, in India, NHA and its partners are pondering two big questions that Indonesia has already made considerable progress on: how to strengthen the continuum of care by aligning primary health service providers – currently not part of PM-JAY but covered through the Health and Wellness Centres initiative – with the scheme, e.g. through a better referral system? And how to promote convergence among India's numerous fragmented health protection schemes?

With plenty left to do, the question for GDC is whether and how it wants to contribute to the two countries' ongoing, challenging journeys towards UHC. The partners are keen for GDC's continued, tangible support, given its track record of being highly effective in helping to advance partner-led processes in India and Indonesia. GDC recently ended its social protection programmatic support to JKN in Indonesia. Work in India continues but renewing funding agreements is becoming more challenging.

Internationally, Germany supports 'UHC2030', a multi-stakeholder platform to promote health systems strengthening and political commitment towards UHC. Germany is also a member of the global partnership on 'Universal Social Protection 2030' and, like Indonesia, forms part of its interim steering committee. Attaining UHC is a major part of the USP agenda, which envisions covering all people for all risks. However, in India, USP does not feature prominently on the political agenda. While Germany's high-level international engagement for UHC and USP is laudable, this case study's key informants feel that it cannot replace the in-depth in-country bilateral support that has helped India and Indonesia to get this far towards UHC – while there is still a long way to go.

Peer review

Prior to publication, each case study in the German Health Practice Collection is reviewed by two independent peer reviewers. The reviewers, who are internationally recognised experts in their fields, are requested to comment on how the case study has answered its guiding questions and whether it has generated new insights into the implementation of the given approach and the development challenge it addresses. In the present case, the insightful queries posed by the two peer reviewers have led the writer to streamline the structure of the study and present certain topics in more detail. The peer reviewers' main observations are summarised here.

Both experts agree that the case study yields significant insights worth sharing with an international audience. Highlighting particularly important success factors for technical cooperation, they emphasise the role of long-term engagement, investing in building trust with government partners, context awareness and the crucial contribution of local expert advisors, as explored in this case study. One reviewer wrote, 'I congratulate the author and the initiative to write such a paper. Often these very relevant experiences are forgotten once the key players [have] disappeared from the playing field'.

One expert reviewer suggested that a discussion on 'replicability' could have added value to the case study from two perspectives: (a) investigating what are the conditions for replicating the technical assistance approach of 'flexibility and patience' in other countries, and (b) exploring similar cases where GDC has supported large-scale social health protection reforms, to assess the extent to which GDC remained flexible in its support of the partner's agenda vs. having promoted its preferred social health protection model. Since this case study was tasked with retracing the UHC reforms in India and Indonesia to learn from implementation in these two countries, the two questions raised by the peer reviewer, while highly relevant, were beyond the scope of this paper.

The other reviewer critically remarked that the study question and methodology, including the use of the policy cycle model, needed to be clarified. The present case study has been revised based on the reviewer's helpful suggestions. This reviewer also suggested to restructure the entire study around five to seven key learnings and to underpin each learning with examples from the two countries. Given that the author had been tasked to identify learnings by retracing the implementation process in each country, a process-oriented approach and structure were chosen, in alignment with another GIZ case study compendium (Kirsch et al., 2017). The cyclical model of the policy reform process is considered to be a suitable structure for this purpose and has therefore been maintained in this case study.

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References

Agustina R et al. (2019). Universal health coverage in Indonesia: concept, progress, and challenges. *The Lancet*, 393(10166), pp. 75-102.

Ahlin T et al. (2016). Health insurance in India: what do we know and why is ethnographic research needed? *Anthropology & Medicine*, 23(1), pp. 102-124.

Alesina A and Glaeser E (2005). *Fighting Poverty in the US and Europe: A World of Difference*. Oxford: Oxford University Press.

Andrews M et al. (2017). *Building state capability. Evidence, analysis, action*. Oxford: Oxford University Press.

Balarajan Y et al. (2011). Health care and equity in India. *Lancet*, Volume 377, pp. 505-515.

Bender K et al. (2008). *Options for Social Protection Reform in Indonesia*. Jakarta: Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH.

Bender K and Knöss J (2008). Social Protection Reform in Indonesia: In Search of Universal Coverage. In: C Küsel, U Maenner & R Meissner, (eds.) *The Social and Ecological Market Economy: A Model for Asian Development?* Eschborn: Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH, pp. 327-338.

Birdsall K and Adams S (2016). *Health insurance for India's poor: Meeting the challenge with information technology*. Berlin/Bonn: Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH.

Brodie M et al. (2007). *A global look at public perceptions of health problems, priorities, and donors: the Kaiser/Pew global health survey*. [Online]
Available at: https://www.kff.org/wp-content/uploads/2013/01/7716.pdf

Bump J (2015). The Long Road to Universal Health Coverage: Historical Analysis of Early Decisions in Germany, the United Kingdom, and the United States. *Health Systems & Reform*, 1(1), pp. 28-38.

Campbell J et al. (2013). Human resources for health and universal health coverage: fostering equity and effective coverage. *Bulletin of the World Health Organization*, 91(11), pp. 853-863.

Cerceau S et al. (2017). Empowering Women through Health Insurance: Lessons from RSBY in India. In: K Miles, M Wiedmaier-Pfister & M Dankmeyer, (eds.) *Mainstreaming Gender and Targeting Women in Inclusive Insurance: Perspectives and Emerging Lessons. A Compendium of Technical Notes and Case Studies*. Bonn and Eschborn: Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH.

Commission on Social Determinants of Health (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health. Final report*. Geneva: World Health Organization.

Dartanto T and Otsubo S (2016). *Intrageneration Poverty Dynamics in Indonesia: Households' Welfare Mobility Before, During, and After the Asian Financial Crisis*. Tokyo: JICA Research Institute.

Dartanto T et al. (2016). Participation of Informal Sector Workers in Indonesia's National Health Insurance System. *Journal of Southeast Asian Economies*, 33(3), pp. 317-342.

DDD Manifesto (2014). *The DDD Manifesto: On Doing Development Differently*. London: ODI.

Directorate General of Health Services (2017). *Work accountability report*. Jakarta: Ministry of Health.

DJSN (2019). *Sistem Monitoring Terpadu* (JKN M&E Dashboard). [Online]
Available at: http://sismonev.djsn.go.id/sismonev.php

Doshi V (2018). India just announced a vast new health insurance program. But can it afford it? In: *The Washington Post*. [Online]
Available at: https://www.washingtonpost.com/world/asia_pacific/india-just-announced-a-vast-new-health-insurance-program-but-can-it-afford-it/2018/02/01/805efb46-0757-11e8-ae28-e370b74ea9a7_story.html

Emont J (2016). A country of a quarter-billion people is trying to provide health care for all. In: *The Washington Post*. [Online]
Available at: https://www.washingtonpost.com/world/asia_pacific/a-country-of-a-quarter-billion-people-seeks-to-provide-free-health-care-for-all/2016/05/18/f36bf7b2-1b93-11e6-82c2-a7dcb313287d_story.html

Ernsthofer A and Stockmayer A (eds.) (2009). *Capacity development for good governance*. Baden-Baden: Nomos.

Fishback P et al. (2007). Births, deaths and New Deal relief during the Great Depression. *The Review of Economics and Statistics,* 89(1), pp. 1-14.

Flint A and Natrup C (2019). Aid and development by design: local solutions to local problems. *Development in Practice*, 29(2), pp. 208-219.

Frenken S and Müller U (eds.) (2010). *Ownership and political steering in developing countries*. Baden-Baden: Nomos.

Frenz P and Vega J (2010). *Universal health coverage with equity: what we know, don't know and need to know. Background paper for the global symposium on health systems research*. Geneva: World Health Organization.

GIZ India (2019). *Information on the current status of PM-JAY (participating states and union territories; beneficiary confirmations issued; priorities for PM-JAY expansion), as of December 2019: provided by GIZ India*. Unpublished, New Delhi: Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH.

Government of India (2017). *National Health Policy*, 2017. New Delhi: Ministry of Health and Family Welfare.

Government of India (2018). Budget 2018-2019: Speech of Arun Jaitley, Minister of Finance. [Online]
Available at: https://www.thehindu.com/news/resources/article22619699.ece/BINARY/Jaitley%20full%20speech

Gutmann A and Thompson D (2010). The Mindsets of Political Compromise. *Perspectives on Politics,* 8(4), pp. 1125-1143.

Harimurti P et al. (2013). *The Nuts & Bolts of Jamkesmas: Indonesia's Government-Financed Health Coverage Program*. Washington D.C.: The World Bank.

Hidayat B et al. (2015a). *Financial Sustainability of the National Health Insurance in Indonesia: A First Year Review. Policy Brief.* Jakarta: Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH.

Hidayat B et al. (2015b). *Out-of-Pocket Payments in the National Health Insurance of Indonesia: A First Year Review. Policy Brief.* Jakarta: Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH.

IIPS & Macro International (2007). *National Family Health Survey (NFHS-3), 2005–06: India: Volume I*. Mumbai: International Institute for Population Sciences.

Jain N (2010). *56 Million Steps Towards Universal Coverage: RSBY Health Insurance for the Poor in India*. Eschborn/New Delhi: Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH.

Karan A et al. (2017). Extending health insurance to the poor in India: An impact evaluation of *Rashtriya Swasthya Bima Yojana* on out of pocket spending for healthcare. *Social Science & Medicine*, Volume 181, pp. 83-92.

Kickbusch I (2019). Advancing universal health coverage in 2019 through the gender dividend. In: J Kirton & I Kickbusch, (eds.) *Health: A political choice*. London: Global Governance Project, pp. 16-19.

Kirsch R et al. (eds.) (2017). *Transformation, Politics and Implementation: Smart Implementation in Governance Programs*. Baden-Baden: Nomos.

Kirton J and Kickbusch I (eds.) (2019). *Health: A political choice. Delivering Universal Health Coverage 2030*. London: Global Governance Project.

Klingebiel S et al. (eds.) (2016). *The Fragmentation of Aid: Concepts, Measurements and Implications for Development Cooperation*. London: Palgrave Macmillan.

Knöss J and Sumadi P (2009). *Political Economy of Reform: A case study from Indonesia*. London, paper presented at the conference: 'Beyond Accra: Practical Implications of Ownership and Accountability in National Development Strategies'. London School of Economics, 22-24 April, pp. 228-236.

Kumar K et al. (2015). Socio-Economic Differentials in Impoverishment Effects of Out-of-Pocket Health Expenditure in China and India: Evidence from WHO SAGE. *PLOS ONE*, 10(9).

La Forgia G and Nagpal S (2012). *Government-Sponsored Health Insurance in India*. Washington D.C.: The World Bank.

Lasswell H D, (1956). *The decision process: seven categories of functional analysis*. Bureau of Governmental Research, College of Business and Public Administration, University of Maryland.

Leppo, K et al. (eds.) (2013). *Health in all policies: seizing opportunities, implementing policies.* Helsinki: Ministry of Social Affairs and Health.

Mahendradhata Y et al. (2017). The Republic of Indonesia: Health System Review. *Health Systems in Transition,* 7(1).

Ministry of Rural Development (2011). *Socio-Economic Caste Census 2011*. New Delhi: Government of India.

National Health Authority (2019a). *Lessons learned in one year implementation of PM-JAY*. New Delhi: Government of India.

National Health Authority (2019b). *About Pradhan Mantri Jan Arogya Yojana (PM-JAY)*. [Online]
Available at: https://pmjay.gov.in/about-pmjay

National Health Authority (2019c). *Annual Report 2018-19. Ayushman Bharat Pradhan Mantri Jan Arogya Yojana*. New Delhi: Government of India.

National Health Authority (2019d). *Capacity Building Guidelines*. New Delhi: Ministry of Health and Family Welfare. Government of India.

National Population and Family Planning Board (BKKBN), Statistics Indonesia (BPS), Ministry of Health (Kemenkes), & ICF (2018). *Indonesia Demographic and Health Survey 2017.* Jakarta: BKKBN, BPS, Kemenkes, and ICF.

Navarro V (1989). Why some countries have national health insurance, others have national health services, and the US has neither. *Social Science & Medicine*, 28(9), pp. 887-898.

NITI Aayog/UN (2018). *SDG India Index Baseline Report, 2018*. New Delhi: NITI Aayog.

OECD/UNDP (2019a). *Making development co-operation more effective: How partner countries are promoting effective partnerships*. Part I of the Global Partnership 2019 Progress Report, s.l.: Global Partnership for Effective Development Co-operation.

OECD/UNDP (2019b). *Making development co-operation more effective: How development partners are promoting effective, country-led partnerships. Part II of the Global Partnership 2019 Progress Report, s.l.*: Global Partnership for Effective Development Co-operation.

Pandey A, Kumar G, A, Dandona R and Dandona L (2018). Variations in catastrophic health expenditure across the states of India: 2004 to 2014. *PLoS ONE*, 13(10), p. e0205510.

Pandey A, Ploubidis G, Clarke L and Dandona L (2018). Trends in catastrophic health expenditure in India: 1993 to 2014. *Bulletin of the World Health Organization 2018*, Volume 96, pp. 18-28.

Pew Research Center (2018). *Many Around the World Are Disengaged From Politics*. Washington D.C.: s.n.

Press Information Bureau (2019). *Celebrating Ayushman Bharat Pakhwara. Press release 17 September 2019.* [Online]
Available at: https://pmjay.gov.in/sites/default/files/2019-09/Ayushman%20Bharat%20Pakhwara%20-_0.pdf

Ramesh M (2009). Economic Crisis and its Social Impacts: Lessons from the 1997 Asian Economic Crisis. *Global Social Policy*, 9(1), pp. 79-99.

Reddy K et al. (2011). *High-level expert group report on universal health coverage for India*. New Delhi: Planning Commission of India.

Republic of Indonesia (2004). *Law No. 40 of 2004 Concerning National Social Security System*. [Online]
Available at: https://www.bpjsketenagakerjaan.go.id/assets/uploads/tiny_mce/Peraturan%20inggris/07112016_081646_EN_UU%20No%2040%20Tahun_2004%20tentang%20SJSN_1.pdf

Republic of Indonesia (2011). Law No. 24 of 2011 *Concerning The Social Security Administrative Body.* [Online]
Available at: https://www.bpjsketenagakerjaan.go.id/assets/uploads/tiny_mce/Peraturan%20inggris/15122015_105624_EN_UU%20No%2024%20Tahun%202011%20tentang%20BPJS.pdf

Republic of Indonesia (2012). *Roadmap toward the National Health Insurance of Indonesia (INA Medicare) 2012-2019: The Brief Edition*. Jakarta: Republik Indonesia.

Roberts M et al. (2015). Disaggregating the Universal Coverage Cube: Putting Equity in the Picture. *Health Systems & Reform*, 1(1), pp. 22-27.

Schaberg L and Ziegler S (2019). *How to identify the poor? The case of India*. New Delhi: Unpublished draft.

Setiana A (2009). *Acknowledgements. Letter written by the Deputy Minister.* Jakarta: Coordinating Ministry for People's Welfare.

Silberhorn T (2015). Germany's Experience in Supporting and Implementing Human Rights-Based Approaches to Health, plus Challenges and Successes in Demonstrating Impact on Health Outcomes. *Health and Human Rights*, 17(2), pp. 21-29.

Steele L (2016). Ethnic Diversity and Support for Redistributive Social Policies. *Social Forces*, 94(4), p. 1439–1481.

Stuckler D et al. (2010). *The political economy of universal health coverage. Background paper for the global symposium on health systems research*. Technical report. Geneva: WHO.

Swarup A (2019). *Not just a civil servant*. New Delhi: Unicorn Books Pvt. Ltd.

Thiede M and Koltermann K (2013). *Access to health services - Analyzing non-financial barriers in Ghana, Rwanda, Bangladesh and Vietnam using household survey data. A review of the literature*. New York: UNICEF.

Ulrichs M and White-Kaba M (2019). *A systems perspective on Universal Social Protection: Towards life-long equitable access to comprehensive social protection for all*. Berlin/Bonn: Federal Ministry for Economic Cooperationand Development (BMZ).

UN General Assembly (2015). *Resolution adopted by the General Assembly on 25 September 2015. A/RES/70/1: Transforming our world: the 2030 Agenda for Sustainable Development*. New York: United Nations General Assembly.

UNDG (2011). *Results-Based Management Handbook: Harmonizing RBM concepts and approaches for improved development results at country level.* New York: United Nations Development Group.

UNDP/UNEP (2015). *Indicators and Data Mapping to Measure Sustainable Development Goals (SDGs) Targets: Case of Indonesia*. Jakarta: United Nations Development Programme / UN Environment Programme.

UNICEF (2012). *National health insurance in Asia and Africa*. New York: United Nations Children's Fund.

WHO/World Bank (2017). *Tracking universal health coverage: 2017 global monitoring report*. Geneva: World Health Organization and International Bank for Reconstruction and Development / The World Bank.

WHO/World Bank (2019). *Global Monitoring Report on Financial Protection in Health 2019*. Geneva: World Health Organization and International Bank for Reconstruction and Development / The World Bank.

WHO (2000). *The world health report 2000 - Health systems: improving performance*. Geneva: World Health Organization.

WHO (2005). *Resolution WHA58.33. Sustainable health financing, universal coverage and social health insurance*. [Online]
Available at: http://apps.who.int/medicinedocs/en/m/abstract/Js21475en/\

WHO (2006). *Working together for health. World Health Report 2006*. Geneva: World Health Organization.

WHO (2007). *Everybody's business: strengthening health systems to improve health outcomes. WHO's framework for action*. Geneva: World Health Organization.

WHO (2010). *Health systems financing: the path to universal coverage. World health report 2010*. Geneva: World Health Organization.

WHO (2014). *Making fair choices on the path to universal health coverage. Final report of the WHO Consultative Group on Equity and Universal Health Coverage*. Geneva: World Health Organization.

WHO (2019a). *Global Health Expenditure database*. [Online]
Available at: http://apps.who.int/nha/database

WHO (2019b). Global Health Observatory data repository: Domestic general government health expenditure (GGHE-D) as percentage of gross domestic product (GDP) (%), Data by country. [Online]
Available at: http://apps.who.int/gho/data/view.main.GHEDGGHEDGDPSHA2011v

WHO (2019c). Health equity country profiles. [Online]
Available at: https://www.who.int/gho/health_equity/country_profiles/en/

WHO (2019d). Global Health Observatory data repository: Out-of-pocket expenditure as percentage of current health expenditure (CHE) (%). [Online]
Available at: http://apps.who.int/gho/data/node.main.GHEDOOPSCHESHA2011?lang=en

WHO (2019e). *Primary Health Care on the Road to Universal Health Coverage: 2019 Monitoring Report*. Geneva: World Health Organization.

WHO (2019f). *Universal health coverage (UHC) fact sheet*. Geneva: World Health Organization.

WHO (2019g). *What is health financing for universal coverage?* [Online]
Available at: https://www.who.int/health_financing/universal_coverage_definition/en/

Wiseman V et al. (2018). An evaluation of health systems equity in Indonesia: study protocol. *International Journal for Equity in Health*, 17(138).

World Bank (2000). *East Asia: Recovery and Beyond*. Washington D.C.: The World Bank.

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