

ANALISIS *TRIANGLE* KEBIJAKAN PUBLIK JAMINAN KESEHATAN: STUDI KASUS PADA SEKTOR INFORMAL DI INDONESIA

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TRIANGLE ANALYSIS OF HEALTH INSURANCE PUBLIC POLICY: A CASE STUDY ON THE INFORMAL SECTOR IN INDONESIA

ABSTRACT

Background: *The proportion of informal sector dominates the labour force in Indonesia. Yet, their presence has not been fully covered in the national health insurance system. Health insurance policy in Indonesia continues to change. In the framework of efforts to achieve universal health coverage, there should be a review of the health insurance policy. This study aims to analyze the health insurance public policy on the informal sector.*

Methods: *We reviewed the health insurance policy document and empirical literature study related informal sectors. The policy was analyzed using triangle analysis.*

Result: *The result of triangle analysis showed that based on actor, National Health Insurance (JKN) existing regulations has involved the role of official policy actors while interest groups (union informal sector and informal sector associations) have not been included optimally. This policy was not able to finance the services that requires large medical expenses such as rare diseases. Along the way, the birth of the existing policy through a top down process and was influenced by many factors such as economic, political and international issues.*

Conclusion: *Informal sector involvement in health insurance policy formulation was still minimal. This policy should be developed by taking into account the informal sector contexts and hopefully will be able to achieve universal health coverage.*

Keywords: *Triangle analysis, health policy, informal sector*

ABSTRAK

Latar Belakang: Proporsi sektor informal mendominasi angkatan kerja di Indonesia. Namun keberadaan mereka belum sepenuhnya ter-cover dalam sistem jaminan kesehatan nasional. Kebijakan jaminan kesehatan di Indonesia terus mengalami perubahan. Dalam rangka upaya pencapaian *universal health coverage*, maka perlu dilakukan kajian terhadap kebijakan jaminan kesehatan. Studi ini bertujuan untuk menganalisis kebijakan publik jaminan kesehatan pada sektor informal.

Metode: Kami melakukan telaah dokumen kebijakan jaminan kesehatan & studi literatur empiris yang terkait sektor informal. Analisis kebijakan menggunakan *triangle analysis*

Hasil Penelitian: Hasil analisis *triangle* menunjukkan bahwa berdasarkan aktor, peraturan JKN yang ada telah melibatkan peran pelaku kebijakan resmi sedangkan kelompok berkepentingan (serikat pekerja sektor informal dan paguyuban sektor informal) belum optimal diikutsertakan. Kebijakan pun belum mampu membiayai pelayanan yang membutuhkan biaya pengobatan yang besar misalnya penyakit langka. Secara proses, lahirnya kebijakan yang ada melalui proses *top down* dan dipengaruhi berbagai faktor ekonomi, politik dan internasional.

Kesimpulan: Pelibatan sektor informal dalam penyusunan kebijakan jaminan kesehatan masih minim. Kebijakan tersebut perlu dikembangkan dengan memperhatikan konteks sektor informal sehingga nantinya diharapkan mampu mencapai *universal health coverage*.

Kata Kunci: *Triangle analysis, kebijakan kesehatan, sektor informal*

INTRODUCTION

The Indonesian government attempting to achieve universal health coverage and has provided health insurance for people through social insurance that is destined for formal workers (civil servants, military and company officials). In addition, the government also held a public health insurance program which is devoted to the poor such as Askeskin/Jamkesmas and regional health insurance which implemented by local governments. Since January 1st, 2014, the government began to implement a national health insurance program. For those who do not have health insurance, it is recommended to register as participants of JKN (National Health Insurance).

Over the past five years, the proportion of informal sector workers remain high. Of total employment is occupied 30% formal sector and the rest 70% is occupied by informal economy.¹ Based on BPS (Central Bureau of Statistics) data per August 2012, about 60.14% of Indonesia labor force working in the field of informal sector.² It is indicated that the informal sector is still dominated Indonesia workforce. Though the large amounts, they are not supported by health insurance. A study conducted by Bappenas (Indonesian Ministry of National Development Planning) in 2012, the Informal Economy Study (IES), estimated that there was 32.5 million informal workers were not covered by the national health insurance scheme in 2014.³

Until now, health insurance policy in Indonesia has not been able to insure all of workers in the informal sector. The existing insurance policies continues to change. In the framework of the implementation of the SJSN (National Social Security System) by 2014, there should be a review of the health insurance policy.

METHODS

Policy analysis used in this study adopting a policy triangle model. Policy triangle is a simplified approach for a complex of relationship system. This triangle has indicated four factors that should be considered in analyzing the contents of the policy; the actors, the context and the process of policy establishment.⁴ This triangle not only help in thinking systematically about various actors, but also served as a map showing the main road.

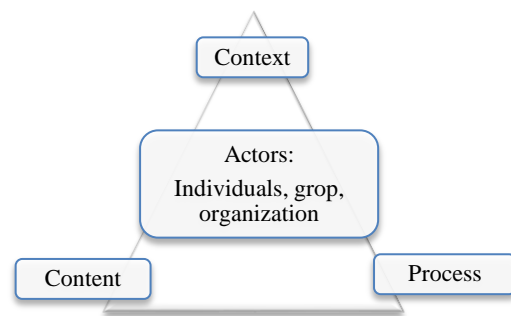


Figure 1.
Triangel Policy Analysis

The terminology of policy:

1. Actor: refers to individuals or organizations or even countries, along with their actions that affect the policy
2. Contents: the substances of a policy that detailing part of the policy
3. Context: systematic factors such as politic, economic, social, cultural, national and international level that may influence policy
4. Policy: a broad statement of intent, purpose and manner to form an action framework
5. Process: how to initiate policies, develop, construct, negotiate, communicate, implement and evaluate policy

Context is a determinant of policy processes. Issues that have been around for a while can instantly turn into a problem for policy actors due to a change in the level of context. Context can affect the content of the

reform. It also affects the implementation, determining the position and influences the emergence of a variety of factors. According to Leichter, context can be divided into four categories: situational factors, structural factors, socio-cultural, and global factors.⁵

According Ayuningtyas, the triangle of health policy is a representation of the complexity entities of the relationship between policy elements (content, process, context, and actors) in its interactions affect.⁶ One of the element of the triangle policy is policy actors (both as individuals and groups) which are influenced by the context where they work or doing their roles. Context is an "engineering or the results of the dynamic interactions of many factors such as ideology or policy change, the historical and cultural values. Triangle policy help to systematically analyze and learn about the various factors that influence the policy. An understanding of the policy triangle is like a map showing the "great road" which also showing contours, rivers, forests, directions, and where the living stay of a forest of public policy development.⁷

RESULT

Analysis Policy Using Triangle Policy (Presidential Regulation No. 111 year 2013)

CONTENT

The Indonesian government decided to provide contribution assistance to poor and vulnerable groups. Other population included informal sector population must pay their own contribution. The policy stated in the presidential regulation on behalf health insurance (Presidential Regulation No.12 / 2013) stated that "premium of workers in the informal sector are not covered by the government". The regulation consists of:

Membership Aspects

Indonesian Presidential Regulation No.12 year 2013 concerning health insurance Article 2 stated that participant of health care benefits are (a). PBI Health Care Benefits, and

(b). Non PBI Health Care Benefits. Furthermore, in Article 4 paragraph (1) mentioned participants non PBI health care benefits as referred in Article 2 letter b, are participant who are not classified as poor and low income people consist and they consist of: (a). Salaried employee and their family members, (b). Non-salaried employee and their family members, and (c). non-employee and their families members.

Non-salaried employee as referred clause (1) letter b consist of (a). Employees without employment contract or self employed; and (b). Employees who are not classified in letter 1 and not receive wages/salary (not included civil servants, Indonesia Armed Forces members, police, state officials, non-civil servant government employees, and private employees, and other who meet the criteria as wage workers). The principle of social security participation is mandatory. It is intended to make all Indonesian are covered. Although it is mandatory for all citizens, its application is based on the citizen economic capacity and government as well as the feasibility of program implementation. In the initial phase, begin with the formal sector employee, along with it the informal sector employee able to participate independently

The subsequent revision of Presidential Regulation No.12 year 2013 became the Presidential Regulation No.111 year 2013. Article 11 paragraph 4 stated "any person as non-employee shall register their self and their family members as participants in health insurance to BPJS by paying contribution"

Contribution Aspects

Based on the calculations and simulations performed on a variety of data from various sources and processing the actuarial method, as it's written in Presidential Regulation Article 16 f related health insurance contribution for non salaried employee participants.

- a. Rp 25,500 (twenty-five thousand five hundred rupiah) per member per month, with health care benefit in class III
- b. Rp 42,500 (forty-two thousand five hundred rupiah) per member per month, with health care benefit in class II
- c. Rp 59,500 (fifty-nine thousand five hundred rupiah) per member per month, with health care benefit in class I

Health Services Aspect

National health insurance benefit package compiled based on the principle of equity in accordance with the mandate of the National Social Security System (SJSN) and formulated in a presidential regulation concerning health insurance. Package benefits received by members are comprehensive which cover promotive, preventive, curative and rehabilitative services, including drugs and disposable materials required. All services will be guaranteed if medically indicated. Premium fees will only be charged for the types of services that may lead to "moral hazard" services.⁸

The regulation for health care insured for non-salaried employee was written in Article 22 of Presidential Regulation No. 11/2013 concerning Health Services consists of:

- a. Primary Health Care, provides non-specialist health care including:
 1. Administrative services
 2. Promotive and preventive services
 3. Clinical examination, treatment, and consultation
 4. Operative or non-operative of non-specialist medical treatment
 5. Drugs and disposable medical materials
 6. Blood transfusion according to indication
 7. Laboratory studies for diagnostic
 8. Basic care for inpatient according to indication
- b. Advance level referral health services, including:

1. Administrative services
2. Clinical examination, treatment, and consultation by specialist and sub-specialist doctor
3. Operative or non-operative specialist medical treatment
4. Drugs and disposable medical materials
5. Advance laboratory studies for diagnostic
6. Medical rehabilitation
7. Blood bank services
8. Clinical forensic services
9. Services bodies of inpatient care
10. Non-intensive and intensive care

The regulation for inpatient care benefit was written in Article 23 of Presidential Regulation No. 111/2013, consists of:

- a. Third class care, is provided for participants which is non-salaried employee who pay contribution for third class services
- b. Second class care, is provided for participants which is a non-salaried employee who pay contribution for second class services
- c. First class care, is provided for participants which is a non-salaried employee who pay contribution for first class services

Health services insured are benefit package that is the right for all member that have paid the contribution and member that contribution covered by the government. The services consist of two important aspect: potential access and quality aspect. The potential access aspect is affected by the availability of health services that influenced by distribution, distance, and transportation vehicles. While, the quality aspect is affected by the amount of payment, health care provider behavior, profit/no-profit motivation, and the availability of drugs and other disposable materials supply.

This Presidential Regulation has not been able to pay for services that require large medical expenses, for example rare diseases: biliary atresia (liver transplant) and the

treatment abroad. The government needs to consider these matter.

ACTORS

According to Buse et al, stakeholders are all parties concerned and involved in every stage of the policy development cycle, in the act of constituting, advocating, implementing, until get the impact from policy either directly or indirectly, negative or positive.⁴ Stakeholders in the policy actors are divided into two groups, the official policy actors and unofficial policy actors. Official policy actors are government agencies (the bureaucracy), the president or the other head of state (executive, legislative, and judicial), while included in the group of unofficial policy actors covering interest groups on a particular issue, political parties and individual citizens , or any individual or group

of individuals who have an interest and the power to influence policy.

The results of the policy document review in the form of a report arranged by Langenbrunner, there are five "actors" involved in the implementation of national health insurance⁹:

1. The National Social Security Council (DJSN)
2. Representatives of the Government of Indonesia consists of the Ministry of Health, Ministry of Finance, Ministry of Labour, Ministry of Social, and Ministry of National Development Planning (Bapennas)
3. Social Security Provider (BPJS)
4. The health care provider
5. BPJS member

The table below shows the roles and responsibilities of the five groups listed above.

Table 1.
Roles and Responsibilities of JKN Actors / Stakeholders

Roles and Responsibilities	Actors			
	DJSN	Government's representatives	BPJS	BPJS participants
Formulate the general policy	X			
Synchronize the administrations from National Social Insurance System (SJSN)	X			
Supervise the health insurance scheme	X			
Propose the social insurance financing	X			
Regulate the benefit packages		X		
Regulate the contributions level		X		
Categorize the poor as the PBI recipients		X		
Regulate the schedules, payment level to provider		X		
Develop the clinical pathways		X		
Regulate the enrollment			X	
Collect the contributions			X	
Receive and collect the contributions from the government general revenues			X	
Collect and manage the funds			X	
Select, appoint, and contract the provider (public or private)			X	
Process the claims and make payments			X	
Utilization/check the claims			X	
Provide information on social insurance administration			X	
Provide the health services				x
Regulate the referral system				x
Pay the contributions				x
Registration at BPJS				x
Receive health care based on need				X

National Health Coverage regulations, one of which is Presidential Regulations No. 111/2013 only involve the role of official policy actors while unofficial policy actors or other interest groups (union of informal sector employee and association of informal sector) have not been included. In fact, employee in

the informal sector are included as stakeholders in economic development. Therefore, the government needs to pay attention to the existence and aspirations of informal sector employee through the health insurance coverage.

CONTEXT

**Table 2.
Country Context Indicators**

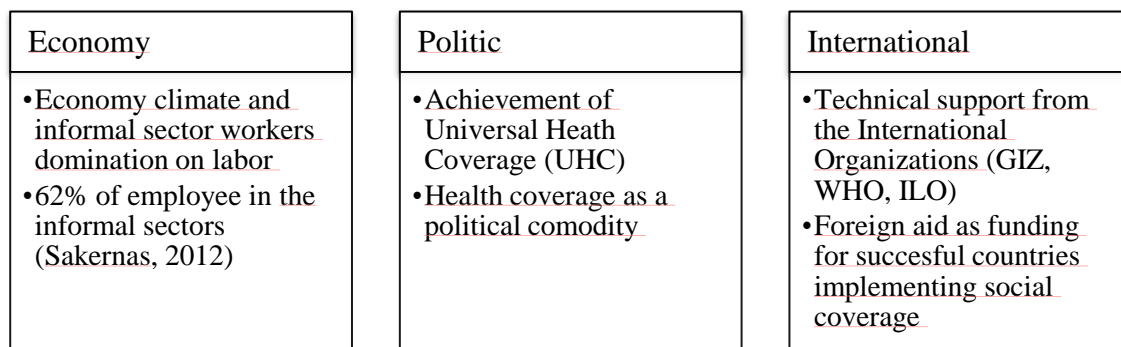
Information	Indonesia
Population ¹	240.1m
GDP per individual ¹	\$ 3.472
Total Expenditure on Health (THE) as % of GDP ²	2.7%
Life expectancy ²	69 tahun
Mortality rate per 1000 births ²	31
Mortality rate per 100.000 births ²	220
Government expenditures on health (% of THE)	34.1%
Social insurance (% of Government expenditures on health)	6.9%
Private expenditures on health	65.9%
OOP expenditures (Private expenditures on health)	49.9%
External resources on health	1.2%

Source: www.resyst.ishtm.ac.uk

Presidential Regulation No. 111 year 2013 is one of the policies in the implementation of National Health Coverage (JKN) program. Indonesia currently running a JKN held by BPJS Health in gradual implementation, beginning in January 1st, 2014 whose the participants at least include: Recipient Contribution (PBI) of health insurance, members of the military/civil/police and their families, participants of PT.

Askes and their family members, and as well the participants of Jamsostek health care insurance and their family members. Furthermore, the second phase include the entire population that has not been registered as a participant of BPJS Health at the latest on January 1st, 2019 including informal sector employee.

The birth of this policy is influenced by many factors such as the following graphic:



**Figure 2.
Contextual Factors affecting the initiation of Perpres No. 111/2013**

Expanding the participatory of informal sector employee is the part of effort to achieve Universal Health Coverage (UHC). Many countries bring up UHC as a political issue

that is very interesting in welcoming the elections and at the power transition phase.¹⁰ In Indonesia, in respond to demands of some communities that are not covered in Health

Insurance, then the House of Representatives (DPR) in October 2011 approved Law No. 24 of 2011 which mandates the government to initiate reformation of health financing in 2014 with the expectation of realization of Universal Health Coverage in 2019.

PROCESS

The birth of Presidential Regulation No. 111 year 2013 had been through a long journey. In preparation of the national health insurance there are some aspects to be done for operational improvements of BPJS Health. One of them is preparation of the draft of Law (RUU) on BPJS according to the mandates of Article 5 of the Law No. 40 of 2004 on National Social Insurance System.

Discussion on BPJS draft of Law was initiated in 2007, but unfortunately the discussion ends deadlock. Discussion was resumed since the President issued an Amanat Presiden (Presidential mandates) in September 2010 through Letter No. R.77/Pres/09/2010 which appointed eight ministers as a representatives of government either independently or jointly to conduct discussion on BPJS draft of Law with the House of Representatives of Indonesia. The eight of them are the Minister of Finance, Minister of State Owned Enterprises, Minister Social Affairs, Minister of Utilization of Apparatus and Reformation, Minister of National Development Planning/Chief of National Development Planning Bureau, and Minister of Labour and Transmigration.¹¹

Since the release of Presidential mandates, discussion run intensively between Parliament and government representatives. One of the crucial issue in the discussion is the different concepts of the corporation structure of BPJS proposed by the Parliament and by the government. At that time, the parliament proposed a single legal entity structure of BPJS in which there was vice chairman who oversees five social programs of social insurance. While the government

objected to the Parliament's proposal in regard to the Law of National Social Insurance System No.10/2004 on National Social Insurance System (article 1 no.2).

“National Social Insurance System is a procedure to implement social insurance program by several agencies of social insurances.”

Through several plenary meetings which was chaired by the vice president and attended by several concern ministers, it proposed two categories of BPJS accordance with the “nature of business”, namely BPJS Health and BPJS Employment. The proposal was set forth in the list of problems (DIM) then was submitted to the House of Representatives, which then after a long debate this proposal was approved and written in Law No.24 of 2011 on BPJS. Various derivative regulations were drafted and since early 2014 BPJS Health had been operating as a “single player” by integrating the former member of PT. Askes, Jamsostek, TNI, Polri, and Jamkesmas in an organized unibody to achieve national coverage.⁸

On January, 18th 2013, the government issued Presidential Regulation No. 12 year 2013 on Health Insurance and was amended by Perpres No. 111 of 2013 regarding changes to Perpres No. 12 of 2013 on Health Insurance. The amendment was tailored to the needs of the organization of health insurance. Presidential Regulation No. 111 of 2013 contained as much as 25 points of changes of earlier Perpres. Approximately two years later, there was another amendment on this regulation into Perpres No.19 of 2016.

Monitoring effort and evaluation of implementing agency of social security based on Law No. 24 year 2011 article 39 said that supervision towards BPJS shall be conducted both externally and internally. The internal supervision of BPJS conducted by Supervisory Board and Internal Supervisory Unit. Meanwhile, the external supervision of BPJS conducted by independent supervisory institution.

DISCUSSION

Presidential Regulation No. 111 of 2013, article 11 paragraph 4 said, “every citizens, non-employee and their family member must register themselves in National Health Insurance (JKN) and pay the premium by themselves to BPJS.”

Regulation on behalf of formal sector members of JKN divided into two:

1. Informal sector who cannot afford the contribution
 - Informal worker with low incomes and cannot afford to pay the contribution, who included in Jamkesmas membership in 2013, as the result of PPLS in 2011 (which is corrected by regional government), suggested to be JKN member in 2014 whose the contribution paid by government. This category is called PBI (contribution assistance recipients).
 - If there are still people in this category who haven't covered as PBI, regional government has responsibility to cover the premium.
2. Informal workers who can afford the premium
 - Informal workers who can afford to pay the contribution enroll individually as JKN member who pay the premium by themselves (2014-2019).

Based on the calculation and simulation from various data or sources and actuarial cost method calculation and then written as Presidential Regulation Article 16 f about premium for informal employee/ non-employee:

1. Class III : Rp 25.500,-
2. Class II : Rp 42.500,-
3. Class I : Rp 59.000,-

The second amendment of Presidential Decree No.12 year 2013 to Presidential Regulation No 19 year 2016, about contribution increase for this category:

1. Class III : Rp 30.000,-
2. Class II : Rp 51.000,-

3. Class I : Rp 80.000,-

This amendment of Presidential Regulation also affects to health care benefit. Health care benefit consists of health promotion, preventive (immunization and contraception/family planning), curative, rehabilitative medicine services (medical acupuncture), medical disposable materials in accordance with the necessary medical indications.

This policy change was done in order to achieve Universal Health Coverage. This policy stipulation is top down policy which involves the central government: (i) The National Social Security Council (Dewan Jaminan Sosial Nasional – DJSN), (ii) Representative of Indonesian government consists of Ministry of Health, Ministry of Finance, Ministry of Labor and Transmigration, Ministry of Social Affairs, and The National Development Planning Ministry (Bapennas), (iii) Social Security Provider (Badan Penyelenggaraan Jaminan Sosial – BPJS).

Both individual interest and group interest influence policy making process. However, stakeholders with more authority will get more voice heard than others on behalf policy making process.⁶ Presidential Regulation No 111 of 2016 is public policy made for every citizens. Therefore, the decision maker should involve as much as people in policy making process, including the informal employee. There are three main aims of the importance of involving the citizens in policy making process: (1). For better public policy. With sufficient information, active and passive participation, and also consultation with citizens or representative; the policy foundation will be strong, right on target, rooted. So, these foundations will be the guarantee of the policy implementation in the community due to the community have been well-informed with the policy before. 2). Manifests greater trust on policies generated by the government. This condition will create a positive relationship

between government and citizens.3). Created a stronger democracy. A good relationship between government and citizens will make the government more transparent and more accountable to each policy.

This policy hasn't been able to involve the informal sector as a source of information for developing policies. This will have an impact on their long-term participation in the JKN program. In addition, the determination of the contribution using actuarial methods have not been able to represent citizen willingness and ability to pay contribution. The results of data analysis from Susenas and IFLS showed diversity of economic levels in the informal sectors. The informal sector is not identical to the poor, but also has middle and rich class. It means that the ability to pay premiums will vary. That should be considered in the determination of contribution among informal sector employee. In addition, many employee in the informal sector have an unstable and irregular income and, for example a farmer who had to wait for the harvest to earn an income. This condition can disrupt the contribution payment regularly and potentially lead to high drop-out rates.

The impact of policy that haven't consider the ability to pay of the informal sector is adverse selection, by the self-employed in the initial implementation of JKN program. On the other hand, most of these workers have not been able to pay the contributions regularly. About 193.344 people in arrears to pay a contribution up to 17 April 2014. Based on BPJS Health data in 2014, it showed that approximately 44% of informal sector employee ay contribution in arrears. The amount of their contribution arrears bill is around 400billion Rupiahs. These conditions impact on BPJS Health deficit. Income that irregular and uncertain by most of these workers could be a cause of delay in paying the contribution.

The informal sector has characteristics that vary. Consisting of poor, vulnerable groups and wealthy, where some of them have

the ability to pay for health insurance. To handle the health insurance sector, could be done by making the health insurance segmentation which describes the economy capability based on population groups.¹² It is needed to assess the income or assets in view of their ability to pay.¹³

The calculation of premiums that only using actuarial methods regardless of the context of the informal sector's ability to pay will not be able to increase their participation in the JKN program at the end of 2019 which target universal coverage. On macro level, social health insurance for the informal sector can be increased by classifying members according to the type of work with the aim of differentiating contribution.¹⁴ Contribution differences can also be made based on characteristics of the informal sector¹⁵ or by location-based. In Vietnam, the level of social health insurance contribution start at \$ 3 in rural areas up to US \$ 21 in urban areas.¹⁶ However, determining the ability to pay is a difficult process, it needs accurate data and analysis, as well as the huge administrative costs.

The successful lessons from developing countries which able to cover the informal sector are Vietnam and the Philippines. Vietnam has an informal sector large proportion (65.4%). Beside, providing full and partial subsidies for the informal sector, contribution system was imposed by the regional minimum wage rates. Contributions collected directly by the health insurance agency office or household visits, which is a system of collaboration between local insurance agencies with local governments. The success of this country begins with a pilot study. Vietnam did a pilot project with voluntary health insurance scheme in the years 1989-1992. Philippine performed various pilot projects to facilitate the informal sector to make a payment: sms, payment outpatient center for the urban population, agricultures and fisheries cooperation in the rural population.

Not only developing countries, but the pilot study carried out by developed countries (Korea, Mexico and China) in expanding the coverage of informal sector health insurance. The pilot study helped to determine the registration group, the level of contribution and benefit package.¹⁷ A Pilot study is very important as an evidence in determining the financing of health insurance among the informal sectors. The pilot study is expected later to provide information regarding the ability/willingness to pay contribution of this sector including determining the appropriate

method for identifying, registering and collecting contribution on an on going basis of informal sector workers.

CONCLUSION

The involvement of the informal sector in policy making is still minimal. Health insurance policies needs to develop by taking into account the context of the informal sector, so that later able to insure the whole informal sector that targeted at the end of 2019.

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