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Public Service Quality and Building Coordinated Policy: An Analytical Study of Jamkesmas And Jamkesda Implementation

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ABSTRACT

This study will examine the implementation of Jamkesmas (Jaminan Kesehatan Masyarakat-Health Insurance Scheme for People) and Jamkedsa (Jaminan Kesehatan Masyarakat Daerah-Health Insurance Scheme for Local People). Both are innovative policies in term of health financing, since they reflect more the spirit of insurance compared to the previous policies which were merely about financial aid. However, these policies do not reflect the ideals of policy coordination. Several theoretical reviews about social health insurance are applied to figure out the spirit of Indonesian health insurance sociologically and culturally. The Colebatch's framework of vertical and horizontal dimensions of policy is used as the main tool of analysis for measuring whether both Jamkesmas and Jamkesda are categorized as coordinated policies or not. Qualitative research approach is used as the method in order to gain in-depth information about the current polemical of Jamkesmas and Jamkesda implementations. Qualitative analysis method is applied during the process of analysis. The secondary data will be collected, sorted, coded and analyzed. Those several steps aim to cross check the validity of each data for answering the research questions. The result of this study shows that Jamkesmas and Jamkedsa lack of coordination during the process of policy making which has led to complicated problems at the implementation stage namely: the lawsuit/multiple interpretations of the law, unstructured policy stages at the vertical level, complicated problems at horizontal stages and conflict among institutional governments. Moreover, the nature of policy coordination

in Indonesia is still reactive. This fact causes policy inconsistency which has the effect of law uncertainty and poor quality of public services. **KEYWORDS;** Policy Coordination, Public Service Delivery, Health Insurance, Jamkesmas, and Jamkesda

INTRODUCTION

Indonesia has been producing plenty of innovative policies which add new content to policies that have been enacted by the policy makers. This is considerable progress for Indonesia compared to the Soeharto Era which merely produced dictated policies. However, Indonesia is still facing a great challenge in terms of producing coordinated policies. This indicates lack of coordination in the process of policy making. Moreover, the policy making is often dictated by the politic interests of the regime. It has been reflected as short-term policy which has not been well-rooted in sociological and cultural values of Indonesian people yet. As a result, when the policy comes into the implementation stage, problems come to the surface, such as, job redundancy, incoherent policy and conflict among departments and NGOs. Therefore, policy coordination is vital in order to mediate between different interests and aims and work towards shared goals. Moreover, "Coordination enables the whole to perform better than the sum of the parts or at least to prevent disintegration and fragmentation" (Metcalf, 2004 p. 9).

This study will examine the implementation of *Jamkesmas (Jaminan Kesehatan Masyarakat-Health Insurance*

Scheme for People) and *Jamkedsa* (*Jaminan Kesehatan Masyarakat Daerah*-Health Insurance Scheme for Local People). Both are innovative policies in term of health financing, since they reflect more the spirit of insurance compared to the previous policies which were merely about financial aid, even though the current health financing mechanism is still far from the perfect implementation.

The analysis will investigate whether both policies reflect the ideals of either policy coordination or uncoordinated policy. These parameters can be measured by analyzing the implementation process of *Jamkesmas* and *Jamkesda*, because policy coordination is important during both policy making and policy implementation. The main argument of this study is that *Jamkesmas* and *Jamkesda* do not reflect the ideals of policy coordination with regard to several problems at the implementation stage, such as: the lawsuit/multiple interpretations of the law, unstructured policy stages, the absence of enacting supported laws and establishing supported institution, overlapping jobs and reactive coordination. Proof of argument will be addressed by discussing the gap between the real facts and the ideal theories.

RESEARCH METHODS

Qualitative research approach is used to gain in-depth information about the current polemic of *Jamkesmas* and *Jamkesda* implementations. The Acts stipulate the schemes of health-cover which are offered by the national and local governments.

Data collection: Secondary data Published academic materials (books and journals) about health-cover scheme, Public policy and public service delivery, Government laws and regulations,

Government and credible NGOs reports and data about related issues, Current reports and publications from credible national and international newspapers.

Data Analysis using Qualitative analysis method is applied during the process of analysis. The secondary data will be collected, sorted, coded and analyzed. Those several steps aim to cross check the validity of each data for answering the research questions.

In order to simplify, this study is divided into seven sections; 1. Introduction; 2. Method of Research; 3 Theoretical reviews on social health insurance; 4. The schemes of *Jamkesmas* and *Jamkesda*; 5. Analyzing the policy coordination of *Jamkesmas* at the implementation stage; 6. Analyzing the policy coordination of *Jamkesda* at the implementation stage and 7. Recommendation and Conclusion.

DISCUSSION AND RESULTS

1. THE SCHEME OF *JAMKESMAS* AND *JAMKESDA*

In the year 2004, Act no 40 regarding the National Social Security System (*Sistem Jaminan Sosial Nasional - SJSN*)¹ was enacted as the universal platform for introducing a new health program for the poor. *Jamkesmas*² is categorised as health insurance for the poor that is funded by the central government from general tax revenue. The implementation of this program is based on the MoH (Ministry of Health) decree number 125/Menkes/SK/II 2008 regarding the guidelines for implementation of the *Jamkesmas*. This program covers about 76,400,000 people who are categorised as poor and nearly-poor people based on the *Susenas* (National Socio Economic Survey)³ in 2008 data provided by

the BPS (Central Bureau of Statistics). The numbers of targeted people are distributed to each local government within a determined quota and then, the local governments are responsible to finance the gap between the actual cost of insuring their local population and the insurance funds provided by the central government via *Jamkesmas*. That scheme of financing the gap is named *Jamkesda*.

There are several beneficial packages⁴ which are offered by *Jamkesmas*, including inpatient, outpatient, maternal, preventive care and ambulatory services. In terms of medication, insured members are only entitled to generic drugs. This insurance scheme contracts with 926 public hospitals and 220 private hospitals for certain procedures (www.healthmarketinnovations.org).

Considering the limited national budget covering health insurance for all Indonesian citizens, the national government initiated the *Jamkesda* program in 2009 in order to encourage local governments not only to support the *Jamkesmas* program but also to manage their own local health insurance. There is no standardised regulation for *Jamkesda* implementation, since the Regulation of MOH - *Peraturan Menteri Kesehatan* number 095 year 2010 regarding the synchronisation system between *Jamkesmas* and *Jamkesda* was rejected by the House of Representatives because it conflicts with Act no 40/2004 (Candra, Kompas 17 June 2010). Therefore the *Jamkesda* program is being implemented in many different procedures based on the capacity of local governments.

2. THEORETICAL REVIEWS ON SOCIAL HEALTH INSURANCE

Jamkesmas and *Jamkesda* are forms of Indonesian social security in terms of health insurance. Discuss-

ing the social security in Indonesia is far from the genuine aims for securing basic individual rights toward the welfare, except for militaries and civil services and other employments which are covered by the private social and health insurance. In developed country such as Australia, social security has developed in resilience. Moreover, this system has been more integrated with the government and private actors in securing individuals and families. Furthermore, the schemes offer in many benefits for example: support for child care, invalid and old-age pensions, health care etc (Herscovitch and Stanton 2008).

Social health insurance is the system in which collecting money (from tax or certain individuals contributions to social health insurance) in order to finance health services. 'This type of insurance is characterized by mandatory membership at least for the majority of population, open enrollment and community rating, exception with no covering premiums related to individual risk' (Zweifel, 2007 p.7-8). According to the previous concept, *Jamkesmas* and *Jamkesda* are considered as the social health insurance.

Compared to developed countries, social health insurance is not simply as insurance scheme, but it is defined as part of social order (De Roo 2003), as 'fabric of society' (Zollner 2001), and as balancing society as a whole' (Le Pen 2001). Moreover, health care system is defined as living entitles not just as an 'artificial bureaucratic structures' (Saltman in Saltman et.al 2004, p.5). However, in Indonesia *Jamkesmas* and *Jamkesda* are still seen as political interests by elites in gaining popularity. Therefore there are uncoordinated policies and structures at the implementation stages. It seems that Indonesian health insurance policies are being imple-

mented half-heartedly, because the spirits of health insurance policies in Indonesia are not well-rooted in its sociological and cultural values. According to Hofstede it is important to refer to the national culture and social values in terms of introducing the new system or institution, such as health insurance. The reason is that, societal norms will smoothly assist the adaptation of new health insurance policy and its institution (cited in Saltman in Saltman et al. 2004, p 6). In Indonesia, the social value of *gotong royong* and *tenggang rasa* could be revitalized and adopted as the basic paradigms and spirits in terms of conceptualizing and implementing the health insurance policy, so that the policies are understood not only as health financial arrangement but also as the way of peoples' life in a balanced society.

3. ANALYSING THE POLICY COORDINATION OF JAMKESMAS AT THE IMPLEMENTATION STAGE

Althaus, Bridgman and Davis state that "Policies are based on shared goals. Programs should work together, and not at cross-purposes. Priorities must be assigned between competing proposals. Coordination in government is a virtue" (2007, p. 124). Therefore, setting up health insurance policy requires effective coordination and solid purposes among related stakeholders. In the case of various health financing schemes in Indonesia, both public (*Jamkesmas*, *Jamkesda*, *Jamsostek*, *Askes*, *ASABRI* etc) and private insurances, they must be synchronised within good guidelines of comprehensive policy in order to avoid cross-purposes. This is reasonable because health is one of the most complex social-sector goods (Mitchell and Bossert, 2010), since it involves several institutions (health

clinics, hospitals, pharmacies) and produces multiple products (outpatient/inpatient consultations and procedures, pharmaceuticals, public health measures). With multiple institutions of health insurance, policy coordination can facilitate different aims of various health insurance providers working together. As Ney points out, the common problem in most middle-income countries is lack of basic regulatory competences with regard to a coherent health insurance scheme. As a result, health delivery systems are widely fragmented and imbalanced (2009). Therefore, Policy coordination is important in order to create consistent policy with overall government priorities (Ben-Gera, 2009)⁵

In the case of *Jamkesmas*, lack of coordination during the process of policy making is reflected in the occurrence of several problems during the policy implementation. Colebatch's vertical and horizontal dimensions are used as the tool of analysis in the figures 1.

According to Figure 1, there are unstructured and uncoordinated processes during "the transmission downwards of authorised decisions at the vertical dimension" (Colebatch, 2008, p. 23). Following the enactment of Act no 40 year 2004 regarding National Social Security System (SJSN), the vertical domains should have concentrated immediately to enact the act of BPJS establishment, soon after that the National Social Security Council-Dewan Jaminan Sosial Nasional (DPJS) and the Social Security Organising Body-Badan Penyelenggara Jaminan Sosial (BPJS) should have been established. This is important to keep the policy consistency before the tasks are distributed at the multiple domains at horizontal dimension.

In facts, the DPJS was established in 2008 the

FIGURE 2. APPLYING THE COLEBATCH'S FRAMEWORK TO THE SSJN ACT

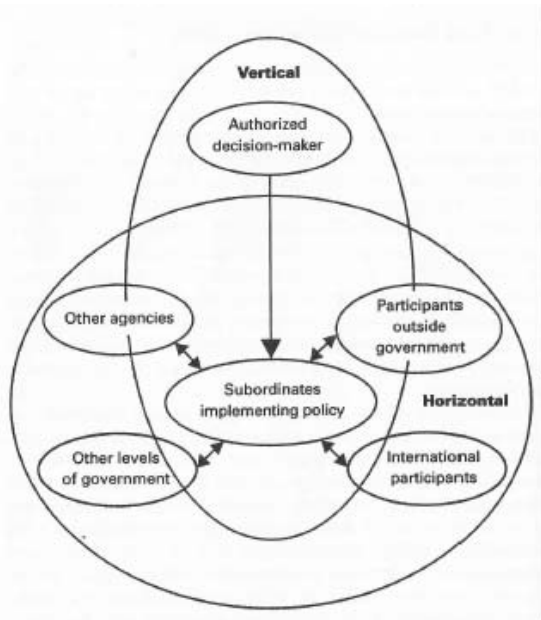


Figure 2.The Vertical and Horizontal dimensions of Policy
Sourced from Colebatch 2002, p.24

Vertical Domains:
(Authorised decision-maker)
The House of Representative (DPR)
The government

Policy :
The Act no 40/2004 regarding
National Social Security System-Sistem
Jaminan Sosial Nasional (SJSN)

The DPJS
(National Social Security Council)

Ideals:
-Established by the President
-The roles are formulating the policy and synchronising the SJSN programs

Facts:
-Established in 2008
-its roles remain weak and they tend to be over handled by the ministries

The BPJS
(The Social Security Organising Body)

Ideal:
-established by the act
- As the implementing agency

Fact:
-The act of BPJS establishment has just been enacted as Act No.24/2011
-the BPJS has not been established yet

The Technical Guidelines for SJSN

Ideal:
-enacted by by the government act

Fact:
The act has not been enacted yet

Interdepartmental:
-The Ministry Coordinator for Public Welfare (Coordinator)
• Ministry of Health
• Social Ministry
-Ministry of State Owned Companies (PT ASKES)
-Ministry of National Development Planning
-Ministry of Home Affairs (Obtaining the National ID cards for Jamkesmas Membership)
-the DPJS

Other Agencies:
PT ASKES
Public Hospitals
Private Hospitals
The BPS (the Central Bureau of Statistic)

Other levels of government:
Health Departments at the Provincial level
Health Departments at the District and City levels

Other Agencies:
NGOs

International Participants/ Actors:
WHO

One of the Programs:
Health Insurance (Jamkesmas)

Ideal: managed by the BPJS

Facts:
-Managed by the Ministry of Health (MoH) since 2008
-The MoH appointed PT ASKES as the administrator of memberships Jamkesmas

same year as *Jamkesmas* implementation. Ironically, the BPJS is still being promised by the government to be established in 2014. As a consequence, because the nature of horizontal dimension works across organisational boundaries which need to accommodate various interests and interpretive frameworks (Colebatch, 2008), several complicated problems occurred during the implementation process of *Jamkesmas*. *Firstly*, a lawsuit against the government especially referring to the Ministry of Health (MoH) regarding the inconsistency of the *Jamkesmas* program with Act no 40/2004. The House of Representatives (HoR) views *Jamkesmas* as one of the SJSN programs. According to the law, this program should be managed by the BPJS. Moreover, because *Jamkesmas* is considered to be the social insurance scheme, this program should be carried out by the Social Ministry not the Health Ministry. Furthermore, the MoH decree regarding the guidelines of *Jamkesmas* implementation should be abolished because it is considered to be a violation of the law (Sijabat, 2010a). On the other hand, the MoH claimed that the *Jamkesmas* implementation is already part of the National Social Security System and is not contrary to the law, because delivering health insurance service is one of basic rights of the people as mentioned in the constitution, and thus this needs to be delivered straightaway. Moreover, health insurance is still part of the MoH's affairs (Sijabat, 2010b). This lawsuit occurred, because the transmission process of authorised decisions has not been completed yet at the vertical level. As a result, it opens multiple interpretations at the horizontal level.

Secondly, According to Act no 40/2004, the BPJS must be established legally by the act. However, the BPJS has just been established in Novem-

ber 2011 as enacted in Act No.24/2011, and in fact The Technical Guidelines for SJSN has not been enacted yet. Therefore, the implementations of SJSN programs are being managed by the previous institutions such as: JAMSOSTEK, TASPEN, ASABRI and ASKES⁶. This indicates that the policy consistency is very poor. The issue of the BPJS establishment arose after *Jamkesmas* become popular under the MoH and PT ASKES management.

Thirdly, the existence of DJSN⁷ which is in charge of policy formulation and synchronisation of the SJSN programs remains weak. This council was established in 2008 by the President. In fact, all programs under the SJSN scheme are unsynchronised and uncoordinated with each other because they are still being managed by the related ministries and state-owned companies based on the previous regulations. This has occurred, because the technical guidelines for Act no 40/2004 have not yet been formulated, therefore the MoH has taken an initiative in formulating and enacting the technical guidelines for *Jamkesmas* implementation. This shows that Act no 40/2004 was enacted but it does not exist at the implementation stage.

Finally, the Ministry Coordinator for Public Welfare-Menkokesra⁸ which coordinates nine ministries public welfare, is not able to be a good facilitator in coordinating the implementation of SJSN programs in the horizontal dimension, the reason being that, coordination meetings regarding the law of BPJS establishment are still being held by Menkokesra after the lawsuit about *Jamkesmas* which occurred in 2010 (Menkokesra, 2011). It means that the important coordination is taking place 7 years after the law was enacted in

2004. According to Metcalfe the important part of coordination at national government scale is inter-organisational process among ministries (2009). In fact, the coordination process among ministries still does not reflect the concept of whole government⁹. Moreover, the pattern of policy coordination is still reactive. As a consequence, there is a lack of shared understanding, values and aims about the health insurance scheme for poor people among related ministries.

The above-mentioned problems indicate that *Jamkesmas* implementation does not reflect the ideals of policy coordination. In fact, *Jamkesmas* is already being implemented via other technical guidelines and institutions. This fact is totally different from the concept of coordination as stated by Bridgman and Davis. "Coordination routines seek consistency in government" means that new submissions either policy or program must be discussed with the central agencies within the perspective of whole of government. After that, the submission is discussed together with related ministers in order to seek "the compatibility of a new policy proposal with the existing policy framework" (1998, p. 88). Indeed, the coordination process needs to be developed and improved both in quality and quantity, because it "requires good management". Moreover, through coordination, different actors and interests can be accommodated within harmonious aims (Ben-Gera, M 2009).¹⁰it important to be taken into account, since the poor law consistency will definitely affects the poor quality of public services, because the process of public service delivery is not guided properly by the uncoordinated law.

4. ANALYSING THE POLICY COORDINATION OF *JAMKESDA* AT THE IMPLEMENTATION STAGE

According to Act no 40/2004 regarding the National Social Security System (SJSN), the *Jamkesda* program is not mentioned and stipulated as one of the Social Security Programs. Therefore, *Jamkesda* is managed by local governments within different schemes (Candra, Kompas 17 June 2010). The first spirit of *Jamkesda* implementation is a replica program from *Jamkesmas*, which is encapsulated within the decentralisation scheme in order to encourage local governments in managing and financing the health expenses gap, which is not covered by the *Jamkesmas*.

However, because the law of BJPS establishment and the act of technical guidelines for SJSN implementation have been delayed, the Constitutional Court has given a verdict about the lawsuit No. 007/PUU-III 2005 regarding the uncertainty of legal guidelines for *Jamkesda* implementation by local governments. The court's verdict allows local governments to establish the local BPJS and to implement *Jamkesda* in accordance with the Act No 40 year 2004 (jamsosindonesia.com). Moreover, the Court referred to Government Act No. 38 year 2007 regarding the division of government affairs between the central government and local governments as a legal basis and justification for *Jamkesda* implementation, which stipulates that local governments implement health programs based on local capacity (jamsosindonesia.com). Hence, *Jamkesda* is implemented within various schemes, names, standards and even more aims.

In the case of Aceh Province the health insurance scheme is very simple and beneficial. This program is also called JKA (Health Insurance of

Aceh-*Jaminan Kesehatan Aceh*) which insures all Aceh residents in all cities and regencies throughout the Aceh Province just by showing both National Identity Card and Family Card-*Kartu Keluarga*, without issuing any other specific health insurance cards. This scheme covers not only the untargeted poor people in *Jamkesmas* but also all Aceh residents from all different professions and economic classes. Moreover, all kinds of illness can be covered by this insurance and the inpatients can be transferred to other hospitals outside Aceh province region to get further health treatment (Candra, Kompas 17 June 2010).

In case the of Sinjai Regency in South Sulawesi, the *Jamkesda* scheme covers all Sinjai residents, but the members must obtain the *Jamkesda* card and they have to pay the insurance premium cost Rp. 10.000 (AUD 1.5) per month and per family, and medical treatment and medicine are limited in certain conditions (www.sinjaikab.go.id).

In the case of Tegal Regency in Central Java, according to the Mayor's Regulation no 21 year 2010, *Jamkesda* only covers the poor people who are not covered either by *Jamkesmas* or other insurance schemes. The list of members is reviewed every year and it must be confirmed by mayor's decision, and moreover, *Jamkesda* cards must be obtained by the members. In addition, only certain types of health care and generic medicines can be covered (www.tegalkota.go.id).

The different health insurance outcomes within these various schemes open the possibility of regional disparities between local governments. As a consequence, people who live in Aceh Province might get more benefits from the JKA health insurance scheme than Sinjai residents in South Sulawesi. According to Bridgman and Davis, these

facts reflect the government's inconsistency, because the local people are not guaranteed equal treatment within coherent jurisdiction (1998).

Moreover, because there is no standardised regulation, on the one hand, local governments do not put in serious effort to finance the health expenses gap, as is indicated by the smaller number of regencies and cities which have implemented the *Jamkesda* program in 2011 compared to 2010 (Gunawan, 2011). In response to this fact, the MoH proposed the regulation of synchronisation programs but it was rejected because of law inconsistency.

On the other hand, there are several regions experiencing financial deficit problems. In the case of Bekasi City-East Java, the local government cannot provide sufficient funds from the Local Government budget for *Jamkesda* Implementation in 2011, because the allocated fund is only enough for covering government debt to the hospitals in last financial period (Post Kota 13 Mach 2011). Even more, in case the of Karawang Regency-East Java, the *Jamkesda* program is being stopped in 2011, the reason being that the Karawang regency government cannot afford to provide funds for *Jamkesda*, since it has exceeded the debt for health financing to the medical providers in 2010 (Kebijakan Kesehatan Indonesia, 2011).

In order to examine whether *Jamkesda* implementation reflects ideal policy coordination or not, Peter's indicators of policy coordination will be applied for finding the gap between ideal and fact. Firstly, in terms of redundancy, the local governments almost present the same tasks in the context of supporting *Jamkesmas* and implementing *Jamkesda*. This occurred because the legal basis of *Jamkesda* is uncertain. This fact is exacerbated by

the limited capacity of local governments in areas ranging from human resources, financial, infrastructure and information. For example, in case the of obtaining data for entitled people in *Jamkesda* programs, most local governments conduct the same survey twice, repeating the previous survey for *Jamkesmas* in order to obtain data regarding poor people who are not covered by *Jamkesmas*. However, the results show that many entitled people under the *Jamkesda* program still miss the survey. There are around 18.300 poor people entitled to *Jamkesda* in Pacitan Regency-East Java who are not registered yet (Ishomuddin, 2010).

Secondly, in terms of lacunae, it is indicated by the absent of a national legislative body to formulate a coherent legal basis for *Jamkesda* implementation. This program needs immediate legal clarity, but this crucial legal basis for *Jamkesda* seems to be ignored by the national government. Therefore, the *Jamkesda* is implemented within various forms of the local regulations. For instance: In Tegal Regency-Central Java, *Jamkesda* is implemented based on the Mayoral Decree No 21 Year 2010 (www.tegalkota.go.id). In Depok City-West Java, *Jamkesda* is implemented based on Local Law (*Perda*) No 03 Year 2010 regarding *Jamkesda*, which was enacted by the Local Representative Body-DPRD Depok City (www.depok.go.id). These different forms of local regulations affect the model of the monitoring program. The local laws (*Perda*) tend to be more accountable rather than the mayoral decrees, because the local laws are formulated by both local governments and local representative bodies.

Finally, in terms of incoherence, under the lawsuit of 2005, according to the Constitutional Court's verdict, *Jamkesda* is categorised as a down-

ward program from *Jamkesnas*, therefore *Jamkesda* implementation must be synchronised with Act no 40 year 2004 about the SJSN. However, analysis of the lawsuit in 2010, indicates that, according to the House of Representatives, *Jamkesda* cannot be synchronised with the SJSN law, because it is not mentioned in the law.

Based on the three mentioned indicators, *Jamkesda* implementation does not reflect the ideals of policy coordination, because this program shows the three factors of uncoordinated policy. Improving policy coordination is not only about enhancing the ability to work across departments but also requiring updated knowledge, data, information and trends in order to create policy development. It has been stated by McKenzie that, the issues of public policy nowadays are complex and interrelated. Hence the policy makers must keep up with updated information in order to formulate integrated policies (in Colebatch HK ed. 2006). This means that, the patterns of policy coordination should be adjustable to new trends and demands (Peters, 1998). Therefore, the government should make serious effort to improve the policy coordination patterns of *Jamkesda*, because those problems related to inconsistency of the laws will absolutely make serious impact on poor public services. The last but not least, it is important to the government by building coordinated policy, so that the quality of public services will automatically enhanced.

CONCLUSION

Several recommendations are offered by this study such as: Enhancing policy consistency before the tasks are distributed at the multiple domains at horizontal dimension through the establishment of

Policy Screening Body in the parliament; Implementing the concept of whole government; Vitalizing the main role of the Ministry Coordinator for Public Welfare (Menkokesra) which is in charge of coordinating nine ministries (including the Ministry of Health and Ministry of Social) in terms of *Jamkesmas* Settlement; Standardizing the implementation of *Jamkesda* across the regions in Indonesia in order to be easily measured and controlled, since this local health-financing scheme is implemented within various number of models and standard qualities of public services delivery.

Indeed, public policy products after the Soeharto era are innovative policies. However, these policies do not reflect the ideals of policy coordination. In the case of the *Jamkesmas* and *Jamkesda* programs, lack of coordination during the process of policy making has led to complicated problems at the implementation stage namely: multiple interpretations of the law, unstructured policy stages at the vertical level that are indicated by the absence of legal support enactment and the BJPS establishment, complicated problems at horizontal stages and conflict among institutional governments. The problem of policy coordination is the lack of coordination. Moreover, the nature of policy coordination in Indonesia is still reactive. This fact causes policy inconsistency which has the effect of law uncertainty.

FOOTNOTES

¹ There are several social security programs namely: health insurance; occupational accident insurance; old age insurance; retirement security; and assurance of death. (*Jamkesmas* is one of mentioned programs)

² “Presently, five main actors are involved in the

administration of the *Jamkesmas* scheme (1) the National Social Security Council (DJSN), (2) national government agencies, including Depkes (MoH), the Ministry of Finance (MoF), the Ministry of Home Affairs (MoHA), Ministry of Social Affairs (Menkokesra), and the Ministry of National Development Planning (Bappenas), (3) provincial and district governments, (4) public and private providers of care, and (5) the insurer/third-party administrator” cited from <http://jointlearningnetwork.org/content/Jamkesmas> this website is empowered and collaborated with the World Bank, Access Health International, The GTZ etc.

³ SUSENAS is a social and economic household survey which defines total household consumption for GDP estimation purposes. The standard definitions of the poor for *Jamkesmas* is based on daily household consumption

⁴ “Exclusions from the *Jamkesmas* benefits package include cosmetic surgery, annual physical check-ups, alternative medicine, dental prosthesis and fertility treatment. Cancer treatment and treatment for heart related problems are also limited” cited from <http://jointlearningnetwork.org/content/Jamkesmas> this website is empowered and collaborated with the World Bank, Access Health International, The GTZ etc.

⁵ Reasons for policy coordination: Creates policies that are not deficient in law or substance, are consistent with one another, are economically efficient and do not impose unnecessary regulatory burdens; Creates policies that are in line with overall government priorities; Creates policies that are sustainable in budgetary terms; Ensures that decisions can be implemented;

- Supports principles of integrity in government through transparency and consultation with the public Ben-Gera 2009, p. 4-5
- ⁶ PT ASKES (the State Owned Companies which is in charge of Health insurance), PT JAMSOSTEK (the State Owned Companies which is in charge of employees' insurance), TASPEN (the State Owned Companies which is in charge of civil services' insurance), ASABRI (the State Owned Companies which is in charge of armies' insurance).
- ⁷ The DJSN was established at 24 September 2008, through the Presidential Decree 110/M 2008. This council consists of 15 people in which 5 people are from the government representatives; 6 people are from expert and figure representatives; 2 people are from company representatives and 2 people are from labour union representatives.
- ⁸ The Ministry Coordinator for Public Welfare coordinates nine ministries namely: Ministry of Health; Ministry of National Education; Ministry of Culture and Tourism; Ministry of Women Empowerment and Child Protection; Ministry of Public Housing; Ministry of Youth and Sports; Social Ministry; Religious Ministry; Environmental Ministry; and other related institutions sourced from : www.menkokesra.go.id
- ⁹ The Australian Public Service (APS) defines whole of government, denoted as public service agencies working across portfolio boundaries to achieve a shared goal and an integrated government response to particular issues. Approaches can be formal and informal. They can focus on policy development, program management and service delivery.
- ¹⁰ There are several important aims of coordination namely: "To make various different things work effectively as a whole, Managing dependencies between activities and interdependencies among actors, The regulation of diverse elements into an integrated and harmonious operation, Coordination does not happen on its own, but requires management, Coordination allows elements and actors to remain plural and different, while it aims for results that are harmonious and effective" (Ben-Gera, M 2009 p.2)

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