The politics of funding universal healthcare: Diverting local tobacco taxes to subsidise the national health scheme in Indonesia

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Abstract
In Indonesia, the national universal health coverage scheme (Jaminan Kesehatan Nasional [JKN]) has consistently overspent against its budget since it was introduced in 2014. In 2017, a new regulation diverted 37.5% of tobacco tax revenue collected at the district and city level to the central government in order to increase government contributions to the JKN. Through a review of policy documents and interviews and focus group discussions with relevant stakeholders, this article explores the history of the JKN and its relationship to local tobacco taxes. Offering an ex-post assessment of the policy and its implementation, we find it negative on three fronts: funding for local anti-smoking initiatives and services was cut, the procedures for implementing the policy were complex and time-consuming, and it did not contribute as much as anticipated to the JKN. These findings underscore potential pitfalls of politically motivated policy that fails to consider implementation and impact. We recommend that the policy be revoked, and local tobacco tax revenue reallocated to its initial pur-
1 | INTRODUCTION

Many countries adopt universal health coverage (UHC) as a ‘national aspiration’, but funding national healthcare schemes presents an ongoing challenge for governments around the world (Reich et al., 2016, p. 811). While often popular with citizens, UHC schemes are both complex and costly, posing a conundrum for national governments that want to appease the population while managing budgetary constraints. The question of how to address this problem has been previously explored in the academic literature. For example, Meheus and McIntyre (2017) argue that governments should avoid increasing the relative financial burden on those intended to benefit from such schemes while also looking to other sources of revenue to meet funding demands. However, there is a broader conclusion in the academic literature that highlights the need for policymakers to carefully consider the local situation if they are to have any hope of designing measures that balance the political and economic demands generated by UHC (Chemouni, 2018; Gilson et al., 1995; Kay, 2007; Kutzin et al., 2016; Pisani et al., 2017). In this article we use an Indonesian case study to interrogate this policy tension. We explore the context that led to a number of regulations, issued in 2017 and 2018, that diverted 37.5% of the local tobacco tax revenue from community-based health initiatives to the national UHC scheme, which is known as Jaminan Kesehatan Nasional (JKN). By addressing a deceptively simple question—should local cigarette taxes be diverted to fund universal healthcare?—this article underscores some of the pitfalls of allowing political motives to drive policy without consideration for implementation and impact. As Oliver (2006) contends, ‘politics, for better or worse, plays a critical role in health affairs’, with this case no exception.

Tobacco taxes reportedly amounted to approximately Rp164.87 trillion (US$11.5 billion) in 2019, representing around 13.1% of Indonesia’s central budget (Kusuma, 2020; Ministry of Finance, 2019). The ongoing political question of whether a proportion of this income should be directed towards the JKN was, in part, answered by the 2017 policy decision to divert funds raised from local tobacco taxes to the JKN. However, the efficacy of this policy can be challenged on several counts. In critically examining this case, we argue that the overall effect of the policy decision was negative on three fronts: the procedures for transferring the tobacco taxes back to the national government were complex and time-consuming; the returns from the policy were miscalculated and, in reality, much smaller than anticipated; and earmarked funding for local anti-smoking initiatives and services was reduced. Moreover, since it was implemented, a new JKN citizen-contribution scheme has been proposed that, if passed, would negate the need for these local tobacco taxes to be directed to the JKN. The data gathered through this study supports the argument that the policy should be overturned, restoring the allocation of the local tobacco tax revenue towards community-based healthcare programs.

**KEYWORDS**
government, health policy, Indonesia, tobacco, universal healthcare

pose, which includes promoting local smoking prevention programs and health service delivery.
Established in 2014, the JKN derives its mandate from the Indonesian Constitution, which allows for the development of a nationwide social security system. The program was launched with much fanfare, as a cornerstone strategy for addressing inequality in access to healthcare services within Indonesia. The JKN is the largest single-payer system in the world and, by 2018, covered 203 million Indonesian citizens (approximately 77% of the population). It has been lauded for improving access to healthcare services for the poor, equity for inpatient care, and increasing the overall quality of healthcare in the country (Agustina et al., 2019). However, the Indonesian Social Health Security Administrative Body (Badan Penyelenggara Jaminan Sosial Kesehatan [BPJS]), responsible for managing and implementing the program, has faced numerous challenges (Mboi, 2015), including large annual budgetary deficits resulting from the fact that the costs of service provision far outweigh earmarked funding for the scheme (Agustina et al., 2019; Erniaty & Harun, 2020).

These funding challenges were highly politicised, with some politicians hoping to make reputational gains from the rollout of a successful healthcare scheme. Even though the UHC scheme was in train prior to the 2014 elections, it was championed by the incoming president, Joko Widodo, who was keen to take credit for the program’s expansion (Pisani et al., 2017; Prastyani, 2019). Being a popular policy, the rollout received ongoing media attention, but also generated protracted political discussions about the viability of the scheme (Erniaty & Harun, 2020). Once the vast expense of the program became more evident, the government initially chose not to increase participant contributions or restrict services, which would be practical but highly unpopular responses. Instead, they opted to hypothecate—the practice of dedicating, in advance, a part of the national or subnational tax revenue to a particular government expense—a proportion of revenue raised through the local tobacco tax scheme to the JKN. Though never intended to solve the budgetary problem completely, the national government believed that the hypothecation of this taxation income for the JKN could assist in alleviating the financial burden presented by the scheme.

The hypothecation, otherwise known as earmarking, of tobacco taxes for health programs can, on the surface, be viewed as positive. As Doetinchem (2010) and the World Health Organization ([WHO], 2016) note, supporters of earmarking for health purposes claim that it protects revenue from political interests and budgetary constraints. It also links taxation closely to public benefit, often in a more transparent and accountable way. In this case, however, the hypothecated funds had already been earmarked, by regulation from the Ministry of Finance, to contribute to health programs at the local level.

There are two significant policy issues at the heart of this discussion. First, as already mentioned, are the challenges of funding the JKN and addressing the discrepancy between its budget and its expenses. The second policy issue is the ongoing impact of cigarette consumption across Indonesia and the need to address smoking rates and reduce associated deaths. It is estimated that more than 200,000 people die in Indonesia each year as a result of tobacco consumption through non-communicable diseases such as heart disease, stroke, cancers and pulmonary disease (WHO, 2018). In 2018, the Ministry of Health approximated that, although rates were declining, 33.8% of all Indonesians were regular smokers, with 62.9% of adult males and 4.8% of adult females identified as smokers (Figure 1). These rates of cigarette consumption are among the highest in the world (Zheng et al., 2018). Moreover, the health impacts of smoking are similar across all socio-economic groups (Liew & Hsu, 2009). Youth uptake is also concerning, with
smoking rates among 10–18-year-olds increasing from 7.2% in 2013 to 9.1% in 2018 (Ministry of Health, 2018).

Tobacco control taxes are recognised as one of the most effective strategies for decreasing smoking rates, as they discourage uptake and encourage cessation (Chaloupka et al., 2012; Contrary et al., 2015). Despite this, current taxation and excise levels in Indonesia fall well below the WHO’s suggested minimum of 70% tax on retail cigarette prices. In 2018, Indonesia’s tobacco tax level was 58.5%, consisting of a tobacco excise of 45%, a value added tax (VAT) of 9.1% and a regional tax (set at 10% of the excise rate) of 4.5% (WHO, 2019). In late 2019, the Ministry of Finance announced that in 2020 the excise tariff on cigarettes would increase by an average of 23% and the retail price of cigarettes across all categories would increase by an average of 35%. However, although base retail prices did increase in 2020, the average tobacco excise rate, in fact, decreased to 37.15%, which the government justified as being offset by the increase in minimum retail prices. Thus, the 2020 overall tax rate for cigarettes actually decreased to 49.97% (37.15% excise + 9.1% VAT + 3.72% regional tax). Regardless, compared to other Southeast Asian countries such as Thailand (78.6% tax rate), Singapore (67.11% tax rate) and the Philippines (71.32% tax rate), or lower middle income countries such as Bangladesh (71% tax rate), Egypt (77.19% tax rate) and Morocco (71.24% tax rate), Indonesian tobacco tax remains low (WHO, 2019). Nevertheless, although Indonesia’s tobacco tax rates are below recommended best practice, directing local tobacco taxes towards community-based interventions that support promotive and preventive measures can play a crucial role in reducing smoking prevalence and decreasing tobacco-related morbidity (Douglas et al., 2015; Lee, 2014; Nichter et al., 2010). This is especially the case in rural areas, where citizens are isolated and removed from national health programs administered by the central government (Septiono et al., 2019).

The existing local tobacco tax policy derives its mandate from the Local Tax and Retribution Law (No. 28/2009). However, implementing regulations for the policy were not in place until 2014, 5 years after the law was passed. In addition to the central government tobacco tax regime described above, this regulation added an extra 10% excise to cigarette sales across the country,
which was intended as a source of revenue for local government. The 2014 policy also stated that 50% of the income generated by this 10% excise must be used to fund community-based health initiatives within the local district where they were collected. Through this policy, the government hoped to support local healthcare and preventive efforts related to smoking, especially aimed at children and young adults, in line with the Ministry of Health’s ‘vision for developing health’ (visi pembangunan kesehatan) in Indonesia (Ministry of Health, 2019). This, in turn, would hopefully decrease the incidence of non-communicable diseases in the long term, while subsequently reducing costs to the JKN in the future.

3 | METHODS

This research, conducted in the first half of 2019, draws from three data sources to analyse the effectiveness and impact of reallocating a proportion of local tobacco tax to address the JKN’s budgetary issues. We used a case-oriented approach that employs multiple sources to construct an overall narrative of the context, actions and consequences posed by the case study (Ritchie & Spencer, 1994). With the data gathered, we gained insights into: (1) the context behind the policy; (2) the justification for the policy; (3) the dynamics of the policy and its implementation; (4) the effectiveness of the policy; and (5) policy recommendations. The data used to inform our understanding of the case study and generate our analysis included official documents related to the income and expenditure of the JKN program, one-on-one interviews with key informants, and a focus group discussion with representatives from government bodies and non-governmental organisations who were in a position to comment on the implementation and impact of the policy.

3.1 | Document review

We reviewed documents obtained from the BPJS, which administers the JKN, regarding measures to cover the program’s mounting costs. We also reviewed relevant laws and regulations guiding both the JKN and local tobacco tax and excise, as well as documents related to the implementation of policies across multiple levels of government (national, provincial and local). Key documents reviewed include:

- Law No. 40/2004 concerning the national social security system
- Law No. 24/2011 concerning changes in the Indonesian social security administrative bodies (BPJS)
- Law No. 28/2009 on local taxes and retribution
- Ministry of Health Regulation (Permenkes) No. 40/2016 on the use of tobacco tax funds
- Ministry of Health Regulation (Permenkes) No. 33/2017 on the use of tobacco tax funds
- Ministry of Home Affairs Regulation (Permendagri) No. 33/2017 referring to Permenkes No. 33/2017
- Ministry of Health Regulation (Permenkes) No. 53/2017 on the use of tobacco tax funds to contribute to JKN
- Ministry of Finance Regulation (Permenkeu) No. 128/2018 on the technicalities of revenue collection and transfers to BPJS
- Presidential Decree (Perpres) No. 82/2018 on the use of tobacco tax funds to contribute to JKN
• Presidential Decree (Perpres) No. 75/2019 on the increase of BPJS citizen [participant] contributions.

In reviewing these documents, we were able to construct an accurate contemporary picture of the policy and situate it within a historical context. We also compared the intentions of the policies, described in their preambles, to the realities of the program in terms of difficulties of implementation and the real benefits (and costs) yielded.

3.2 | Interviews

We conducted semi-structured interviews with two key informants from BPJS and the Ministry of Health who had experience in the rollout of the policy, to ascertain the concrete outcomes of the policy between 2018 and 2019. These government officials provided facts and figures, including the most recent budget and expenditure data. We also questioned them about the official perspective on the policy, and the realities of implementing the policy in practice. Questions focused on (1) the financial outcomes of the policy for the JKN and (2) the challenges of implementing the policy on the ground, particularly at the provincial and local level.

3.3 | Focus group discussion

We conducted one focus group discussion, giving us an opportunity to seek clarification and solicit perspectives from key informants, allowing for an investigation of interrelations between multiple stakeholders (Queirós et al., 2017). The focus group discussions involved representatives from BPJS, the Ministry of Health, the Ministry of Finance, the Health Promotion Department, and Pusaka, a non-governmental organisation that focuses on children’s and women’s rights (five organisations represented in total). The goal was to obtain a more accurate picture of how each institution perceived the policy. Our questions focused on four themes:

1. How has the policy shift affected the JKN budget overall?
2. What procedures are being used to calculate, collect and manage local tobacco tax revenues?
3. What are the provincial and local government sentiments towards the policy?
4. What are the ongoing challenges posed by the policy for different stakeholders?

The nature of the focus group discussion allowed us to capture different organisational perspectives on the policy, while observing the discussions and debates that occurred organically between participants throughout the session.

4 | RESULTS AND DISCUSSION

4.1 | Indonesia’s universal healthcare scheme (JKN)

Indonesia’s universal health scheme is ambitious, aiming to provide comprehensive and quality healthcare services to a population of over 260 million people, regardless of income and geographic location (Bredenkamp et al., 2015; Pisani et al., 2017). The estimated budget for the
program in 2014 was Rp26 trillion (Noviani, 2013). Initial conceptualisations of the scheme envisaged that the JKN would derive around 50% of its funding from participant contributions by the time 70% of the population had registered, with the remainder subsidised through the national budget (Thabrany, 2019). However, it became apparent within the first few years of the program that the government had both underestimated projected costs of rollout and service provision and would not be able to meet the 50% target for participant contributions. In 2017, approximately 60% of JKN subscribers were from subsidised groups, paying either lower or no user contribution (Agustina et al., 2019). By October 2018, 203 million Indonesians had enrolled for the scheme, approximately 76% of the population; however, 2018 figures reveal that 23% do not regularly pay their fees (Agustina et al., 2019).

The 2014–2017 BPJS Financial Evaluation Report from the National Social Security Board (Dewan Jaminan Sosial Nasional [DJSN]) reveals a consistent gap between expenditure and hypothesised funds since it was launched (Figure 2). In 2014 there was an initial budget deficit of Rp1.94 trillion, increasing to Rp16.4 trillion by 2017, as more citizens began to access JKN services. In 2018, the cumulative budget deficit reached Rp28.73 trillion.

In essence, this disparity arose because the initial government calculations regarding participant contributions to the JKN overestimated exactly how much money these contributions would generate. Calculations shared with us by representatives of the DJSN (see Table 1) show a disparity between the existing monthly tariffs and initial estimates for JKN participants, and the 2015 projected contributions for 2019 according to different classes of healthcare users. Subsidised groups include those officially designated as ‘poor’. According to Law No. 40/2004 on the national social security system, the ‘poor’ are defined as those who are unemployed, unable to fulfil basic necessities, or people with a disability. Those designated as ‘informal workers’ and ‘formal workers’ pay significantly higher JKN contributions to BPJS but are still subsidised by the government.

Funds collected through participant contributions to the JKN are further influenced by how many contributors fall into the respective JKN categories. The original DJSN fee projections fell short of expectations, especially in higher fee categories, meaning that BPJS did not receive the anticipated amount of contributions when its annual budgets were first conceptualised. For example, in 2019, the actual JKN fees for those classified as ‘poor’ (which was the majority of users) were Rp23,000 per person/month, while BPJS projected the total cost of providing the JKN to these citizens to be Rp36,000 per person/month. Thus, the government paid an additional Rp13,000 per month as a subsidy for each registered recipient in this category. The same pattern is seen in other segments. For each informal sector Class II worker registered, BPJS was amassing a loss of Rp12,000 per person/month and Rp28,000 per person/month for Class III workers.

The fees for formal workers in 2019 were calculated as 5% of their wages, with no minimum fee but an upper threshold of Rp8 million in income/month, resulting in a maximum JKN contribution of Rp400,000 per person/month. However, DJSN’s original plan was to implement a progressive system where those earning above the regional minimum wage were expected to contribute 6% of their salary. The upper wage limit was originally calculated as 6 × Rp63 million, or Rp378 million (based on DJSN estimates of average non-taxable annual income of a married man or woman with one child), meaning that formal workers in this category were projected to pay up to Rp1,890,000 per month in BPJS contributions. However, with the current upper wage limit being Rp8 million per month, and no prospect of revision, actual contributions collected from this group were also significantly less than projected.

Given the budgetary challenges, experts offered four key suggestions to overcome the financial hurdles of implementing the JKN: (1) increase contribution fees; (2) lower the costs of
medical treatment; (3) make the healthcare reimbursement process more efficient; and (4) increase the overall efficiency of the healthcare system (Agustina et al., 2019). The government was reluctant to lower the cost of treatment or to increase user contribution fees, even though these solutions would be the most straightforward and have the most immediate impact on the JKN budget. At the same time, while efficiency measures were being considered, the potential financial benefits would not be felt in the short term as it would take many years to implement the

**TABLE 1** Contribution fees for the national universal health coverage (UHC) scheme (Jaminan Kesehatan Nasional [JKN]) in 2019 (rupiah per month)

<table>
<thead>
<tr>
<th>Contribution category</th>
<th>Current fees</th>
<th>DJSN projection(^a)</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subsidised groups</td>
<td>23,000</td>
<td>36,000</td>
<td>(13,000)</td>
</tr>
<tr>
<td>Informal workers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Class I</td>
<td>80,000</td>
<td>80,000</td>
<td>–</td>
</tr>
<tr>
<td>b. Class II</td>
<td>51,000</td>
<td>63,000</td>
<td>(12,000)</td>
</tr>
<tr>
<td>c. Class III</td>
<td>25,000</td>
<td>53,000</td>
<td>(28,000)</td>
</tr>
<tr>
<td>Formal workers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Wage deduction</td>
<td>5%</td>
<td>6%</td>
<td>(1%)</td>
</tr>
<tr>
<td>b. Upper wage limit (Rp8 million per month)</td>
<td>Up to 400,000</td>
<td>Up to 1,890,000</td>
<td>Up to (1,490,000)</td>
</tr>
<tr>
<td>c. Lower wage limit (No minimum)</td>
<td>5% of actual monthly salary</td>
<td>5% of monthly regional minimum wage</td>
<td>–</td>
</tr>
</tbody>
</table>

Abbreviation: DJSN, Dewan Jaminan Sosial Nasional.

\(^a\)DJSN’s 2015 calculation for fees per user.

\(^b\)Original calculation based on 6 × average non-taxable income K/1/year, totalling Rp378 million. DJSN classifies Group K/1 as married men/women with one child.
changes to reduce overall JKN delivery costs. This placed pressure on the government to come up with alternative solutions.

### 4.2 Local tobacco taxes

Tobacco taxation in Indonesia is complex, with several different taxes imposed on cigarettes: excise tax, VAT, import duty (for foreign cigarettes), corporate income tax and local tobacco tax (Prasetyo & Adrison, 2019). In 2016, the Ministry of Health issued revised implementing regulation No. 40 (PMK No. 40/2016), which dictated that a minimum of 50% of income from the local cigarette tax was hypothecated for health programs. Article 2(1) further clarified that 75% of this budget must be allocated for health promotion and prevention activities including tobacco control (37.5% of the total), and the other 25% (12.5% of the total) was to be dedicated to public health infrastructure building and equipment.

The Ministry of Health later discovered that many local governments were not implementing this regulation, necessitating a supporting regulation from the Ministry of Home Affairs (Permendagri No. 33/2017) in 2017, explicitly stating that the use of tobacco tax funds must comply with the Ministry of Health’s 2016 regulation. However, these regulations were amended again in 2017, redirecting a portion of funds collected through the local tobacco tax to the JKN. As at the time of writing, these regulations remain in place.

### 4.3 Interaction between the universal healthcare scheme and tobacco taxes

After 4 consecutive years of overspending against its budget, the economic viability of the JKN became a serious political question. In 2018, President Joko Widodo criticised the Ministry of Health, contending that it was failing in its responsibility to solve the JKN’s funding issues, in order to distance himself from the problem and avoid a political backlash in the 2019 elections (Erniaty & Harun, 2020). Given the mounting political attention and the pressure to respond to JKN’s budget woes, the Ministry of Health turned to the tobacco taxes to try to address this tension (Ahsan, 2018).

The JKN and local tobacco tax policies were not intended to interact when they were originally conceived. However, since 2017 they have become intertwined (Figure 3). In 2017, the Ministry of Health formally issued an amendment to previous regulation Permenkes No. 53/2017, which changed Article 2(1) to redirect a proportion of the local tobacco tax towards the JKN. Local governments were now required to hand over 75% of the 50% from these taxes that was previously earmarked for community healthcare services to the BPJS. This meant that 37.5% of the total funds received through the local tobacco tax initiative would now go towards the JKN. This policy was reinforced by a Presidential Decree in 2018 (PP No. 82/2018) and a Ministry of Finance regulation (PMK No. 128/2018).

One of the main critiques of this policy lies in its complexity. The technicalities of calculating the revenue owed and transferring it from the Ministry of Finance to the local government and then to BPJS, as outlined in the Ministry of Finance regulations from 2018, were complicated. Rather than taking a simple 37.5% cut of the local tobacco tax, Articles 3 and 6 of PMK No. 128/2018 adjusted the calculation to account for local government contributions to the regional health fund (Jaminan Kesehatan Daerah, Jamkesda), a fund that is separate from, but intended...
FIGURE 3  Summary of laws and regulations related to the national universal health coverage scheme (Jaminan Kesehatan Nasional [JKN]) and local tobacco taxes. BPJS, Badan Penyelenggara Jaminan Sosial
to supplement, the JKN. Article 3(3) of this regulation states that the contribution from the local tobacco tax should be adjusted according to how much local governments contribute to the regional health fund, managed by the provincial government.

Therefore, per the existing regulation, local cigarette tax contributions to the JKN are calculated as:

(1) Local cigarette tax revenue = (cigarette excise revenue × 10%) × population weight
(2) JKN funding = local cigarette tax revenue × 37.5%
(3) Local government contribution to BPJS = JKN funding – Jamkesda allocation

Provisions regarding how the provincial contribution offsets the national contribution are further outlined in Article 6 of the Ministry of Finance regulation. Article 6(a) states that if the local contribution to Jamkesda is already equivalent to 37.5% of the local tobacco tax revenue, then no additional contribution to the JKN is required. Article 6(b) states that if the contribution is less than 37.5%, then the difference in these amounts should be given over to the BPJS.

Because local governments negotiate their contributions to Jamkesda on an individual basis, the BPJS must calculate the JKN payment of each local government individually, depending on their existing agreements with their provincial counterparts. Determining the correct contribution, under Article 6(c), requires the provincial government to submit a comprehensive compilation of minutes of the meeting during which contributions from the local government to the provincial healthcare fund were confirmed. Under Article 5(3), if these documents are not submitted before 31 March each year, then the local government is subject to a tobacco tax deduction of 37.5%, regardless of what they have already surrendered to the provincial government.

Focus group discussion participants highlighted the complex nature of these calculations as they recounted how BPJS had miscalculated the funds owed by local governments in 2018. Due to an internal error, the calculations failed to account for local contributions to Jamkesda, forcing them to recalculate the amounts after the funds had already been transferred and received. In total, BPJS collected Rp1.58 trillion from local governments; however, after recalculation it became apparent that BPJS was only entitled to receive Rp681 billion. This, in turn, led to another administrative challenge because the mechanisms to return the excess funds were not outlined in the Ministry of Finance regulations at all. Moreover, returning this money was an urgent matter because if the money was not returned within a reasonable timeframe, the BPJS could face legal action from either the Supreme Audit Agency or the Financial and Development Supervisory Agency, leading to even more costs for the institution. As a result, local governments were presented with a number of solutions: (1) the excess funds are not returned to the regions—in other words, the local government granted the excess funds to BPJS; (2) the excess funds be used to pay outstanding BPJS fees for citizens in the local area; (3) the excess funds be deducted from the following year’s fees. The majority of local governments chose option (2) or (3), both of which required extra employee hours from the BPJS in order to calculate how these options would translate for each local district.

The administrative burdens created by the new regulations required additional resources and created more work for all government institutions involved. Multiple forms, paperwork and approvals were needed to correctly channel the necessary funds to the BPJS. As mentioned, the BPJS was legally required to obtain official documentation on the existing healthcare funding agreement between the local and provincial government, in addition to the minutes of annual meetings in which these agreements were determined. These documents had to be signed by provincial and local government heads and witnessed by an official appointed by the BPJS. The
minutes had to also include details related to tobacco tax revenue plans, Jamkesda budget plans, and an outline of how they are integrated into BPJS’s funding plan.

In our interviews and focus group discussion, it became clear that many provincial and local government officials were either unfamiliar with the new policy or did not fully understand its implications. The required meetings were rarely prioritised and were often not even scheduled until after BPJS officials requested the paperwork for their calculations. Organising these meetings presented a further burden to local government and the BPJS, requiring bureaucrats to align the schedules of all the necessary government representatives. Furthermore, once the meetings had been held, significant follow-up was required to obtain the minutes of relevant meetings between the provincial and local government representatives, approved and signed off by the heads of both the provincial and local government, witnessed by a BPJS official. This generated further costs to the BPJS, with officials having to travel across Indonesia in order to witness signatures and obtain the appropriate paperwork before the deadline. Several cases were reported where BPJS officers had to journey to remote areas of the country to witness these papers being signed and, even then, had difficulty collecting the documents. Several such cases were reported, including having to travel to a local regency’s favourite fishing spot, or waiting long hours in the evening for the governor to return from a field trip, to witness their signatures. Since Indonesia has thousands of islands, and many areas that are remote and expensive to reach, this meant that the BPJS was required to spend funds it did not have on overtime and travel for staff so that the policy could be enacted.

Finally, the change in policy has done very little to actually address the gap between budget and expenditure of the BPJS. Based on projections for 2018, the BPJS hoped to receive approximately Rp5.5 trillion from this new funding source. However, with all the calculation problems and costs associated with the implementation of the policy, it contributed only Rp681 billion in 2018—over Rp4.66 trillion less than anticipated. As it turned out, the cost of complying with regulations associated with the policy heavily affected its benefits. In 2019, BPJS officials stated that the institution only received Rp831 billion from local cigarette tax revenue. With a cumulative deficit of Rp28.73 trillion in 2018, the funds from local cigarette tax revenue represented approximately 2.89% of the money that the government needed to cover JKN expenditure in that year.

In tacit recognition that the JKN’s funding problems are far from being surmounted, a new regulation—Presidential Decree No. 75/2019—was created in 2019 to mandate an increase in participant contributions to the JKN. The government had hoped to avoid implementing such a policy, believing it would be publicly unpopular, but the ongoing JKN budgetary crisis forced it to review this decision. Under this new policy, the minimum increase to participant contributions would be Rp19,000 for subsidised groups and Class III informal workers—those in Indonesia’s lowest income brackets—but higher for other wage groups (Table 2). The Ministry of Finance estimates that this increase would create an approximate surplus of Rp4.81 trillion for the JKN program in 2021 (Widyastuti, 2019).

This decree was planned to take effect on 1 January 2020; however, it was challenged in the Supreme Court, which issued a judicial review of the policy in response to citizens groups protesting the fee increase (Jakarta Post, 2020). While the new approach appears better positioned to address the JKN budget shortfall than the current strategy, the legal uncertainty created by the judicial review effectively revoked the planned increase in participant contributions until further notice. Thus, the ongoing funding problem facing the JKN is far from being solved, necessitating further efforts to implement policy solutions that effectively address the problem without creating more dilemmas for the government.
5 | CONCLUSION

On 1 January 2014, two policies concerning public health in Indonesia were simultaneously implemented: the JKN and a new local tobacco tax. Though they were not related to each other when enacted, government decisions from 2017 saw them become highly interconnected. The relationship that emerged between these two policies was driven by the political need for more funding to be allocated to the JKN, which was not only economically troubling but also reflected poorly on the government’s financial management capabilities. There was an initial reluctance to raise participant contributions or restrict healthcare services, both of which would be unpopular with voters. This prompted the Ministry of Health to seek out new funding sources to bridge the JKN budget gap and identify the local cigarette taxation program as a potential source for additional revenue.

This case study offers some insight into what can happen when policymaking is driven by political interests rather than a deep consideration of existing circumstances and a realistic analysis of the consequences of new policies. Using local tobacco taxes to address the JKN’s budgetary problems may have seemed like a convenient stop-gap solution when it was conceived, but in reality it was flawed. Its implementation was not effectively supported by local government counterparts, it was complicated and resource-intensive to enforce, and it generated less funds than anticipated. Overall, policymakers failed to fully consider the implications of this strategy and, as a result, created a poorly conceived policy that did not meet its own objectives. At the same time, it undermined existing tobacco control measures by diverting funding away from local programs, despite the fact that such programs can represent a significant intervention to decrease Indonesia’s troublingly high smoking rates. While it will be some time before we see exactly how this decrease in earmarked funds influences local tobacco control measures, the existing regulatory regime continues to require local governments to direct funds 37.5% of local tobacco tax revenue to the JKN.

The most recent policy development—a presidential decree that increases participant contributions to the universal healthcare scheme—is a more practical strategy for generating the additional funding required to cover the existing shortfalls and future expenditures of the JKN. Furthermore, it is a tacit admission that this policy has failed. Although the fate of this most recent presidential decree remains uncertain due to ongoing legal challenges, we suggest that the tax policy of channelling 37.5% of local tobacco taxes towards the JKN should be overturned.
and restored to its previous form, boosting funding to local governments for community-based health programs in local areas. At less than 3% of the existing cumulative JKN budget, the funds collected by BPJS from tobacco tax funds are comparatively small for the effort required to collect them. This necessitates a rethink of how best to proceed with this policy for funding the JKN into the future and a continued search for better solutions to this ongoing issue.

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ETHICAL APPROVAL
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DATA AVAILABILITY STATEMENT
The data that support the findings of this study are available from the corresponding author upon reasonable request.

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