Assessing the Implementation of Public Service Contracting in the Universal Health Coverage Policy in Indonesia, the Philippines, and Thailand: The Government Tools Approach

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ABSTRACT

Health and well-being are significant UN's sustainable development goals (SDGs) in improving living conditions and guaranteeing human rights to adequate standard of living. The Universal Health Coverage (UHC) policy is recommended in achieving these SDGs. However, the existing literature on the implementation of public service contracting mechanism in the UHC policy mostly focused on the Anglophone countries or medical-based perspective. Little is known about the structure, management, and outcomes of UHC contracting in developing countries under the government tools perspective, especially in Southeast Asia. This paper thus adopts qualitative document research and applies Salamon's government tools framework in assessing the implementation of public service contracting in the UHC policy in Indonesia, the Philippines, and Thailand. These countries were selected based on their relative similarities on the political regime, economic status, and the implementation of the UHC policy. The results suggest that while all countries demonstrate policy convergence on the use of multiple policy tools with public service contracting mechanism, which demonstrates the importance of the accountability structure in implementing UHC contract, different contexts in these countries also influence different UHC contracting structure, management, and outcomes. The results also provide supports and variations of the implementation of the POS contract against the previous observations. Key lessons learned for future public administration research and practice in UHC policy and government tools framework are also discussed.

Keywords: Universal health coverage, Public service contract, Government tools approach, New public management, Southeast Asia

INTRODUCTION

Health and well-being are significant UN's sustainable development goals (SDGs) in improving living conditions and guaranteeing human rights to adequate standard of living (United Nations, 2018). With both individual's well-being and societal benefits such as decreased risk of communicable diseases, reduced financial risks from unanticipated diseases, and maintaining economic stability and productivity from decreased health risks (Evans et al., 2012; The Economist, 2018), the United Nations also urged the governments around the world to provide accessible, high quality, and affordable health care services for all citizens (WHO, 2012, December 12), namely the Universal Health Coverage (UHC) (WHO, 2018, December 5). UHC is the healthcare system aimed at ensuring that everyone receive needed health services "without suffering financial hardship" (WHO, 2018, December 5). It focuses on the balance between target population to be covered, types of services provided, and whether the covered population must pay out-of-pocket or not (Cotlear et al., 2015). There are currently 33 developed countries and 24 developing countries that adopt UHC policy in delivering health care services (Cotlear et al., 2015), though the actual implementation and key components between each country may be varied.

One of the key components of UHC policy is the implementation of the purchaser-provider split, a system where "the purchaser, as principal, uses financial, contractual, regulatory and monitoring mechanisms as levers to ensure that the health provider, as its agent, delivers an appropriate mix of quality healthcare services, at an agreed price" (Honda et al., 2016, p. 6). It is based on the notion of services marketization based on New Public Management (NPM) in establishing the quasi-market system aimed at improved quality, efficiency, effectiveness, and access to the public services (Bevir, 2009; Kjaer, 2004; Lane, 2009), including health care services (Evans et al., 2012). In achieving these goals, the use of purchaser-provider split relies on the contracting-out of health services with public health providers, as well as private and nonprofit providers (Cotlear et al., 2015). The current literature demonstrates the uses of contracting-out of health care services in developed countries (Ashton, Cumming, & McLean, 2004; Klasa, Greer, & van Ginneken 2018; Siverbo, 2004), as well as developing countries (Honda et al., 2016; Mbau et al., 2018).

However, studies of the contracting-out of UHC policy that focus on the implementation of NPM instrument in different contexts under public administration perspective are relatively scarce (Cheung, 2005; Pollitt & Bouckaert, 2011). Little is known about whether there is the similarity in the implementation of purchase-for-service (POS) contract in different countries and policy areas, or there are differences characteristics and outcomes in different contexts. Specifically, while the study from DeHoog & Salamon (2002) suggested that the implementation of the POS contract seems to reflect the moderate degree of policy tool's coerciveness (i.e., the degree of enforceability), directness (i.e., the degree of authorization, funding, and execution under the same entity), and automaticity (i.e., the degree of utilization of current administrative structure for tool's implementation) under the market assumption, the literature of UHC contract in the European countries demonstrated the assumption of cooperative-oriented contract instead (Ashton, Cumming, & McLean, 2004; Perrot, 2006; Siverbo, 2004). This strand of research in

Southeast Asian countries is limited, despite there are countries that recently implemented the UHC policy with the use of the contracting-out mechanism (Cotlear et al., 2015). The assessment of policy convergence and divergence in this context, therefore, is important in exploring similarities and/or differences of the implementation of the POS contract in UHC policy, which is beneficial for theory-building and practice.

Furthermore, the application of Salamon's government tools framework in studying the implementation of contracting-out of UHC policy instrument in Southeast Asian countries seems to be overlooked in the literature. Thus, this study uses Indonesia, the Philippines, and Thailand as case studies in assessing how the use of NPM instrument, the contracting-out of UHC, operates in developing countries. The cases selection of this study is based on countries' relative similarities on the political regime, economic status, and the implementation of the UHC policy. The findings demonstrates both policy convergence and divergence of the UHC contract as a policy tool. While all countries demonstrate tool's convergence in the use of policy mix and the importance of accountability structure in implementing UHC contract, different contexts in these countries influence different UHC contracting structure, management, and outcomes. The result also supports previous literature on the notion of UHC contract as cooperative-based contract and opposes previous observations on policy tool dimensions, particularly tool's automaticity and coerciveness in some countries.

LITERATURE REVIEW

Contracting-out in healthcare services

Contracting is one among market-oriented government instruments aimed at improving efficiency and effectiveness of public services delivery (Cohen & Eimicke, 1998; Cooper, 2018; DeHoog & Salamon, 2002; Kelman, 2002). Contracting generally refers to "[A] business arrangement between a government agency and a private entity in which the private entity promises, in exchange for money, to deliver certain products or services to the government agency or to others on the government's behalf" (Kelman, 2002, pp. 282). However, the contracting out of healthcare services delivery is another type of contract, namely purchase-of-service (POS) contract (DeHoog & Salamon, 2002). The key difference between general contract and POS contract is that the latter focuses on the services delivery to the third party (e.g., citizens), whereas the former focuses on the procurement of goods and services directly used by the public organizations (e.g., office cleaning contract; stationary contract) (DeHoog & Salamon, 2002; Kelman, 2002).

The implementation of the POS contract in public services delivery generally aims for enhancing efficiency and effectiveness of such services (DeHoog & Salamon, 2002; Kelman, 2002). Theoretically, based on the competitive market assumption, the effectiveness of contracting-out depends upon the availability of services providers in the market, which creates the competition among services providers that results in increasing efficiency, quality, and lower costs of services (Cooper, 2018; DeHoog & Salamon, 2002; Kelman, 2002). In addition, the use of POS contract also aims for the increased flexibility of public services delivery, especially

when the government may not have the in-house capacity to deliver public services efficiently and effectively (Cooper, 2018; DeHoog & Salamon, 2002).

However, key challenges for the use of POS contract are that, firstly, the performance of such contract may be questionable if there are limited services providers, which rejects the competitive market assumption in enhancing the competition among services providers for better results (Cooper, 2018; DeHoog & Salamon, 2002). Furthermore, the rigorous monitoring system created by the principal agencies is also required to ensure the accountability of such contractual relationships between the purchaser and provider, purchaser and government, as well as purchaser and citizens (Cooper, 2018; DeHoog & Salamon, 2002). Thus, the principal of the contractual relationship should have relative control over the agent, or the contractor, in ensuring that the public services delivery aligns with the purpose and key indicators set by the principal (Honda et al., 2016; Siverbo, 2004).

The POS contract of healthcare services delivery can be categorized into two types. First, strategic purchasing or performance-based contract (Martin, 2020) refers to an active purchase from the search of providers based on types of services and how to purchase such interventions (Honda et al., 2016; Klasa, Greer, & van Ginneken, 2018). The second type is the reimbursement contracting, which refers to the passive financing of healthcare services based on reimbursement of the costs from healthcare services (Honda et al., 2016). The existing literature on the implementation of contract in healthcare services generally suggests that healthcare contracts are generally shifting from competition-oriented contracting towards cooperative contracting (Ashton, Cumming, & McLean, 2004; Perrot, 2006; Siverbo, 2004), as there are limited healthcare providers in healthcare services delivery compared to other competitive markets (Honda et al., 2016; Siverbo, 2004). In Sweden, the implementation of healthcare services contract is based on the soft contract, or negotiation and cooperation-based contract between purchasers and providers, which do not include comprehensive details on penalties and legal enforceability (Siverbo, 2004). The experience from New Zealand also suggests that contracting of healthcare services delivery requires relationship building between the purchasers and providers of services, which can maintain services continuity (Ashton, Cumming, & McLean, 2004). Interestingly, the study of ten European countries (e.g., Denmark, Estonia, France, Germany, Italy, Netherlands, Slovakia, Spain, Switzerland, and England) by Klasa, Greer, & van Ginneken (2018) suggests that the strategic purchasing of healthcare services with the providers are actually not strategic, as it focuses more on ensuring smooth relationship between purchasers and providers, rather than the health-related performance, due to the problem of limited providers (Honda et al., 2016; Siverbo, 2004). Overall, this means that many healthcare services contracts are leaning toward cooperative-based contract than market-oriented contract.

Analytical framework of contracting-out in healthcare services: towards government tools approach

The use of POS contract in public services delivery is one among other government's tools in providing public services to the citizens. The literature of government tools approach generally focuses on the categorization of policy mechanisms for public services delivery and public affairs. Hood & Margetts (2007)

propose that there are four types of tools: nodality (i.e., information inquiring tools); authority (i.e., the legal power in authorizing government to do something but not others); treasure (i.e., resources exchange ability to buy goods and services, or incentivizes the non-governmental "policy mercenaries"); and organization (i.e., the use of direct government actions). In a similar vein, Lane (2009) proposes that there are different government tools, ranging from the use of formal organization to regulations and laws, independent agencies, contracts, marketization and privatization, and policy networks and multi-level governance structure. Salamon (2002) and Cooper (2018) agree that the government tools include direct government, government corporations and government-sponsored enterprise, public information, regulations, and financial-based tools (e.g., contracts, grants, vouchers, tax expenditures, government insurance). The key argument from the government tools literature is that the modern government has a variety of options ranging from the use of direct government to market-based mechanisms and the networking between multiple policy actors, which the government still has relative authority in governing under different forms as the "pastmodern state" (Smith, 2016, p. 337).

Despite these attempts in categorizing government tools with the notion of state management, the works from Lane (2009) and Hood & Margetts (2007) did not provide an analytical framework in analyzing a particular policy tool in public services delivery. In contrast, Salamon (2002) provided the government tools framework in analyzing policy tools in public services delivery. This framework consists of two broad analytical aspects: the tool dimensions (i.e., tool's characteristics), and the process and outcome evaluation of the tool (Salamon, 2002). For the tool dimensions, there are 4 key analytical categories: policy mix[1], automaticity, directness, and coerciveness, whereas there are 5 key analytical categories for the tool evaluation: legitimacy, manageability, effectiveness, efficiency, and equity (Salamon, 2002). Table 1 summarizes key analytical categories of the framework.

[1]Although the original framework from Salamon (2002) does not include policy mix in the framework, it should be included because the literature argues that one key aspect of tool's implementation is the consideration on whether to implement more than one policy tool in particular policy domain or not (See also Cooper 2018; Salamon 2002).

Table 1. The Government Tools Framework (Adapted from Salamon, 2002, p.22-37)

Tool Dimensions		**Tool Evaluation**	
Categories	Descriptions	Categories	Descriptions
Policy Mix	The number(s) of implemented tool(s) under the same policy	Legitimacy	The degree of public acceptance and support towards policy and tool
Automaticity	The degree of utilization of current administrative structure for tool's implementation	Manageability	The degree of ease in implementing the tool
Directness	The degree of authorization, funding, and execution under the same entity	Effectiveness	The degree of policy objectives achievement
Coerciveness	The degree of controllability and enforceability of the tool	Efficiency	The degree of optimization between costs and benefits
		Equity	The degree of redistribution of benefits to disadvantaged population

Salamon (2002) and DeHoog & Salamon (2002) propose that the POS contract may generally has the medium level on tool's automaticity, directness, and coerciveness, due to challenges in implementing an indirect policy tool against the existing administrative system, the nature of contract as an indirect tool that involves multiple policy stakeholders with specifications for quality control, and the relative weak controllability of the services providers despite having authoritative conditions in the contract. However, the tool's characteristics are subjected to an assessment of the actual implementation, which may constitute policy divergence deviated from observations from the literature.

Despite the emergence of government tools approach, the current literature applying the government tools framework in healthcare policy is relatively scarce compared to other public policy analytical frameworks such as policy network framework (Zheng, De Jong, & Koppenjan, 2010), advocacy coalition framework (Gagnon, Turgeon, & Dallaire, 2007; Larsen, Vrangbæk, & Traulsen, 2006), multiple streams framework (Odom-Forren & Hahn, 2006; Smith et al., 2016), punctuated equilibrium framework (Feder-Bubis & Chinitz, 2010), and to name but a few. In particular, the current literature focused on the use of contract in UHC policy also neglects the use of government tools framework in studying how the contracting-out of UHC policy operates in general (Klasa, Greer, & van Ginneken, 2018), and in developing countries (Honda et al., 2016). Thus, this study uses the government tools framework in studying the implementation of contract in healthcare services delivery in Indonesia, the Philippines, and Thailand, in fulfilling this literature gap.

METHODOLOGY

This study adopts qualitative research methodology, including multiple-cases case studies design (Yin, 2018) and document analysis of previous research and official documents in studying the contracting-out of UHC policy in these Southeast Asian countries. The research question of this study is: How the implementation of

NPM instrument, the contracting-out of UHC policy, operates in Indonesia, Thailand, and the Philippines. The selection criteria of case studies are based on the existence of the UHC policy with purchaser-provider split mechanism (Cotlear et al., 2015), country's economic status as middle-income countries (Dayrit et al., 2018; Jongudomsuk et al., 2015; Mahendradhata et al., 2017), and are considered as democratic/hybrid regimes instead of the communist regime (The Economist Intelligence Unit, 2018). Documents for the analysis of the current study include official documents and research from World Health Organizations and UHC research from scholars of each selected country to provide rich data for the analysis. This study uses the government tools framework in assessing the key components of the policy tool(s) and the degree of convergence/divergence of policy implementation from these documents.

The measurement of the policy tool dimensions and evaluation in this study is developed based on Salamon's (2002) and DeHoog & Salamon's (2022) groundworks. However, these literatures do not provide a quantitative measurement scale but only the qualitative scales (e.g., High, Medium, and Low) without explicit and specific criteria for these scales. Thus, this study then develops the measurement criteria of these qualitative scales based on some key considerations from these literatures. The researcher also additionally adds the policy mix criteria in the analysis. Table 2 provides the qualitative measurement scales of the government tools framework on tool dimensions and tool evaluation.

Table 2. The measurement criteria of the government tools framework (Adapted from DeHoog & Salamon, 2002, p.321-322; p.336-337 and Salamon, 2002, p.22-37).

Tool dimensions	Measurement scale		
	High	**Medium**	**Low**
Automaticity	There is previous policy, program, institution, and/or regime that enhance the ease of tool's implementation.	There is/are challenge(s) in tool's implementation, despite the existence of previous policy, program, institution, and/or regime.	There is no previous policy, program, institution, and/or regime that enhance the ease of tool's implementation.
Directness	Only a single organization implements the policy tool in execution, authorization, and funding.	There are two or more organizations that manage the implementation of policy tool, but there are also some institutional obligations/conditions to be strictly complied.	There are two or more organizations that manage the implementation of policy tool with no or flexible terms and conditions to be complied.
Coerciveness	The policy tool is being implemented and controlled strictly by the policy stakeholder(s) through legal power or written specifications.	The policy tool is being implemented and controlled through legal power or written specifications, yet the policy stakeholder(s) may have their own interests and/or incentives.	The policy tool is being implemented based on policy stakeholder(s)'s own interests and/or incentives with no or flexible written specifications.
Policy Mix	Yes: There are the implementation of more than one policy tool. No: There is only one policy tool being implemented.		

Tool dimensions	Measurement scale		
	High	Medium	Low
Legitimacy	There is substantial public and political supports of the implemented policy and tool.	There are public and political supports of the implemented policy and tool with some disagreements from others.	The implemented policy and tool is substantially unsupported from the public.
Manageability	The implementation of the policy tool has no or little challenges to deal with.	The implementation of the policy tool has some challenges to be managed.	The implementation of the policy tool faces substantial challenges and/or policy deadlock.
Effectiveness	The policy goal(s) has been achieved.	Some of the policy goal(s) has been achieved.	The implementation of the policy tool fails to achieve determined policy goal(s).
Efficiency	Costs can be contained with possible maximized benefits.	Incremental increase of the contained costs over time or having some challenges in cost containment	Cost containment is not possible or problematic.
Equity	The policy either provides a universal service or remedy for underrepresented groups.	The policy either provides a universal service or remedy for underrepresented groups with some challenges.	The policy fails to achieve either a universal service or remedy for underrepresented groups.

RESULTS

Background of the cases

Table 3. Key backgrounds of UHC contracts in Indonesia, the Philippines, and Thailand

	Indonesia	The Philippines	Thailand
Total Population	262 Million	105 Million	64 Million
UHC Policy	2014 National Health Insurance System (JKN)	1995 National Health Insurance Program (PhilHealth)	2001 Universal Coverage Scheme (UCS)
Target Group	Everyone (currently 80% coverage)	Everyone (currently 80% coverage)	48 million people who don't have employment-based coverage (currently 99% coverage)
Purchaser Organization	Indonesia Social Security Corporation (BPJS)	Philippines Health Insurance Corporation (PHIC)	National Health Security Organization (NHSO)
Provider Organization(s)	907 Public hospitals 20,000 Public primary care centers 1,106 Private hospitals	726 Public hospitals 20,216 Public health centers 1,084 Private hospitals	984 Public hospitals 10,120 Public health centers 44 Private hospitals
Types of Services	Comprehensive	Basic Coverages	Comprehensive
Financing Mechanisms	Premium and Taxes Capitation and CBG without global budget cap	Premium and Taxes Fee-for-Services and Case rates package	Taxes Capitation and DRG with global budget cap

Indonesia. Indonesia is an archipelago country, consisting of approximately 17,744 islands (Agustina et al., 2018, p.2), including key islands such as Java, Sumatra, Kalimantan, Sulawesi, and New Guinea. The total population is approximately 262 million people (Agustina et al., 2018, p.2). The healthcare system in Indonesia is the Bismarckian model, or employment-based social health insurance, although the poor population is also subsidized by the government (Trisnantoro et al., 2016). In 2014, the Indonesian government implemented a major healthcare reform, aiming for merging different existing healthcare systems to become the single payer system, or National Health Insurance System (Jaminan Kesehatan Nasional - JKN) (Mehendradhata et al., 2017; Trisnantoro et al., 2016). Specifically, the policy was aimed to merge civil servants and retirees' health insurance scheme (PT Askes), formal sector workers scheme (PT Jamsostek), national government-funded poor and near-poor scheme (Jamkesmas), and local government-funded poor and near-poor scheme (Jamkesda) (Trisnantoro et al., 2016).

The JKN scheme aimed to cover all citizens by 2019, which approximately 80% of the total population are already covered (Agustina et al., 2018). The scheme provided comprehensive healthcare services, including inpatient and outpatient care, surgery, pharmacy, and health prevention services (Trisnantoro et al., 2016). Indonesian government uses the existing government-owned enterprise, namely the Indonesia Social Security Corporation (Badan Penyelenggara Jaminan Sosial - BPJS), as the single purchaser of healthcare services (Mahendradhata et al., 2017). The providers include about 20,000 public primary care centers, 907 public hospitals, and 1,106 private providers (Agustina et al., 2018). The JKN system also uses capitation, the healthcare budget per capita per year, to control healthcare costs for primary care, and uses IND-CBG, a context-based modified version of diagnosis-related groups (DRGs), for inpatient and outpatient services (Trisnantoro et al., 2016). However, there is no global budget cap for the overall healthcare expenses (Trisnantoro et al., 2016).

The Philippines. As an archipelago nation, Philippines has approximately 7,107 islands (Dayrit et al., 2018, p.2), including key islands such as Luzon, Visayas, and Mindanao. The total population is approximately 105 million people (Dayrit et al., 2018, p.4). Philippines uses the Bismarckian system for healthcare services delivery, as well as some tax-based subsidies for poor population (Picazo et al., 2016). In 1995, the Filipino government implemented major healthcare reform, namely National Health Insurance Program (PhilHealth), which aimed at providing healthcare coverage for all citizens (Dayrit et al., 2018; Picazo et al., 2016). However, there are approximately 80% of the total population who are covered under this program (Picazo et al., 2016).

To implementing the health insurance for all, the Filipino government established the government-owned enterprise, namely the Philippines Health Insurance Corporation (PHIC), as a single purchaser of healthcare services (Dayrit et al., 2018; Picazo et al., 2016). The PhilHealth scheme covered only inpatient care (Dayrit et al., 2018), although other benefits such as primary care services, health prevention and promotion, and some special services were evident to be included (Picazo et al., 2016). In terms of healthcare cost control mechanisms, PhilHealth

scheme adopts the fee-for-services and case rates package for both inpatient and outpatient services without global budget cap (Dayrit et al., 2018; Picazo et al., 2016).

Thailand. The total population in Thailand is approximately 64 million people (Jongudomsuk et al., 2015, p.4). In 2001, Thailand implemented the Universal Coverage Scheme (UCS), which is the tax-based healthcare coverage aimed at all 48 citizens who do not have employment-based coverage (e.g., Social Health Insurance (SHI) or Civil Service Medical Benefit System (CSMBS)) (Hanvoravongchai, 2013; Hughes & Leethongdee, 2007; Tangcharoensathien et al., 2012). Current citizens who are under the UCS coverage are approximately 99% of the eligible targeted population (Hanvoravongchai, 2013; Patcharanarumol et al., 2018). The services included under UCS are inpatient and outpatient care, surgery, pharmacy, and health prevention services (Hanvoravongchai, 2013). National Health Security Office (NHSO) has been established as an independent purchaser organization to implement contracts with healthcare providers, which there are approximately 984 public hospitals and approximately 10,120 public health centers (Jongudomsuk et al., 2015, p.87-88), with only 44 private providers (approximately 13% of total private hospitals) joined the scheme (Hanvoravongchai, 2013). The NHSO uses capitation for inpatient care, and use DRG for outpatient services, which the global budget cap of overall healthcare expenses is also included (Hanvoravongchai, 2013; Tangcharoensathien et al., 2012).

Key policy tool dimensions of UHC contracting

Table 4. Comparative tool dimensions of UHC contracts in Indonesia, the Philippines, and Thailand.

	Indonesia	The Philippines	Thailand
Policy Mix	Yes	Yes	Yes
Automaticity	High	Medium	Medium
Directness	Medium	Medium	Medium
Coerciveness	Medium	Low	High

Policy Mix. In addition to the use of POS contract, all countries adopt several policy tools in implementing UHC policy. The implementation of UHC policy in Indonesia (Trisnantoro et al., 2016), the Philippines (Picazo et al., 2016), and Thailand (Hanvoravongchai, 2013; Patcharanarumol et al., 2018) suggests that the use of law and regulations in enacting the UHC policy is still necessary for authorizing the implementation, which domestic politics is the major driver for the agenda-setting of UHC policy in these countries (Evans et al., 2012; Picazo et al., 2016; Pisani, Kok, & Nugroho, 2017). In addition, the use of direct government through healthcare services provided by the public hospitals is also evident in these countries (Agustina et al., 2018; Hanvoravongchai, 2013; Picazo et al., 2016). However, Thailand is the only country that established a new independent organization under the government supervision, the NHSO (Hughes & Leethongdee, 2007), as the purchaser of healthcare services, whereas both Indonesia and the Philippines adopt the government-owned enterprise as the services purchaser instead (Mahendradhata

et al., 2017; Picazo et al., 2016). Interestingly, the UHC policy in these countries is also based on tax-based health financing, although Thailand is the only country that solely relies of this type of financing for the UCS (Hughes & Leethongdee, 2007), comparing to Indonesia and the Philippines, which taxation is used for subsidies to the poor population (Picazo et al., 2016; Trisnantoro et al., 2016).

Automaticity. Indonesia is the only country that has high automaticity, as it has previously had different four social health insurance schemes for employees and poor population, the know-how in implementing capitation and IND-CBG, and only transformed the previous government-owned corporation that operated PT Askes scheme into Indonesia Social Security Corporation (Mahendradhata et al., 2017; Trisnantoro et al., 2016). However, the standardization of the capitation and IND-CBG is challenging due to the previous differences of these financing mechanisms in different local areas (Trisnantoro et al., 2016). Thus, the use of POS contract under this context is relatively automatic.

In the Philippines, despite having current public and private healthcare providers and the Ministry of Health, the newly establishment of government-owned corporation as the service purchaser (i.e., PHIC) and the monitoring system between the PHIC board, PHIC, and healthcare providers are relatively new and additionally needed for the implementation of the UHC contract (Dayrit et al., 2018; Picazo et al., 2016). This means that the automaticity in implementing the UHC contract in the Philippines is medium. In a similar vein, Thailand also needs new system design such as the purchaser-provider split, the establishment of the NHSO, and the monitoring process between the NHSO board, NHSO, and healthcare providers, in addition to the existing public and private hospital networks (Evans et al., 2012; Hanvoravongchai, 2013) and lessons learned from the implementation of SHI since 1991 (Tangcharoensathien et al., 2012). Thus, the degree of automaticity in Thailand's UHC contracting is at the medium level.

Directness. All countries have medium level in terms of tool's directness, as the authorization, funding, and execution of the POS contract are not under the single organization authority. In Indonesia, although the BPJS, as the purchaser organization, is responsible for POS contract management and monitoring, the "actual implementation" of healthcare services is relied on healthcare providers, who have relative autonomy and authority in providing healthcare services to meet the services requirement, as well as balancing services with the financial stability (Trisnantoro et al., 2016). The relative autonomy and authority of healthcare services providers can also be seen from the case of the Philippines (Dayrit et al., 2018) and Thailand (Treerat & Ngamaroonchot, 2012) from the use of UHC contract. In short, the POS contract, as a government tool, can be perceived as an indirect tool instead (DeHoog & Salamon, 2002; Kelman, 2002).

Coerciveness. Interestingly, the degree of coerciveness in implementing the UHC contract in three countries are varied. In Indonesia, although the enactment of laws, healthcare financing mechanisms, and contract's strategic purchasing conditions are key conditions in increasing the controllability of UHC contract over healthcare providers (Mahendradhata et al., 2017; Trisnantoro et al., 2016), the actual implementation of such coercive formal frameworks is under the medium level. This is due to the actual implementation in merging between previous different social health insurance schemes, as well as between the local governments and the central

government, which resulted in incremental reform rather than the rapid change (Trisnantoro et al., 2016).

In the Philippines, the degree of tool's coerciveness is low. The contract arrangement, in fact, is the passive reimbursement contract that still relies on fee-for-service financing mechanism, despite the availability of PHIC laws in controlling the system (Dayrit et al., 2018; Picazo et al., 2016). In Thailand, however, the degree of tool's coerciveness is high. In addition to the enactment of laws and coercive contracting based on the use of capitation and DRGs with global budget cap (Patcharanarumol et al., 2018; Tangcharoensathien et al., 2012), most healthcare providers (approximately 94%) under the UCS program are public hospitals and public health centers that mostly under the control from the Ministry of Public Health (MOPH) (Thailand National Health Security Office, 2011, p.89). This centralized structure accounts for the high coerciveness of the POS contract. In contrast, the public hospitals in Indonesia and the Philippines under the UHC policy are accounted for approximately 45% and 40%, respectively (Agustina et al., 2018; Picazo et al., 2016). Thus, the financing mechanisms and the degree of controllability of the central government are key components in influencing the degree of tool's coerciveness as a result.

In short, the analysis of the tool dimensions in these countries suggests that there is the implementation of other policy tools with the POS contract for UHC policy. Although the degree of tool's directness is at the medium level in these countries, different administrative contexts also influence different characteristics of the tool's automaticity and coerciveness.

Key policy tool evaluation of UHC Contracting

Table 5. Comparative Evaluation of UHC contracts in Indonesia, the Philippines, and Thailand.

	Indonesia	The Philippines	Thailand
Legitimacy	High	High	High
Manageability	Low	Medium	High
Effectiveness	Medium	Medium	High
Efficiency	Medium	Medium	Medium
Equity	Medium	Medium	Medium

Legitimacy. All countries have a high degree of tool's legitimacy, though there are some political oppositions in Indonesia and Thailand. While the citizens in Indonesia and Thailand generally support the UHC policy (Evans et al., 2012; Pisani, Kok, & Nugroho, 2017), the local governments that previously managed local health insurance schemes in Indonesia opposed the UHC reform as it decreases their authority and budgeting power (Pisani, Kok, & Nugroho, 2017), whereas some health workers in Thailand's public hospitals negatively perceived the UHC contract as it increased workloads from increased services utilization, as well as decreased authority in the case of MOPH (Treerat & Ngamaroonchot, 2012). However, the Philippines case suggests that the citizens generally support this policy (Picazo

et al., 2016), and there is currently no evidence in demonstrating the opposition against the UHC policy in the Philippines (Dayrit et al., 2018).

Manageability. Interestingly, the degree of manageability in implementing the UHC contract in three countries are varied, which Thailand has a high degree in tool's manageability, whereas the Philippines is at the medium level, and Indonesia falls under the low level. In Indonesia, although there is the establishment of the formal monitoring system of the UHC contracting, the information system of the monitoring system is ineffective, due to the previous fragmented health insurance schemes prior to the 2014 reform (Mahendradhata et al., 2017; Trisnantoro et al., 2016), absence of clinical and frontline health worker data (Agustina et al., 2018), as well as the limited cooperation between the central government and local governments (Trisnantoro et al., 2016), not to mention the infrastructure problem in maintaining the internet connection across country in supporting the information system (Mahendradhata et al., 2017). In addition, poor public information also accounts for limited awareness on citizens' rights and benefits of the JKN scheme, resulting in limited registration and coverage gaps (Trisnantoro et al., 2016).

In the Philippines, despite the establishment of formal monitoring system between the PHIC board, PHIC, and healthcare providers, the actual implementation of the monitoring system is generally ineffective, including limited information system in registering PhilHealth membership and paper-based claim processing (Picazo et al., 2016). In addition, the gatekeeping and referral systems of PhilHealth is weak, as there is no mechanism in controlling services utilization in certain geographical areas (Picazo et al., 2016). The problem of limited registration is also influenced from the limited public information on citizens' rights and benefits of the PhilHealth scheme (Picazo et al., 2016).

In Thailand, the monitoring system is relatively strong, as the formal monitoring system between the NHSO and healthcare providers are effective under reliable centralized information system (Hanvoravongchai, 2013; Patcharanarumol et al., 2018). However, the politics between the NHSO and the MOPH has led to the failure in health workers distribution to rural and deprived areas, as the MOPH reallocated the salaries budget from the capitation mechanism to health providers directly since 2002 (Hughes & Leethongdee, 2007; Lindelow, Hawkins & Osornprasop, 2012).

Effectiveness. Both Indonesia and the Philippines are considered as medium in terms of tool's effectiveness, whereas Thailand falls under the high level. In Indonesia, the covered population has been increased from approximately 50% in 2014 to approximately 80% in 2017 (Agustina et al. 2018, p.3), with enhanced healthcare benefits such as inpatient and outpatient care, health prevention and promotion, as well as pharmacy and surgery package (Trisnantoro et al., 2016). However, the problems of quality of care, long services queue, and inadequate drugs and medical supplies in rural and remoted areas are key challenges in services effectiveness (Agustina et al., 2018; Mahendradhata et al., 2017; Trisnantoro et al., 2016), not to mention the problem of information management in the first place (Mahendradhata et al., 2017).

In the Philippines, the covered population has also been increased to approximately 80% in 2013 (Picazo et al., 2016, p.167). However, the benefit coverage mostly remains for inpatient care (Dayrit et al., 2018), despite the ongoing inclusion

of health prevention and promotion and primary healthcare (Picazo et al., 2016), while poor services quality influenced from limited distribution of health facilities and health workers, as well as hospitals' extra services charges not covered by PhilHealth, are also key effectiveness challenges in the implementation of UHC contract (Dayrit et al., 2018; Picazo et al., 2016).

In Thailand, the UHC policy fulfills the previous coverage gap for almost 48 million people who don't have employment-based health coverages (e.g., CSMBS or SHI), contributing to approximately 99% coverage of the total population (Hanvoravongchai, 2013; Patcharanarumol et al., 2018). The use of UHC contract also decreases the risk of household financial burden from catastrophic health expenditures, due to the enhanced coverage and healthcare benefits (Lindelow, Hawkins, & Osornprasop, 2012). However, despite the comprehensive benefits of UHC contract (Hanvoravongchai, 2013), the problems of quality of care in rural areas and long services queue in elite public hospitals are also key challenges in services effectiveness (Lindelow, Hawkins, & Osornprasop, 2012).

Efficiency. All countries fall under the medium level in terms of tool's efficiency. In Indonesia, the use of central drug procurement enhances purchasing power and decreases drugs price (Agustina et al. 2018). Although there is no current research evidence on the use of UHC contract and efficiency (Mahendradhata et al., 2017), the use of cost containment mechanisms such as capitation and IND-CBG can also control the healthcare budgeting and financing more efficient than the fee-for-service mechanism (Agustina et al., 2018), although there is no global budget cap in these mechanisms (Trisnantoro et al., 2016), and particular indicators are yet to be finalized (Trisnantoro et al., 2016).

In the Philippines, however, there is no central drug procurement put in place, although the PHIC has national essential drugs list and drugs price reference index (Picazo et al., 2016). Furthermore, the cost containment mechanism in the system is relatively inadequate, as the current mechanism still relies on the use of fee-for-service, although the implementation of case rates package is increasingly used in some healthcare services with recent global budget cap (Picazo et al., 2016). Despite these limitations, the UHC contract in the Philippines also includes some indicators in monitoring care quality, patient satisfaction, financial risks, and fraud, although the actual implementation and results are still problematic at current stage (Picazo et al., 2016).

In Thailand, the use of cost containment mechanisms (e.g., capitation and DRG with global budget cap), as well as the implementation of national essential drugs list and central drug procurement, increases efficiency of services delivery by decreasing costs per patient and provide incentives for providers to decrease overall costs (Hanvoravongchai, 2013; Patcharanarumol et al., 2018; Tangcharoensathien et al., 2012). In addition, the establishment of health technology assessment and health services indicators also helps the overall efficiency and effectiveness assessment for UHC scheme improvement (Hanvoravongchai et al., 2013). However, the government health spending has been increased substantially from 127,534 million THB in 2002 to 499,393 million THB in 2019 (Thailand National Health Security Office, 2021, p.48), which demonstrates incremental budget increase rather than strict cost containment.

Equity. All countries are considered as medium in terms of tool's equity. The numbers of covered population have been increased in all countries (See also effectiveness subsection). However, all countries have also had challenges in the quality of healthcare facilities, and inequality from the allocation of health facilities and healthcare workers between rural and remoted areas versus urban areas. In Indonesia, the majority of health facilities and health workers are disproportionately concentrated in the western part of the country (e.g., Java island, Sumatra island) (Mahendradhata et al., 2017; Trisnantoro et al., 2016), whereas the majority of health resources are also disproportionately concentrated in the capital areas and Luzon island (Picazo et al., 2016). In Thailand, although the implementation of capitation in UHC contract was also aimed at incentivizing health workers to work in rural and deprived areas by including salaries budget in capitation, the move from the MOPH in "slicing" the salaries budget from the capitation and directly allocate to health providers since 2002 dampens proportional distribution of health workers instead (Hughes & Leethongdee, 2007; Lindelow, Hawkins, & Osornprasop, 2012).

Overall, the tool evaluation demonstrates the importance of the local contexts in influencing the implementation of the UHC contract. The variations on the degree of manageability and effectiveness among these countries are also accounted from different administrative contexts. However, these countries have relative similar degree of legitimacy, equity, and efficiency in the implementation of UHC contract, which are also based on each country's implementation contexts.

DISCUSSION AND CONCLUDING REMARKS

The current study aims to explore how the implementation of NPM instrument, the contracting-out of UHC policy, operates in Indonesia, Thailand, and the Philippines. The overall results suggest that the use of UHC contract in Indonesia, the Philippines, and Thailand contains both policy convergence and divergence, which generally support previous literature on the implementation of NPM mechanisms in different contexts (Cheung, 2005; Pollitt & Bouckaert, 2011). In terms of the tool's convergence, all cases demonstrate the importance of policy mix in the implementation of the UHC contract. This is a novel contribution to the literature of government tools, as the literature generally focuses on the implementation of a single policy tool (Cooper, 2018; Salamon, 2002). The emergence of policy mix in these cases, in part, may resulted from the fact that the implementation of the UHC policy is a novel reform that requires additional policy tools and institutions to operate with the POS contract simultaneously.

Secondly, the findings also suggest that strong monitoring and accountability system is mandatory and significant for the implementation of UHC contracting in three countries. All countries have formal structures for system monitoring, however, only Thailand has relatively strong actual monitoring system in implementing UHC contract. The limitations in identifying indicators for services performance data, data management and utilization, the coordination between purchaser and providers, and the technological infrastructure in information system are key issues for enhancing tool's manageability and improving services effectiveness and efficiency. This supports the previous literature (Cooper, 2018;

DeHoog & Salamon, 2002; Kelman, 2002) that contends for the significance of effective monitoring system in ensuring the accountability and positive services outcomes.

For the divergence of policy tool's implementation, the findings suggest that different contexts in these countries may also contribute to different UHC contracting structure, management, and outcomes. In Indonesia case, the previous different health insurance schemes and decentralization of public services influenced the coordination problem between the local governments, local providers, and the central government in merging different schemes under the same umbrella, although previous schemes also provided key lessons and experiences in health financing and cost containment mechanisms, as well as the establishment of government-owned enterprise as the purchaser organization for the UHC reform. In the Philippines, the policy transfer of previous formal employment-based national medical care scheme since 1969, as well as the emergence of private providers as major healthcare providers, create the market-oriented UHC system instead. In Thailand, the centralized strong state tradition influences the UHC contracting to be centralized controlled by the NHSO, as well as the MOPH in the case of public hospitals and health centers. However, despite the establishment of the relative strong management and monitoring systems, the conflict between the NHSO and the MOPH requires cooperative approach in managing the UHC system.

The result from this study seems to support the literature of UHC contract in European countries (Ashton, Cumming, & McLean, 2004; Perrot, 2006; Siverbo, 2004), as the implementation of UHC contract in the case studies are based on cooperative-oriented contract, which contrasts with the market-based nature of the POS contract as observed by Salamon (2002). This is due to the limited number of services providers and market conditions of the services in the local context (Salamon, 2002), especially in healthcare settings (Honda et al., 2016; Siverbo, 2004). Furthermore, while Salamon (2002) and DeHoog & Salamon (2002) propose that the POS contract may generally has the medium level on tool's automaticity, directness, and coerciveness, there are variations in terms of tool's automaticity and coerciveness. Indonesia, which previous operations of different healthcare schemes, has a high degree of tool's automaticity instead. Thailand case also portraits the high degree of coerciveness as its existing administrative system is a centralized bureaucracy which most healthcare facilities and medical staffs are in the governmental domain. The result demonstrates variations, or another policy divergence, of the implementation of the POS contract in particular, and NPM-oriented instrument in general.

The study of policy convergence and divergence of the implementation of NPM instruments generally focuses on whether there is the universalism of the implementation of NPM instruments, or the local contexts may influence different variations of implementation (Cheung, 2005; Pollitt & Bouckaert, 2011). This research strand is significant for the theory-building in public administration, as the implementation of NPM-oriented tools in different contexts may demonstrate different contributing factors, implementation paths, and even coexists with other administrative modes such as hierarchical bureaucracy and the governance network of governmental and non-governmental actors. This, in turn, also helps practitioners to pay attention more on how to create a "tailor-made" NPM policy implementation

in each country than "one-size-fits-all" approach. In particular, the assessments of current basic healthcare infrastructures (Hanvoravongchai, 2013; Mahendradhata et al., 2017; Picazo et al., 2016), resources allocation in different areas, especially rural and remote areas (Lindelow, Hawkins, & Osornprasop, 2012; Picazo et al., 2016; Trisnantoro et al., 2016), and relationships between healthcare providers, purchasers, and local citizens (Ashton, Cumming, & McLean, 2004; Honda et al., 2016; Perrot, 2006; Siverbo, 2004) in enhancing positive outputs and outcomes in services delivery, accountability structure, and monitoring system are key areas in the implementation of the UHC contract.

However, this study also has some limitations. First, this study compares only few countries in Southeast Asia and focuses more on administrative components rather than domestic leadership, political changes, and cultural factors, which may reduce the transferability of findings to other settings. Future studies that compare more countries in different regions are needed to explore possible variations and explanations of policy convergence/divergence of the implementation of NPM-oriented tools in UHC policy. Second, this study develops its own qualitative criteria of the measurement scales derived from the literatures, which may be subjected to researcher's epistemology and interpretation instead of having the standardized criteria and scales. Future research using government tools framework in the UHC policy and different policy domains are also needed to test and/or develop the criteria and scales of policy tool's evaluative measurement. Overall, this study provides the comparative case studies of the implementation of the NPM-oriented instrument in the UHC policy, which demonstrates policy divergence of the implementation based on different local administrative contexts, as well as policy convergence among the selected countries on the use of policy mix. The overall result also provides supports and variations of the implementation of the POS contract against the previous observations.

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