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Contracts between Referral Health Facilities and Social Health Insurance in Indonesia and England

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Abstract

Purchasers and providers are important in providing quality health services for participants. This is formally regulated through a contractual mechanism to achieve the potential benefits of strategic health purchasing (SHP) and ensure effectiveness, efficiency, and quality. The experience of contracting with providers differs in each country due to underlying determinants. This study aims to identify differences in contracts between referral health facilities and social health insurance in Indonesia and England. A normative legal research approach is used, utilizing secondary data sources such as literature, regulations, and contractual arrangements. Important clauses in the contract, such as rights and obligations, service tariff setting, agreement period, monitoring and evaluation, settlement of expired or disputed claims, mechanisms for providing information, and handling complaints, have been regulated in contracts in both Indonesia and England. Unlike the case in England, incentive payment policies have not been further regulated in Indonesia's contracts. Additionally, notification and communication procedures for the parties involved have been integrated into the system in England. It is expected that learning from the NHS contracts will provide the potential for developing a more ideal contract implementation, effective monitoring and evaluation, and the delivery of optimal and high-quality health services.

Introduction

Healthcare purchaser organizations must seek the best interventions to purchase the best providers and use the best contractual arrangements to achieve standard and equitable health outcomes. Healthcare purchasers are key stakeholders in the healthcare chain as they can improve provider collaboration by making quality and cost agreements. Therefore, the role of purchasers and health service providers here is very important in efforts to provide quality health services for their participants. The relationship between the role of the purchaser and the healthcare provider is generally regulated in an integrated contract or system. Purchasers can be more passive or more strategic in managing healthcare funding. With passive purchases, information, and evidence are not used to determine a benefit package or to choose a service provider who will provide the service. More passive purchasers also do not use contractual mechanisms to define and enforce quality standards. These purchasers typically pay service providers using a budget based on historical inputs (Sanderson *et al.*, 2019; Noort *et al.*, 2020; Ezenduka *et al.*, 2022) reimbursement, without being explicitly linked to the provision of priority services in healthcare. In other extreme cases, purchasers use open payment of service fees and do not

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have an expense management mechanism (Cashin & Gatome - Munyua, 2022).

The contract mechanism aims to achieve the maximum potential benefits of strategic health purchasing and can guarantee important aspects, namely effectiveness, efficiency, quality, and equality. The contract is an instrument to determine the health service needs of participants and the performance of health care providers, including being able to strategically know which health services should be prioritized for public funding (Klasa *et al*., 2018) what to buy, who will provide services (from whom to buy), and how and how much health care providers will be paid (how to buy). A healthcare contract is defined as a purchasing mechanism used to obtain quality services from healthcare providers within a certain period at an agreed price. The contract involves a prospective and explicit agreement between the purchaser and the service provider regarding the terms and conditions of payment. A contract will specify the type and volume of services provided over a certain period, with specific objectives and indicators to measure contract fulfillment. Under the contract system, the purchaser enters into a contract with a healthcare provider to provide healthcare services to its applicants. Revealed that strategic purchasing requires some form of contract between the purchaser and the health care provider, as well as the separation of the functions of the purchaser and the service provider to facilitate the contractual relationship. In the contract mechanism, the selection process for health facilities, including advanced referral health facilities (FKRTL), is important. The purchaser as the main actor who uses the contract needs to ensure that the health service provider provides quality health services following the specified service criteria (Cashin & Gatome - Munyua, 2022; Mathauer *et al*., 2019; Mbau *et al*., 2018; Etiaba *et al*., 2018; Vilcu *et al*., 2020; Kachapila *et al*., 2023).

In Indonesia, health facilities that collaborate with BPJS Kesehatan are required the fulfill the provisions contained in the contract. The condition in question is that the health facility is recognized and has a permit from the Government agency responsible for the health sector. This is an effort to increase access to services while ensuring the quality of services for participants in the national health insurance program. Similar to in the UK, private hospitals that want to work with the NHS also need to be registered with the Care Quality Commission and the NHS Improvement Institution first. Through the selection of health facilities, service purchasers can assess starting from the availability of human resources (competent medical personnel), the completeness of facilities and infrastructure, the scope of services, and service commitment. The implementation of contracts can be an effective tool to provide excellent service to the community and can contribute to improving the performance of the health system. From a public health point of view, the success of a "contract" depends on many factors, such as the region, the conditions of implementation, the institutional capacity, the modalities of monitoring and evaluation, and the arrangement of the contract. Revealed that the implementation of contracts varies between countries because the determinants that exist in each country are also different. Therefore, this study aims to identify the difference in contracts between Advanced Health Facilities and social health insurance in Indonesia and the United Kingdom (Klasa *et al*., 2018).

METHOD

This type of research is qualitative normative law research that uses secondary data in library materials as the main source of data. Normative legal research can be said to be literature review research in which most of the data sources are secondary data sources. This study was conducted to analyze the content of BPJS Kesehatan cooperation contracts with Advanced Health Facilities (FKRTL) in Indonesia and the content of the NHS UK standard contract used to contract all clinical services with a statutory approach and a conceptual approach. The data collection technique carried out is to combine data from the content of the cooperation contract with Advanced Health Facilities (FKRTL) between BPJS Kesehatan and NHS England and connect it with applicable regulations, as well as other literature studies. Data analysis was carried out qualitatively using descriptive and comparative

analysis instruments to explain the differences in cooperation contracts between BPJS Kesehatan and NHS England. The results of the analysis are displayed in the form of a comparison table and also a descriptive explanation based on the theory related to the contract between the purchaser and the health service provider applicable in Indonesia and the UK based on the clauses stipulated in the contract.

RESULTS AND DISCUSSION

Based on, institutions that can make purchases can be in many forms, such as the Ministry of Health, local government agencies (for example at the provincial or district level), compulsory or voluntary health insurance institutions (or some insurance institutions), community-based health insurance institutions, non-governmental organizations, etc. BPJS Kesehatan is an institution in Indonesia that is responsible for conducting cooperation contracts with hospitals. The number of hospitals that collaborate with BPJS Kesehatan is increasing every year. SISMONEV DJSN data in 2019 shows that 2,213 hospitals have collaborated with BPJS Kesehatan. This number continues to increase until 2023, with the number of hospitals cooperating in 2020 as many as 2,259, in 2021 as many as 2,497, and in 2022 as many as 2,573 hospitals. Data as of May 2023 reports that the number of hospitals, both government and private, in collaboration with BPJS Kesehatan has reached 2,953. Meanwhile, in the UK, cooperation contracts with health service providers are under the full authority of a government agency, called (Mathauer *et al*., 2019; Ariani & Pujiyanto, 2019) the National Health Service (NHS). The NHS Trust is a healthcare provider formed to provide hospitals, community, and other aspects of patient care. There were around 219 NHS Trusts in the UK in 2021. However, this number does not represent the number of Hospitals as some NHS Trusts run more than one Hospital, for example, Manchester University NHS Foundation Trust (MFT) runs a total of nine Hospitals. In 2021, there were around 1,257 hospitals in the UK, this number includes NHS Trust-managed hospitals and additional private hospitals.

Purchasers need to further define and determine from the provider level which types of providers, interventions, and medicines will be available and how these can be accessed from the public sector and/or the private sector. In some cases, the decision may be taken by a higher level of government, but the purchaser needs to concretize and align this with the access conditions mentioned above. When the purchasing function and governance arrangements are in place, the purchaser can directly influence (positively or negatively) the allocation of resources (for priority services and population groups, geographical regions, types of service providers, and so on), accountability, and even incentives that will influence encouraging the behavior of individual providers through contracts. Contract creation is very useful for strengthening accountability between the purchaser and the service provider when the contract mentions the benefits to be provided, the level of payment, the terms of service delivery, referral guidelines, as well as the compensation mechanism. Contractual agreements are the basis for setting standards, performance targets for service providers, and monitoring service delivery competencies, and encouraging service providers to comply with agreements, such as ensuring the availability of skilled staff in sufficient numbers to meet public health service needs. It is important to monitor and enforce contractual agreements with healthcare providers to ensure the desired objectives of those agreements are achieved. Thus, the health service contract seeks to determine the characteristics of the provision of services and the level of reimbursement, as well as to determine performance. In essence, contracts are the primary policy instrument for strategic purchasing and effective payment systems by providing a greater focus on achieving measurable outcomes. Forms of contracts can vary, from highly structured and competitive to more implicit and relational, and the most appropriate approach is likely to be context-specific (Klasa *et al*., 2018; Mikkers & Ryan, 2016; Cashin & Gatome-Munyua, 2022).

Selective contracts and accreditation are key instruments in strategic purchasing to choose which provider to buy. Accreditation is a review process that allows healthcare providers to demonstrate their ability to meet established quality-related standards (e.g., related to

TABLE 1. Comparative Matrix of Cooperation Contracts in Indonesia and the UK

It	Clauses in the Contract	NHS England	Indonesia	Note
1.	Scope of the agreement	✓	✓	
2.	Rights and obligations	✓	✓	NHS adjusts to the conditions of the parties, while Indonesia is standard
3.	Healthcare rates	✓	✓	NHS national rates are based on service specifications that can be developed, while in Indonesia they are based on predetermined service tariff standards.
4.	Incentive payments	✓	✗	
5.	Agreement term	✓	✓	NHS contracts are reviewed every 2 years, while in Indonesia every 1 year
6.	Monitoring and evaluation	✓	✓	
7.	Claim expiration	✓	✓	
8.	Dispute resolution of claims	✓	✓	

structure, processes, and/or outcomes), and thus the accreditation results provide relevant information to purchasers about the provider's performance. Selective contracts mean that the purchaser can choose between (competitive) providers, i.e. the purchaser has the right not to enter into contracts with all available providers. This selection can be based on predetermined criteria or the results of the provider's accreditation to further improve quality and good performance. However, the use of selective contracts is a limited practice for a variety of reasons. On the one hand, especially in rural and remote areas, there may only be one healthcare provider for the community in a given region. On the other hand, including certain service providers, but not contracting with other providers may be a political challenge. However, all of these conditions may be rarely met in low- and middle-income countries. Selective contracts are often impractical or contrary to the purpose of guaranteeing access to health services. Nonetheless, contracts are an important tool for communication, even if they are not meant to spark competition. In some countries, selective contracts are used for private healthcare providers based on the provider's location, the range of services available as set out in the scheme guidelines, and the provider's willingness to contract (Mathauer *et al.*, 2019; Kuwawenaruwa *et al.*, 2022).

If you look at the NHS system, there is something called the NHS Standard Contract. This contract assigns healthcare providers to provide specific healthcare services that can be adapted for use in a variety of services. NHS England is responsible for the preparation and publication of NHS standard contracts. The NHS agency in the UK also oversees and allocates funds to (Petsoulas *et al.*, 2014) Clinical Commissioning Groups (CCGs) to work with public and private hospitals, as well as organize and pay for the delivery of care at the local level. This CCG group is responsible for planning most primary care services, community services, and hospitals including emergency care. Since April 1, 2021, the number of CCGs has decreased from around 209 CCGs to 106 CCGs due to mergers. After the passage of the Health Bill, CCG was abolished in July 2022 and replaced with an (Parkinson *et al.*, 2021) integrated care system (ICS). Private hospitals can offer a range of services that are not covered by the NHS or offer services that can reduce waiting times (Thorbly, 2020; Cooper *et al.*, 2018).

In the cooperation agreement between BPJS Kesehatan and Hospitals regarding advanced referral health services for participants of the National Health Insurance program, some components have been determined which include the scope of the agreement, rights, and

obligations, confidentiality of information, class of treatment, health service rates, procedures for submitting and paying for health services, agreement period, post-claim verification and claim administration audit, monitoring and evaluation, expiration of claims, sanctions, termination of agreements, complaints, dispute resolution, notification, and settlement of disputed claims. The scope of the contract agreement in the UK and Indonesia has listed the types of services that participants can access. In Indonesia, if the Hospital wants to add a new scope of services that are not available at the beginning of the agreement, then the Hospital needs to notify BPJS Kesehatan in writing no later than 3 (three) months. BPJS Kesehatan will then conduct a credentialing on the type of service in question, to then be outlined in the Addendum to the Agreement. The purpose of implementing credentialing is to obtain health facilities that are committed and able to provide health services effectively and efficiently through assessment methods and standards. The standard must be measurable with the objectives that have been identified by the service provider. Thus, there will be no difference in service delivery that will affect patient service satisfaction. However, the process of applying for credentials in various institutions in Indonesia is still varied and has not been standardized (Ulandari & Indrayathi, 2016).

The rights and obligations of BPJS Kesehatan as the purchaser and the Hospital as the health service provider have been listed in the cooperation agreement. In 2022, updates have been made to clarify the rights and obligations clause of each party. The form of contract is standardized and applied the same for all of Indonesia. If you look at the existing contracts in the British NHS, the rights and obligations listed in the contract are not made by default but are adjusted to the conditions of the parties. The term commonly used in stating rights and obligations is set by the NHS as a national guide. If the NHS contract states that the party must do something (e.g. must comply, deliver, or perform), this means that the party has an absolute obligation to do so regardless of the costs or risks incurred. However, rights and obligations can also be mentioned by not requiring both parties to do something. This statement has a lower level of liability than the previous statement, which means that the relevant parties still need to make efforts to achieve the objectives required in the contract. The details of the rights and obligations of the parties are the actual formulation of a cooperation contract. The benchmark for the implementation of an agreement can be seen from the extent to which the parties carry out their rights and obligations well. Revealing that identifying responsibilities in the form of clear rights and obligations between parties is one of the absolute conditions necessary for the determination and enforcement of contracts. Therefore, the preparation of the provisions of the rights and obligations of the parties in the contract requires meticulousness from the normative theoretical aspect and the empirical side. With a good agreement, it is hoped that it can prevent disputes that can occur to the party who commits.(Wolff, 2020; Mikkers and Ryan, 2016; Wolff, 2020).

The standard of health service tariffs in Indonesia has been regulated in the Regulation of the Minister of Health. The service tariff standards currently used in FKRTL are adjusted to the type of hospital, type of hospital ownership, regionalization, inpatient class, and type of service/disease diagnosis. Before the tariff was set in regulation, there was an agreement on the determination of tariff regionalization between the Ministry of Health and BPJS Kesehatan and the Indonesian Hospital Association Organization as representatives of each regional hospital. This aims to reduce the inequities in health service payments based on the regionalization of health facility locations. However, this cannot fully accommodate health service providers and purchasers to negotiate prices and service coverage directly due to the establishment of regulations based on initial agreements that have become binding standard rules. As a result of rigid regulations, saying that healthcare providers are supposed to receive case-based payments, but the rules do not allow them to change the combination of inputs, the expected efficiency gains will not materialize, and the quality of services will decline. In the UK, NHS standard contracts require that CCGs must pay

healthcare providers following the principles and rules set out in the National Tariff Payment System guidelines. Pricing in the National Rates on the NHS UK is based on the actual cost history of the healthcare provider proposing to provide a particular service activity to a patient. For national rates to achieve the expected financial impact, patient activity in the NHS scheme continues to be recorded in detail as the basis for calculating and developing service rates in the future. The national rate for secondary health services is calculated centrally based on the cost information submitted by the service provider. There is legal consultation on the methodology used to determine prices and any changes to payment rules, and fare coverage. If the objection threshold is violated, the methodology will be reviewed. Informal consultations are conducted first on the main proposals, and adjustments are made as needed before the legislative consultation. A clinical group of experts reviews the pricing plan, and manual adjustments can be made. The determination of health service costs is a key component in the purchase of benefit packages (covered services) in the overall financing system. According to, the contract must include the large tariff and terms of the payment method. The amount of the rate set should reflect the actual cost and consider the health system objectives and Mathauer *et al.* (2019)(Barber *et al.*, 2019). Barber *et al.* (2019) broader health outcomes. The number of unfair tariffs will have an impact on the quality of services provided, service efficiency, and the sustainability of the contracts carried out. However, in theory, if an insurance institution covers a large portion of the population, the beneficiaries (the public) can be directed to use the "in-network" service provider contracted by the institution. In such a system, healthcare providers may agree to receive relatively lower rates from insurance institutions to ensure patient volume and income security. However, private service providers or the largest or only service providers in a given region have a strong influence to request higher rates from insurance institutions and can control price changes over time. Clinical standards of care and an impartial line of treatment are the basis of purchasing and pricing. Managerial capacity at the central and healthcare facility levels is required to analyze and implement changes and manage contracts. Prices are also not directly shaped by the interaction of demand and supply, but rather are regulated, negotiated collectively, or negotiated individually.(Schut & Varkevisser, 2017; Berenson *et al.*, 2012; Baker *et al.*, 2014; Barber *et al.*, 2019).

The contract between BPJS Kesehatan and the Hospital does not discuss the payment of incentives or non-financial incentives. The non-financial incentive approach through rewards is one approach in which the system can reward healthcare providers to improve productivity and service quality. Health sector reforms often require policymakers to rethink the incentives they want to set for providers. Indeed, there has been a growing consensus that healthcare purchases must be more active or strategic if a country is to make progress towards (Allen *et al.*, 2014; WHO, 2017) Universal Health Coverage (UHC). However, healthcare purchases are often passive without considering their performance, and benefit packages are not well defined. Therefore, there are few to no financial incentives for service providers to do better. Meanwhile, in the NHS contract, a policy related to national financial incentives has been described, and the Mathauer *et al.* (2019). Commissioning for Quality and Innovation (CQUIN), applicable to contractual relationships that fall within the scope of the Harmonized Payments and Incentives rules in the National Tariff Payment System. However, the rules related to separate arrangements for the Local Incentive Scheme on contracts have been removed since 2022 as they are no longer required. Currently, the NHS has developed some DRG rates that are set by including incentives given to the best services, such as the use of day-case surgery (same-day surgery) where appropriate. Thus, as much as 2.5% of the contract value is associated with the achievement of several quality objectives through the CQUIN initiative. When healthcare providers are rewarded based on the results of the performance achieved, those payments must also be appropriately priced and given the right incentives. Provider contracts can be a way to influence provider behavior and incentivize the provision of quality health care. The allocation

of incentives can ultimately affect the progress of health care delivery aimed at achieving UHC (fairness in resource distribution, efficiency, transparency, and accountability) and long-term UHC goals (utilization of services according to needs, financial protection financial equity, and quality). Purchases are also considered strategic if one of them uses incentives to limit the provision of services that are expensive to provide (Tikkanen *et al*., 2020;Gatome-Munyua *et al*., 2022; Cashin & Gatome-Munyua, 2022; Sieleunou *et al*., 2021).

NHS system in 2020, all Government Hospitals contracted with local CCGs to provide services and were paid according to the nationally determined diagnosis-related group (DRG) rates, which covered medical staff costs. Hospitals are also paid for this type of outpatient consultation at a predetermined rate. However, the scope of services guaranteed by the NHS is not specified in the law, and there is no absolute right for patients to receive specific care. NHS contracts only provide standard service category or specification information, not a detailed list of all possible types of services. So that the content of the contract can be adjusted to reflect the nature of the services that will be provided by the health care provider. The CCG/commissioner makes decisions on the determination of the scope of services and the development of service specifications for the hospitals that will collaborate. The specifications of the developed services will vary according to local circumstances. However, the commissioner can adjust to the procurement suggestion and involve prospective service providers in developing a specification. Clinical and service user engagement is excellent for specification development. With the existence of an independent CCG under the NHS, there will be more negotiation between the purchaser and the service provider to determine what services will be covered and how much will be paid according to the hospital's ability to provide services to participants. In 2022, the NHS has simplified the content of service-related contracts. In many cases, the specifications in the contract are less restrictive and encourage (Thorbly, 2020; Tikkanen *et al*., 2020; Thorbly, 2020) input-driven in the future. This allows healthcare providers more leeway to adapt, improve services over time, and provide the best service to meet the commissioner's long-term goals. Based on this, the service buying landscape is growing as many healthcare provider sectors continue to grow and diversify, including for-profit and non-profit service providers. One of the first steps towards UHC is to determine what services can and will be offered to participants. This shows that determining the health care package has a great impact on health outcomes and financial protection. Therefore, important benefit packages are designed comprehensively and adequately according to the needs of participants to improve access and coverage of services and reduce (Mathauer *et al*., 2019; Aman *et al*., 2019; Pillay *et al*., 2020) out-of-pocket (Mugo, 2023).

The term of the BPJS Kesehatan cooperation agreement with the Hospital is effectively valid for 1 (one) year with a contract review carried out at least every 2 years according to needs. If the extension of the cooperation agreement is to be carried out, the parties to the contract need to notify a maximum of 6 months before the end of the agreement. Meanwhile, in the NHS contract in the UK, the term of the cooperation agreement is valid for 2 years, but there is a policy of reviewing the contract every year. Regular reviews are important to ensure legal compliance and adjustment to changing conditions. The content of the contract must comply with applicable regulations and laws so that through a review the provider can monitor its behavior towards the contract being executed. If there is a change in the recommended treatment or other needs, the results of the review can be used as a guideline for the parties to adjust the content of the contract to the needs of the community and the performance of the provider and develop a payment method. So, contract review is also able to improve the quality of service received by participants. According to the contract, the contract Odendaal *et al*. (2018) The review procedure is the process of analyzing the terms in a contract to ensure that the terms are fair and do not have potential risks. The contract review process is a stage to approve changes in areas that require significant improvements to improve the quality of services provided. The

Mühlbacher *et al.* (2018), the review process is carried out based on the data available to the service provider, so detailed and up-to-date information is very important for purchasers to be able to allocate funds according to service needs. The information needed includes clinical and financial data as well as data on the quality and output of service delivery, all of which require a harmonized or interrelated data system. However, such detailed information is not available or accessible in many low- and middle-income countries, making it difficult to use evidence as the basis for strategic purchasing decisions (e.g. in contract design). As in Indonesia, there are still several obstacles in the implementation of cooperation between purchasers and service providers, namely, there are still service providers whose values are below standard but are still contracted to serve JKN participants because the number is still relatively small. This means an agreement cannot be unilaterally terminated so that people can still access health services. Although the results of the Mathauer *et al.* (2019). Review shows that some performance indicators cannot be met, and regular monitoring is still needed to improve medical quality (Ulandari and Indrayathi, 2016).

Regarding monitoring and evaluation, both in Indonesia and in the UK have included this in contracts with health service providers. This is an important point and follows the statement, which reveals that the monitoring and evaluation provisions in the contract are a benchmark in evaluating the common goal concerning the expected results. In Indonesia, the monitoring and evaluation component consists of Onyango & Juma's (2020). Utilization Review (UR), customer feedback, assessment of compliance with the quality commitment of the implementation of the agreement, and evaluation of the referral potential. In addition, monitoring and evaluation are also carried out through a review of the implementation of the Information Provision and Complaint Handling (PIPP) function in the Hospital which includes the level of attendance or coordination of officers and the resolution of complaints following the Service Level Agreement (SLA) and the quality of SIPP recording, feedback on the level of participant satisfaction with the service through customer feedback, as well as identification and analysis of causes/obstacles to the implementation of the PIPP function of the Hospital in the Hospital. Meanwhile, the NHS contract with healthcare providers in the UK also states that service providers must continue to review and evaluate services, act on information obtained from reviews, and evaluate feedback, complaints, audits, clinical outcome review programs, and patient safety incidents by involving service users, staff, GPs, and the public (through survey results). The success of a contract often depends on whether it creates a sense of accountability as well as formal requirements to monitor compliance and provide information to improve services when needed. Reported that the lack of monitoring and evaluation mechanisms resulted in hospitals setting service prices that exceeded the prices stated in the contract. The absence of monitoring and evaluation mechanisms forces hospitals to raise costs to reflect rising costs and changing economic contexts. Studies in other regions also revealed similar results, some purchaser organizations suffer from poor monitoring and evaluation. These findings show that the purchaser organization as a party to the contract needs to monitor and evaluate the delivery of health services to stay aware of the development of the situation faced by health service providers. (Maluka *et al.*, 2018; Benova *et al.*, 2015).

In the United Kingdom, there is an institution called the Care Quality Commission that regulates the quality of all health and social services for adults. The development of the NHS to regulate the use of resources, financial development, and operational performance is also carried out by the Care Quality Commission. This institution has the authority to monitor performance using quality standards set nationally. This institution assesses the results of hospital evaluation monitoring and can close services when the hospital does not meet the standard requirements. This monitoring process includes an annual survey conducted nationwide to assess the patient's experience in the Hospital. On the other hand, the (Barber *et al.*, 2019). The National Institute for Health and Care Excellence is also developing quality standards, guidelines, and

guidelines for various clinical conditions, safe staffing levels, technology, medication handling, antimicrobial prescribing, and diagnostics that include primary, secondary, and social care services for providers. Monitoring and evaluation activities to improve service quality can be carried out through various activities. Concerning clinical staff, healthcare providers need to evaluate periodically by monitoring the actual number of clinical staff on duty against the planned number in each. Tikkanen *et al.* (2020) shift and conducting and compiling a review of the ratio and workload and its impact on service quality at least once every 1 year. Monitoring and evaluation are also carried out by considering the feedback given, complaints submitted, surveys, and patient safety incidents. All of these activities are used as a basis for decision-making and improvement for health service providers and other stakeholders to improve the quality of services provided. The contract also states that it is important for CCG to use contractual tools to set high-quality standards for healthcare providers and conduct periodic quality monitoring. In addition, there is also a local agency, namely the Local Quality Surveillance Group, which provides a communication forum for local CCGs and other related partners to share information and discuss the best quality of service to be provided. Information on the quality of services at the organizational level, departments, and the condition of some service procedures from the perspective of doctors has been published on the NHS website. The results of the health service quality inspection that have been carried out by the Care Quality Commission are also accessible to the public. Revealed that monitoring and evaluation interventions in health services have been shown to encourage optimal use of resources, and best practices, and help ensure that services are implemented efficiently and effectively and achieve the intended target groups.(Tikkanen *et al.*, 2020; WHO (2017).

In contracts that apply in Indonesia, there is a clause related to the expiration of claims, namely claims that have exceeded the limit of the submission provisions, which is more than six months since the health service has been provided. Regular claim submission by the Hospital to BPJS Kesehatan in practice is carried out collectively every month accompanied by claim submission documents such as service recapitulation, supporting files for each patient, and other proof of service. BPJS Kesehatan as the purchaser will then make payment based on the claim submitted no later than 15 days after all conditions are met. However, there is a condition where the Hospital cannot submit a follow-up claim in the same month as the regular claim submission. In this regard, the parties to the contract, namely BPJS Kesehatan and the Hospital, need to agree to submit a claim to be stated in the Minutes of Agreement with the provision that it does not exceed the expiration limit of the claim. If the submission of a claim exceeds the specified time limit, the claim cannot be resubmitted. A clause on the expiry of claims has also been set out in the draft NHS contract in the UK. NHS contracts require healthcare providers to ensure that indemnity arrangements remain in place until the statutory limitation period on claims expires. Similar to Indonesia, the submission of claims in the UK is also carried out periodically by attaching submission documents. In addition, the NHS also has a system for scheduling monthly file submission deadlines called the " Secondary Uses Service (SUS) Submission Schedule". The date of reconciliation or file submission is set flexibly. Healthcare providers should make every effort to make the data as accurate as possible at this early flexible stage. On the post-reconciliation date, which is the point at which the data submitted by the service provider each month is "frozen", if any data inaccuracies are found, they can be corrected at that time for that month. New service provider payments can be made after the data is corrected. Claim data submitted by healthcare providers to purchasing organizations generally includes information about medical diagnoses, treatment procedures performed, prescribing information, and details of several financial metrics such as costs, expenses, and reimbursement amounts. According to the report, the submission of claims within a certain time frame and all-important information from the service provider as well as the payment period are provisions that need to be mutually agreed upon by the service provider and the

purchaser's organization to be able to implement an effective accountability mechanism. As in other countries, the provider is responsible for filling out and submitting the claim form within the period specified in the contract, which is 30 days after the health service is completed for the patient. The verification process is then carried out to determine the reimbursement of fees provided to the service provider. However, payment suspension is still often experienced by service providers. Payment suspension is inevitable in the process of submitting a claim. Some of the factors that were found to be closely related to the suspension of payments were the completeness of the required documents and the ability or accuracy of the claims administration staff at health facilities (Konrad *et al*., 2020; Hanson *et al*., 2019; Marshall *et al*., 2023; Rahmatiqa *et al*., 2020). The same findings were reported, the submission of inaccurate reports and the lack of ability of qualified officers to prepare claims led to delays in reimbursement of claims costs. This can affect the operational needs to facilitate the provision of services. To reduce the potential for deferral of claims payments, healthcare providers need to: 1) establish a good claims management system with the use of facilities, infrastructure, and technology support, 2) improve the capabilities of parties involved in the claims submission process, and 3) establish good communication with purchaser organizations (Akweongo *et al*., 2021; Tarigan *et al*., 2022).

In addition, the procedure for resolving claim disputes has also been regulated in contracts in Indonesia and the United Kingdom. In Indonesia, the settlement of claim disputes is carried out in stages starting from the district, provincial, and central levels. In addition to being carried out by related parties, this discussion can also involve external parties such as the Quality Control and Cost Control Team (TKMKB), INA CBGs coding organizations or experts, and related stakeholders such as the Ministry of Health and the Clinical Advisory Council (DPK). If deliberation and consensus are not reached, the settlement is carried out through the court. Meanwhile, in the UK, the NHS standard contract has stated that the settlement of claim disputes only applies when the cooperation contract has been signed. This procedure requires the disputing parties to try to resolve differences through negotiation. If the issue has not been resolved, then move up to resolution through senior managers and then board-level representatives as needed. If the dispute remains unresolved, the parties should refer it to mediation, where the appointed mediator will attempt to facilitate a dispute settlement agreement that benefits both parties. However, if mediation still fails to resolve the issue, the dispute should be referred to an independent expert for a decision. The expert verdict on the dispute will be binding on the parties. Dispute claims are problems that can affect budget allocation policies and planning of service providers, increasing the cost burden that will affect the health services provided. Therefore, the procedure for resolving claim disputes needs to be clearly defined in the cooperation contract between the purchaser's organization and the health care provider. Before proceeding to the litigation process, it is important to resolve the dispute through open communication between the parties and turn the dispute into a conflict (Alhassan *et al*., 2016; Amirthalingam, 2017; Hyman *et al*., 2010).

Indonesia does not enforce copayment, and this has been explained in the contract. Hospitals that charge additional fees to participants outside the provisions and/or violate the provisions as stipulated in this agreement, will be given sanctions in the form of written warnings. This is like the situation in the UK in 2020, where the NHS does not impose cost-sharing on patients for services included in NHS coverage in Government Hospitals. However, for certain services such as vision tests, dental services, and transportation costs, there are certain categories of patients who are exempt from the policy. The cost-sharing of vision tests does not apply to children/adolescents, older adults, or low-income adults. Meanwhile, for dental care, cost sharing is exempt for children/adolescents, students, pregnant women, new mothers, inmates, and low-income communities. In addition to those included in the categories mentioned, dental services are subject to a copayment fee of up to USD 365.00 per treatment. Cost sharing for transportation to and from health facilities is also waived for people who qualify for low-income incomes. Including outpatient drug services, only certain patients are exempt from cost-sharing such as children, adolescents aged 16 to 18 years in full-time education, adults over 60 years old, low-income individuals and families, and women who are or have recently become pregnant. Outside of this criterion, you need to pay USD 12.50 per prescription for outpatient drugs. Patients who need prescription drugs in large quantities can purchase a prepaid certificate for USD 41.40 for three months or USD 148 for 12 months. Medications prescribed in NHS hospitals during hospitalization have no (Thorbly, 2020) copayment

(Tikkanen *et al*., 2020). Cost sharing refers to direct payments made by patients to healthcare providers. In the healthcare system, cost sharing is usually used to reduce the demand for health services to control costs. However, cost-sharing reportedly reduces not only unnecessary care but also what patients should need. This policy can also affect the access of low-income groups to health services because they must bear more care costs. Another review found that cost-sharing was associated with lower rates of utilization and adherence to ongoing treatment in different areas of therapy. Therefore, as in the UK, holistic views such as the level of economic ability of the community, the type of services that will be subject to (Stadhouders *et al*., 2019) cost-sharing and the number of fees paid need to be considered before implementing a cost-sharing policy in a cooperation contract (Fusco *et al*., 2023).

In Indonesia, the mechanism for providing information and handling complaints is regulated in a contract in the form of rooms and posters for providing information and handling complaints that are strategically located and easily accessible. In the NHS UK contract, this mechanism for providing information and handling complaints is also explained in the contract. Concerning the provision of information, NHS standard contracts have required that good quality information be provided to enable healthcare providers and commissioners to monitor performance under agreed contracts. Several guiding principles have been determined to support the provision of quality information, including that the provision of information must be used for high-quality care and must be able to answer questions. Parties also need to be aware that some requests for information may require a certain period to respond. In addition, the contract also explains that each service provider must issue, maintain, and carry out complaint procedures following the Fundamental and Legal Standards of Care and other guidelines.

Meanwhile, regarding official communication between the parties to the contract, in Indonesia, it must still be done through correspondence, notices, statements, or written approvals that are delivered directly either by email, expedition, post, or facsimile to the BPJS Kesehatan Branch office. However, in the NHS system, all communication and procedures between parties have been described in an integrated system. So, prospective health service providers who will extend the contract can easily find out the flow/steps to submit a cooperation contract. This can also be used as an example for the implementation of contracts between BPJS Kesehatan and health service providers in Indonesia. Especially now BPJS Kesehatan is in the preparation stage towards comprehensive coverage. One of the main things that must be improved is the information system which still has many challenges in daily management, participant administration, databases, data distribution, and others. Currently, the use of health information systems has become a staple in every health service organization. An adequate and functional information system is the foundation of a strong health system. Information systems help improve service delivery and quality of care because they consist of management systems that affect service delivery. This improves patient safety and contributes to service delivery as it can provide quick access to patient data and distribute it to various databases (Nurhayati and Hidayat, 2018; Haule *et al*., 2022; People *et al*., 2019).

Strategic procurement reform through the strategic contract system does not have to be a major change but can be carried out gradually and in several service packages. Reforms aimed at making purchases more strategic are not always easy, but the most important thing is that they can be carried out step by step to build an information management system, establish benefits to align with payment methods and vice versa, modify payment methods and rates to suit the needs to improve service provision, and implement an accreditation system, etc. These steps can certainly also encourage changes in the health sector system that is currently running in Indonesia.

CONCLUSION

Contracts are recognized as an increasingly important tool for implementing strategic health service purchasing policies in meeting public health needs. Enforcing compliance with contractual agreements between suppliers and purchasers is essential to providing quality services to the community in an efficient manner. For this reason, contract-making requires the purchaser of the service to have the capacity to design, deliver, and manage the contract to know what services the community needs, from whom the service is provided, and how the service is paid. Lessons learned from contracts with healthcare providers implemented in the NHS can provide the potential for contract development between BPJS Kesehatan and existing health service providers in Indonesia, as well as the

development of monitoring ineffective contract implementation. Contracts are a means and not an end in themselves, so they must be used or implemented, especially to provide quality health services for the community. More research is needed to identify determinants in developing contracts with healthcare providers and implementing contracts in specific regions of Indonesia.

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