

Annex 3

SOCIAL HEALTH INSURANCE IN INDONESIA: CURRENT STATUS AND THE PLAN FOR NATIONAL HEALTH INSURANCE¹

Executive Summary

The health status of people in Indonesia has improved very slowly over the last two decades. Many factors are responsible for the low improvement of health status in Indonesia, such as low education, low income, difficult geographical access, cultural problems and health care financing. Lessons learned from the World Health Report 2000, despite criticisms over the rank, clearly suggest that health care financing is the most important element in the achievement of health improvement. The level of health care financing affects the availability of human resources, medical supplies, distribution of health care facilities, quality of health services, and other important processes. The main hypothesis of this study is that health care financing is the key component to sustainable and significant health improvement.

The main research question for this study is how health care financing has progressed in Indonesia in the last two decades. The objectives of this study are: (1) to identify health care financing from various sources in the last two decades; (2) to identify gaps in health care financing in relation to health care needs; (3) to assess philosophy and regulations that may affect health care financing, and (4) to identify various feasible options to improve equity in health care financing.

In order to attain the objectives, the team reviewed various documents related with health care financing, both in Indonesia and other countries. National and international journals were reviewed to study the progress of health improvement and health care financing in Indonesia. In addition, the team also compared basic assumptions and philosophies that may distinguish health care in Indonesia with health care in other countries. The team also collected health expenditure data from the government budget. In addition, the team also discussed with prominent health economists to obtain their views about health care financing in Indonesia.

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The findings show that health care financing in Indonesia has been stagnant for the past two decades and is now moving away from equity principles. Although many speeches addressed by executive governments and legislatures voiced the importance of equity, there is currently no written law or policies that assure the people of equity in health care financing in Indonesia. Current transformations of public hospitals into state-owned companies (BUMN Perjan) or local government-owned companies (BUMD) have clearly paved the way to increased the gap of inequity in health care financing in Indonesia. After the transformation, most hospitals have increased the price of hospital services. The behavior of health professionals in the transformed hospitals does not have significant concern over the access to services of the poor. Several studies suggest that *swadana* or autonomous public hospitals, or providing a private wing in public hospitals, benefit health professionals more than the low-income people. In the meantime, the transformation of public hospitals into *swadana* and presumably *Perjan* with the assumption of reducing government subsidy to public hospitals, the term in view of the authors is inappropriate, will not benefit the low-income category. Without adequate channelling of subsidies towards demand, the transformation of health care facilities into autonomous bodies, not to mention companies, will jeopardize the access and equity in health care financing. Out-of-pocket payment for health care, the most regressive health care financing, will increase.

The transformation of hospitals and health centres in several provinces into state or local government companies is, to a certain degree, a response of the recommendation made by many national and international consultants that the government must spend less for health care, especially for those who can afford. The recommendation made has too much emphasis on the burden of government subsidies, without adequate consideration of the nature of health care and the equity aspect. On the other hand, many developed and developing countries are working hard to establish universal coverage to ensure equity in health care. South Korea, Mexico, Thailand, and the Philippines for example are moving towards expansion of insurance for their people, before the transformation of public hospitals. Indonesia seems to have followed the trend of transformation but with no balance in improving access to essential health care by increasing public spending or developing social health insurance schemes. Access to, especially hospital services, has been very low for the middle and low-income brackets.

Data from Susenas 1992 to Susenas 2001 (ten year annual survey) reveal that access to hospital care has been very poor for the bottom 60% of the population. On average, each household must spend more than 100% of the household income for one admission, regardless of public or private hospitals. This amount of health care costs is definitely a catastrophic spending and can impoverish a household. However, there have been very few written policies to fill this access problem. Although during the crisis the government launched social safety net programmes to protect the poor from being impoverished for health care, hospital data show that the proportion of poor and nearly-poor patients to the total patients served by public and private hospitals was far below the proportion of poor to the population. In many public hospitals the proportions of the poor patients admitted was less than 1% of the total patients. In contrast, the proportion of the poor to the community is far above 20% of the total population. The gaps in access to hospital services between the poor and the rich continue to be very high. The gaps for outpatient care in health centres, in which the costs are relatively small, have been narrow and most low-income households could afford fixed payments for outpatient care. The social safety net programming launched during the crisis, funded by a loan from the Asian Development Bank, has improved access to the poor. However, the program was terminated in 2002.

A health care financing scheme for catastrophic illnesses for non-civil servants is currently not available. Apparently the health care financing policy in Indonesia does not follow the analytical framework recommended in the World Health Report 2000. The report clearly recommends public funding for catastrophic illness to ensure equity, even though the care is a private goods. Under the Indonesian health care policy, there is misunderstanding of public-private goods and the financing of goods. Many executives often mention that the government should only finance public goods, while financing of private goods or health services will be the responsibility of the individual. The statement may be misleading if there is no explanation of the financing of private goods, such as hospitalization and expensive surgical procedures being the individual's responsibility. If the individual responsibility is limited to paying the contribution for the social health insurance scheme, the catastrophic care will be covered. In addition, there are also philosophical problems in the definition and the policy regarding affordable health care. Many government executives think that by setting low prices for third-class hospital services, all people could afford the services. This is not true, because the amount of health care needed and the costs of related services is

uncertain. So setting low prices for room and board or a procedure will not guarantee that a member of low-income household could afford services he/she needs. Even if someone pays, often he/she is *forced to pay* rather than he/she is able or afford to pay. The other misunderstanding is in the concept of subsidy on the supply side or public hospital. The concept of subsidy to public hospitals is somewhat misleading, since the concept of subsidy is usually used for financial assistance by the government to non-government agencies. Most policy-makers think that by providing subsidy to hospitals, for example by purchasing expensive equipments and paying salaries to doctors, the poor could receive the services. In reality, most poor people could not get access to hospital services, as the data suggested.

The government financing for health, from the Central Government budget, over the last two decades has been stagnant at a level below US\$ 2 per capita per year at related exchange rates. The Central Government budgets normally cover about 80% of the total public spending on health in provinces and districts. As percentage of the total Central Government expenditures, health expenditures during the last twenty years have been stagnant at below 2%. These data suggest that compared to the increasing risks of the more expensive and chronic illnesses, funding for health from the government has been diminishing. In addition, out-of-pocket health expenditures by households have also been stable at the rate of below 3% of the total household expenditures.

In all developed countries, except in the US, more than 50% of financing for hospital services is from the public fund, either directly from general revenues, social security scheme, social health insurance, or national health insurance funds. A very small portion of hospital services comes from out-of-pocket payment, because of regressive policies and concerns about inequity. However, the Indonesian health insurance systems are far from equitable due to distorted implementation. For example, in social health insurance for civil servants (*Askes*), payments to hospitals by the insurers are set much below the public rates by the Ministry of Health and/or by a joint decree between the MoH and the Ministry of Internal Affairs. As the hospitals have been transformed into autonomous hospitals, the hospital managements feel that (and this is justified by the standard public hospital accounting developed by MoH) the hospitals are subsidizing *PT Askes*, the insurance company. This accounting standard creates conflict between *Askes* and public hospitals, as all of them are public entities and are supposed to ensure that

the patient receives services according to his/her medical needs. Because of payment differences, in many cases, the insured must pay the difference. While for outpatient care in health centres, the insured does not have to pay the difference or he may choose to opt out by receiving and paying services from private providers out of pocket. Since the out of pocket costs for outpatient care are relatively small, this payment will not impoverish the insured. The paradox is that when the insured is facing catastrophic costs he has to pay on an average more than 100% of his monthly income, up to 1 000%, as "cost-sharing". This scheme covers 13.8 million civil servants and their families.

The social security scheme (*Jamsostek*) also faces inequity problems because the regulation allows larger companies to opt out, resulting in pooling of low income and small employers in *Jamsostek*. Those who enrol in *Jamsostek* are those in lower income groups. Only 1.3 million workers have enrolled in the scheme since the law was introduced ten years ago. In addition, the *Jamsostek* only covers workers and their families during their active duties. Once the employees retire and their income reduces significantly, there is no coverage at all. Again, this scheme creates bias selection so that social solidarity between workers in high-income industries to low-income industries does not occur. In addition, subsidy between the young to the old is not possible also in the *Jamsostek* scheme.

The JPKM schemes (the Indonesian HMOs) is more regressive than the ones in the US and since the schemes are commercial health insurance, the schemes are not fair health care financing schemes. Under the current Ministry of Health decree, only for-profit companies are eligible for a licence to sell JPKM products. The JPKM products are sold to private employees on risk-based premium that does not provide social solidarity or equity among employees or members. The JPKM products sold by JPKM bapels (HMOs) are health insurance products sold by non-insurance companies but the MoH denies that JPKM products are health insurance products. There are imminent risks of solvency if JKPM products are not recognized as insurance products. Lately, there is significant progress within the MoH that debates on JPKM versus health insurance have reduced and the MoH goes along with other sectors to support the development of a national health insurance scheme. Currently, less than one million people are covered under JPKM bapels. In addition, various health insurance products sold by insurance companies also do not facilitate equity since the products are sold on risk-based premiums.

The health insurance schemes sold by insurance companies currently cover more than four million people.

Financing for the poor and the vulnerable groups, such as pregnant mothers, children under five years of age, and the elderly is severely inadequate. Following the economic crisis, the social safety net programmes terminated and there is no sustainable system currently in place. Many policy-makers were worried about a severe reduction in access to health services in the year 2003. The government is introducing a temporary solution by switching a small portion of oil subsidy for health care. But this subsidy is temporary in nature and the amount is very small, averaging about Rp 1 000 (about US\$ 12 cents) per capita per year. The money saved from the reduction of oil subsidy goes more to pay the country debts rather than to finance health care for vulnerable groups. Options to finance these groups adequately to avoid losing generations, and to reduce severe social consequences, must be developed as soon as possible. At present, there are some propositions to establish a more sustainable social protection scheme that will be funded with an ADB loan.

The above findings should create high pressures on the government to establish equitable health care financing system(s). Currently the President has established a Task Force to design and develop a law on a National Social Security scheme, including health coverage. A lot of issues need to be resolved since currently there are many players who already enjoy the cream of commercial health insurance. This study provides alternative options for the National Health Insurance Bill, within the framework of National Social Security, which may work with varying degrees of efficiency, equity level, and implementation. The options and the recommended option are presented in this document. A strong leadership with a good vision and without individual or group interest is absolutely needed to establish a national health insurance system.

In order to meet the goal of universal coverage to ensure fairness in health care financing, it is recommended that the opt-out provision of current health benefit programmes in social security must be repealed. The expansion of social health insurance is integrated, in law, with the other social security programmes, such as pension, provident fund, and unemployment benefits. In addition, to be consistent with the goal to maximize benefits for members the legal status of *PT Persero*--for-profit oriented, of *PT Askes* and *PT Jamsostek* must be transformed into a Trust Fund or a not-for-profit public corporation. If

the opt-out provision is taken out then the number of insured in five years will soon cover about 100 million or almost 50% of the population. Along with its unique characteristics the health programmes will be managed separately from other social security programmes by a National Health Insurance Trust Fund(s). All employers, starting with employers having 10 or more employees and gradually covering employers employing one or more employees, will be mandated to enrol their employees into the scheme. The local district health offices must enrol the poor and the Central Government must share the burden by contributing funds to cover the poor. Until all employees are covered, those who work in the informal sector may join the scheme voluntarily.

In terms of the NHI Trust Funds, this study proposes five options. The first option is consolidation of *Jamsostek* and *Askes* into a new Trust Fund to be a single payer at national level. The second option is in line with regional autonomy, whereby the compulsory health insurance schemes are decentralized by creating an independent trust fund in each region covering one province, several provinces, or several districts. The second option is creating a single payer on a regional basis. At the national level, a National Trust Fund is established to finance only catastrophic illnesses as an equalization fund among various regional funds. The third option is maintaining current schemes where vertically there are schemes for certain population groups such as civil servants, private employees, farmers, informal sector, etc. The fourth option is to create one independent scheme for various groups on a regional basis. And the fifth option is to have multiple not-for-profit health insurance agencies in various regions and at the national level out of which people freely select an insurance organization for at least two-three years. The options affect the effectiveness, efficiency, portability, and client satisfaction. Efficiency and portability reduced in case of more insurance organizations, while client satisfaction increases in the case of more insurance organizations. Selection of options is a political process. However, the study strongly suggests to base the selection on efficiency and portability while client satisfaction can be improved by management interventions.

Several focus groups discussions held during the study, as well as the Task Force have recommended to go with the first option, i.e., the creation of a single National Health Insurance Trust Fund. For the first five to 10 years, the compulsory health insurance scheme should concentrate on enrolling employees from employers with ten or more employees including pensioners.

The contribution is estimated at 6% of monthly salaries paid: 50% by employers and 50% by employees, applied for government and non-government employees. Self-employed individuals and member of cooperatives may join the scheme voluntarily. In addition, the government should establish a mechanism to cover the poor and nearly poor through public assistance programmes. Gradually, the non-salaried workers must join the compulsory health insurance scheme when a reliable contribution collection system becomes feasible.

To optimize social solidarity scheme and to fulfil the right of workers, the benefits of the compulsory health insurance scheme must be in reasonable and acceptable quality. Otherwise, the higher-income workers will resist to enrol happily. The benefits will be provided to the private health care providers and at least in the form of a second-class hospital bed in public hospitals. This level of care will be acceptable by the majority of workers and will encourage employers and employees to join the scheme. The payment will be negotiated on a regional basis between the Fund and association of providers facilitated by Regional Health Officers. Outpatient care will be delivered through the family physician system while inpatient care will be provided by private and public hospitals paid on prospective payment system. By pooling a large number of workers, the scheme is expected to have a strong bargaining power to negotiate certain standards of care and certain level of prices from health care providers. Therefore, the compulsory health insurance scheme will have a strong power to encourage cost-effective health care financing and delivery system in Indonesia.

Introduction

The health status of the people of Indonesia has improved very significantly but slowly over the last two decades. Many factors have contributed to the slow improvement of health status in Indonesia such as: low education, low income, difficult geographical access, cultural problems, and health care financing. Lessons learned from World Health Report 2000, despite criticisms over the methodology and data used, clearly suggest that health care financing is the most important element in the achievement of health improvement. The level of health care financing affects the availability of human resources, medical supplies, distribution of health care facilities, quality of health services, and other important processes. Therefore, many studies have revealed that there is a strong relationship between health status of a

population and health care financing. Data from the WHO 2000 Report clearly show that health care financing, both in terms of nominal amount and percentage of gross domestic product, is relatively lower in developing countries than in well developed countries.

As a developing country currently hit by severe financial crisis leading to a fall in the national per capita income, Indonesia is struggling to finance health care for the poor known as the social safety net programme. At the same time, Indonesia is undertaking a massive government reform by decentralizing almost all authority, except fiscal, national security, foreign policy, and religious affairs to regional government. The crisis and the decentralization of authority have raised awareness and concern over sustainable health care financing in Indonesia. It is critical to review how current health care financing affects the outcome of health development, as measured by traditional public health indicators such as infant mortality rate or outcome indicator such as access to health services. Additionally, health care financing through health insurance scheme will be reviewed to identify problems and potentials for development. In developed countries, health insurance especially social health insurance, becomes one of the most viable solutions to improve the health status of the population. However, health insurance alone will not be sufficient to overcome many health problems. This study reviews various health care financing schemes in Indonesia and recommends resource mobilization through expansion of the social health insurance scheme.

More than 30 years ago, a health insurance scheme for civil servants was first implemented in Indonesia. The scheme has evolved slowly and continued to evolve, despite many problems and unsatisfactory services complained to by members. The scheme is based on the social health insurance concept and is now administered by a state owned company, a for-profit company, that is not consistent with the concept and philosophy of social health insurance. For more than two decades, only civil servants have been protected by a health insurance scheme. Various initiatives of health care financing in small scales such as community health insurance (*dana sehat*) have been introduced and promoted by the Ministry of Health without any significant effect on the access to health services and on the health status.

Ten years ago, for the first time a comprehensive Social Security Act of Indonesia was passed by the Parliament (*Dewan Perwakilan Rakyat*). The social security includes four basic benefits: provident fund, occupational

injury, death benefits, and health benefits. The health benefits differ from other benefits in which participation is mandatory upon the availability of other health benefits provided by employers. Employers who may offer better benefits from those offered by *PT Jamsostek* may not join the social security scheme. The opt-out-option has resulted in low enrolments of health benefits and low coverage of health insurance for private employees. On the other hand, private health insurance scheme has grown faster than the public one. At the same time, the Ministry of Health introduced and promoted private insurance schemes based on managed care principles of Health Maintenance Organization in the United States called *Jaminan pemeliharaan Kesehatan Masyarakat (JPKM)*. The confusion and misunderstanding regarding the managed care roles in assuring equitable health care financing among officials of the MoH and other health professionals have led to intense debates over the continuation of JPKM in health care financing in Indonesia. Despite strong evidence that the development of JPKM was unsatisfactory and has been inconsistent with the goal of equity in health financing, the MoH continues to promote the development of JPKM. A thorough and objective review of managed care and JPKM will help health professionals to understand why Indonesia needs health care financing reform.

The review covers an overview of current health policy and financing, access to modern health care by the Indonesian population and health care financing problems, especially regarding the public sources. In addition, this review examines in detail the conceptual and managerial aspects of various health insurance schemes including *Askes*, *Jamasostek*, *JPKM*, and other private health insurance forms. At the end of the review, we suggest various options for expansion of health insurance and recommend further steps to expand and to achieve universal coverage.

Existing Health Care Policy and Financing

Indonesia is currently at the crossroads between centralized and decentralized governments and between strong state controls and market driven health care. In the health sector, reforms are being undertaken in various levels of governments to accommodate global changes and to respond to the local demand. The Ministry of Health (MOH) has set a vision of Healthy Indonesia 2010 by prioritizing four main elements of health sector development namely: *healthy paradigm, professionalism, decentralization, and development of*

managed health insurance.² This vision sets healthy life for all Indonesians in the year 2010. Many public hospitals are transformed into state or local government companies, legally for profit companies.³ In depth analysis, from the central government officials' viewpoint, reveals that the transformation of vertical public hospitals into *Perjan* (state-owned companies) is to avoid inadequate capacity of local governments to manage the hospitals. The regional government officials alleged that the transformation reflects the hesitation of Central Government to decentralize health services. State-owned pharmaceutical companies, previously appointed to ensure equitable distribution of essential drugs are being privatized to stimulate quicker response to market changes. The privatization of government pharmaceutical companies and transformation of public hospitals into state-owned companies is likely to increase the health care prices while improving the quality of health services. However, this rise of health care costs may reduce the access to necessary health services for the poor and nearly poor residents.

Infectious diseases continue to be a major problem for health services in Indonesia. However, chronic diseases requiring expensive treatment, and HIV/AIDs are on the rise. Therefore, hospitals and other health care facilities must be equipped with resources to cure infectious diseases, as well as chronic and expensive diseases. Cardiovascular diseases have been the number one cause of death since 1992, while tuberculosis and upper respiratory tract infections (URI) remain among the five leading causes of death. Tuberculosis combined with URI, has become the leading cause of death⁴. Very few hospitals provide adequate cardiovascular services in the country. Public hospitals at district levels must focus their services to fight prevalent infectious diseases while public and private hospitals in urban areas must also provide expensive services for the growing chronic diseases' patients. The market mechanism has shaped skewed distribution of specialists and other health care facilities in urban and big cities in Java. The pressure to provide more expensive equipment to accompany specialists in urban public hospitals has absorbed large amount of the government budget for urban residents. It is estimated that more than 50% of specialists are serving population in five big cities in Java. In contrast, the cities have only about 15% of the Indonesian population.

² ____Healthy Indonesia 2010. MOH, Jakarta, Oktober 1999

³Djoyosugito, A. Rumah Sakit Perjan. JMARS, 2002

⁴ ____MOH. Health Profile 2000. MOH, Jakarta 2000

Significant policy changes such as providing access to essential health services in Indonesia come from the devolution of health services and health care financing scheme from the public sector. Under the regional autonomy law, financing of public health services is the responsibility of city or district governments, the smallest local government units. The local governments received block grant funds (*dana alokasi umum*) from the Central Government. In addition to block grant funds, local governments receive additional income from local taxes, portions of natural resources, and some earmarked central government budget in health sector. Due to varying degrees of awareness and local capacities, some districts allocate significant portion of local government budget for health, while others spend very little for health. For example, the city of Depok in south of Jakarta spent only one per cent of the local government expenditure for health, while Jambi city spent 13% of government budget for health. In terms of per capita government expenditure also, there are wide variations. For example, in 2001 Solok district in West Sumatra spent Rp 1 141 (US 13 cents) per capita while city of Padang Panjang in the same province spent Rp 80 045 (about US\$ 9) per capita.⁵ Before the devolution, the central government allocates health expenditure in more equitable ways, depending on the per capita budget. The changes in local government responsibility in financing and delivering public health services threaten equity in access to essential health services across districts.

The pressure for policy changes in health care is reinforced by the recent currency crisis in Indonesia. Among other Asian countries hit by the crisis, Indonesia suffered and continues to suffer the worst. The Indonesian currency (Rupiah) to US\$ plunged from Rp 2 500 in June 1997 to Rp. 13 500 per US\$ 1 in January 1998 (the lowest). During 2002 the Rupiah floated around Rp 9 000 per US\$ 1, still about less than one third of its value before July 1997. As the crisis began to affect industries and individuals in early 1998, the government suddenly realized that the burden of debts, both in the public and private sector was as high as nearly US\$ 150 billion, a little less than the gross domestic product in the year 2002, estimated at US\$ 170 billion. To pay the public debts, the government has been selling-state owned companies to domestic and international investors.

⁵ ___ District Health Account Survey. PT Geosys, Jakarta 2003.

Following the financial crisis of 1997, while the Indonesian currency continued to plunge, there were many political, social, and economical changes through out the country. After July 1997, the cost of living suddenly became four times more expensive for Indonesians compared to the beginning of 1997, while their real per capita income in US dollar fell to only one third of their income in the preceding year. The income per capita that had been around US\$ 1,200 at current spending (it was estimated about US\$ 3,200 using purchasing power parity) and then declined to around US\$ 618 in 1998, is now about US\$ 700⁶. This condition has driven much social unrest in Jakarta and other parts of Indonesia. At the same time, devolution of political powers from the central government to local governments was unavoidable in all parts of the country, accelerating social and economical changes in Indonesia.

Stagnant Health Care Financing

Traditionally, health care financing for the public sector comes from the Ministry of Health, the provincial health care budget, the district health budget, military health services, other sector spending on health, social health insurance corporations, and foreign aid and loans. The proportion of district health allocation became the largest health care financing source after decentralization. Private sector health care financing comes from out-of-pocket payments by individuals and households, employers, and private insurance companies. The amount of money the private sector contributes on health care each year is not known since Indonesia does not have a reliable health accounts system. However, recent studies indicate that the private sector contributes much more than the public sector. According to the best estimates collected during the last ten years, health care financing from the public sector accounted for about 30-40% of total health expenditure while the private sector contributed about 60-70%. Data on health expenditure show that health care financing in Indonesia is severely under-funded, far below health care financing in Indonesia's neighboring countries. Even if it is compared with a county of similar or lower per capita gross domestic product, such as Vietnam and India, Indonesia spends much less.⁷

⁶ ___ Bureau of Census, January 2003

⁷ ___ WHO Report 2000, Geneva 2000.

Table 1. Health care financing in selected countries in Asia, 1997

Countries	PCHE at exchange rate (US\$)	PC GDP at exchange rate (US\$)	PCHE in international dollars (US\$)	THE as % of GDP (%)	Public share (%)
Indonesia	18		56	1.7	36.8
Vietnam	17		65	4.8	20.0
India	23		84	5.2	13.0
Philippines	40		100	3.4	48.5
Malaysia	110		202	2.4	57.6
Thailand	133		327	5.7	33.0

Source: WHO Report 2000

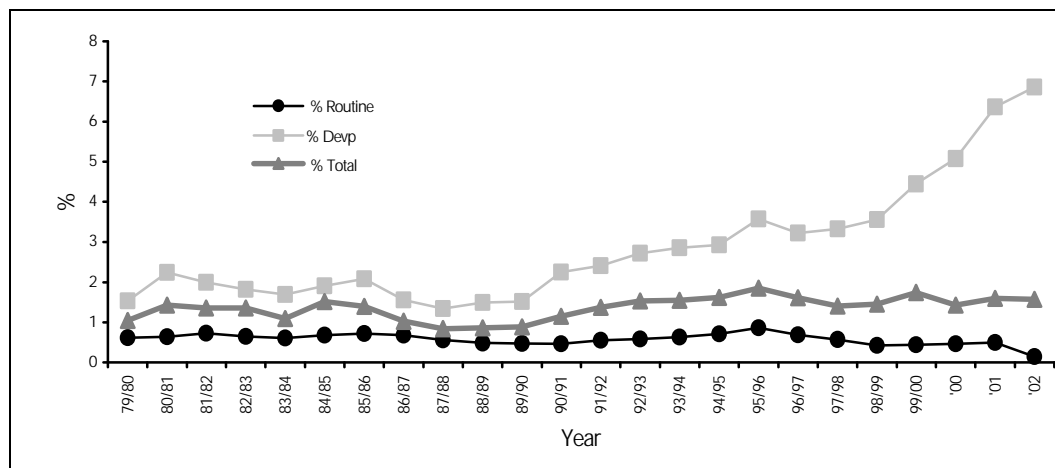
Table 1 shows data summarized from the World Health Organization (WHO)'s World Health Report, 2000 indicating that Indonesia spent only US\$ 18 per capita on health in 1997 while the Philippines spent more than double than Indonesia. In international dollars, Indonesia spent even less than Vietnam with much lower GDP per capita. After the crisis when the GDP per capita of Indonesia plunged to about US\$ above 700, much less than its per capita GDP in 1997, the health spending was much lower than Vietnam with the GDP per capita being US\$ 382.⁸ Indonesia only spent 1.7% of its GDP for health while India and Thailand spent 5.2% and 5.7% of GDP respectively.⁹ For more than two decades, the Central Government of Indonesia has been spending less than 2% of the total government budget for health (see Figure 1). This finding is consistent with study by Malik (1997)¹⁰ who found that public health care financing from Central and local government expenditures had been below four per cent to total government expenditures. Separate analysis shows that since 1998 there has been significant increase in development budget. However, further in-depth analysis uncovers that the increase has been the result of foreign aid and loans for social safety net to alleviate the impact of severe financial crisis hitting Indonesia.

⁸ ___ Asia Week, November, 2001

⁹ ___ World Health Report 2000. WHO, Geneva, 2000

¹⁰ Malik, R et. al. Evaluasi Pembiayaan Kesehatan, and Bureau of Planning Data, Jakarta 1997

Figure 1. Central government spending on health as per cent of total government expenditures



In most European and developed Asian countries, the public sector contributes more than 50% of the total health expenditures because of strong social security or social health insurance systems. Among developed countries in the world, the United States, (US) public spending on health is less than 50% of total health care expenditure. The public share on health expenditure in Thailand and the Philippines has been greater than the private sector.¹¹ Health care financing in Indonesia is dominated by the private sector, between 60-70% of the total health expenditure mainly from out-of-pocket financing. This large portion of private health expenditure leads Roemer (1993)¹² to classify Indonesian health care system and the US health care system as *entrepreneurial health care systems*. This entrepreneurial health care system of Indonesia continues to date. The large portion of private health expenditure in Indonesia leads to regressive and unfair burden of health care financing on the population. The impact is clear. A large portion of Indonesian people could not afford to pay for even essential health services, especially inpatient care and expensive treatments. The high infant mortality and maternal mortality rate of Indonesia may be strongly attributed to this regressive system. Although the World Bank report of 1993 entitle "Investing

¹¹ __WHO Report, 1999

¹² Roemer. Health System of the World, Oxford University Press, New York, 1993

on Health”¹³ reached many decision-makers in Indonesian Ministry of Health, apparently there have been very few changes in health care financing policy in Indonesia. The government had not been convinced to prioritize and to invest more on health. In 2002 the government received taxes from tobacco sales more than US\$14 per capita but at the same time the government spent less than US\$ 2 per capita on health.

The government spending on health in US\$, at exchange rates, varied from US\$ 0.46 to US\$ 2.49 per capita per year. The highest spending occurred in fiscal year (FY) of 1999-2000 because at that time, there was more money coming from foreign grants and loans for social safety net programme in response to the financial crisis. Although in local currency (Rupiah) the government spending on health increased constantly and significantly from Rp 368 per capita per year in FY 1979-1980 to Rp 13 513 in FY 2001, but in US\$ the government spending remains stable on the average US\$ 1.40 at exchange rates. This means that the Central government has not payed significant attention to health in the last two decade. Despite the relatively low spending, the health risks increased significantly due to epidemiological and demographic changes.

The local government spending has not offset the low Central government spending on health. Table 2 shows that the total government health expenditures, including Central government, provincial government, and city/district government expenditures since fiscal year 1994 in US\$ have decreased. The conversion to US\$ is very important since Indonesia imported more than 90% of medical supplies and raw materials for drugs. The high dependency on foreign supplies affects the purchasing power of government development expenditures. In US\$, the total government expenditure on health during fiscal year 1994 to FY 2000 on average was only (less than) US\$ 3. The government expenditure on health in US\$ for fiscal year 1997-1998 decreased 54.8% due to the exchange rate crisis hitting Indonesia in mid-1997.

¹³ World Development Report 1993: Investing in Health. Oxford University Press, New York, 1993

**Table 2. Central government per capita health spending
for fiscal year 1979/1980 to FY 2002**

Fiscal year	Per capita (Rupiah)	% increase	Per capita (US\$)*	% increased (US\$)
1979/1980	368	–	0.58	–
1980/1981	822	123.4	1.30	124.1
1981/1982	h901	9.6	1.41	8.5
1982/1983	909	0.9	1.36	–3.5
1983/1984	916	0.8	1.02	–25.0
1984/1985	1,210	32.1	1.17	14.7
1985/1986	1,492	23.3	1.34	14.5
1986/1987	850	–43.0	0.66	–50.7
1987/1988	767	–9.8	0.46	–30.3
1988/1989	1,055	37.5	0.62	34.8
1989/1990	1,311	24.3	0.74	19.4
1990/1991	2,275	73.5	1.23	66.2
1991/1992	3,048	34.0	1.56	26.8
1992/1993	3,946	29.5	1.94	24.4
1993/1994	4,296	8.9	2.05	5.7
1994/1995	4,680	8.9	2.12	3.4
1995/1996	5,277	12.8	2.29	8.0
1996/1997	5,845	10.8	2.45	7.0
1997/1998	6,343	8.5	1.11	–54.7
1998/1999	11,575	82.5	1.43	28.8
1999/2000	17,832	54.1	2.49	74.1
2000	13,776	–22.7	1.47	–41.0
2001	13,513	–1.9	1.29	–12.2
Average	4,479	22.6	1.40	11.0
Minimum	368	–43.0	0.46	–54.7
Maximum	17,832	123.4	2.49	124.1

*At average exchange rates of the same year

Figure 2. Central government development budget per capita at 1980 constant prices fiscal year 1980-1981 to 2000

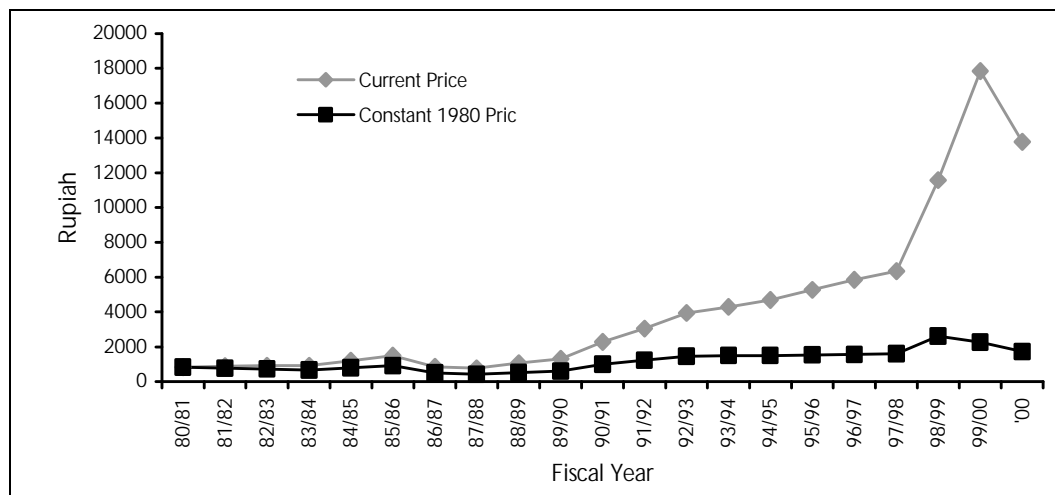


Table 3. Government development spending from all sources per capita-fiscal year 1994/1995 – 2000

Fiscal Year	Central (Rp)	Province (Rp)	District (Rp)	Total (Rp)	% Increase (Rp)	US\$ [†]	% Increase (US \$)
1994/1995	4,680	573	1,148	6,401	–	2.90	–
1995/1996	5,277	717	1,242	7,236	13.0	3.14	8.3
1996/1997	5,845	896	1,443	8,184	13.1	3.43	9.2
1997/1998	6,343	755	1,761	8,859	8.2	1.55	-54.8
1998/1999	11,575	531	1,778	13,884	56.7	1.71	10.3
1999/2000 [¶]	17,832	†	2,676	20,508	47.7	2.86	67.3
2000	13,776	3,385	1,995	19,156	-6.6	2.04	-28.7

[†] At average exchange rates at the same year

[‡] Some local provincial expenditure is not available, not included

[¶] Total does not include provincial expenditure on health

Conceptual Problems in Health Care Financing

Since the beginning of the New Order government, the health care financing policy has aimed to provide affordable health care for all. The government constructed public health centres, sub-health centres, and public hospitals in almost all districts. To ensure affordable health care, local governments set user charges (now it is often called prices) 'conceptually affordable by all'. The charges in health centres and sub- health centres have been affordable for all because the majority charges have been all- inclusive medicines for three days with uniform charges. The public hospital charges have been based on fee-for-services. The concept of affordable health care was understood by setting low room and boards, low charges of medical procedures and examinations, and other ancillary services. This is a "misconception" of affordable health care, since the true charges have been not determined in advance. The users have never been able, and will not be able to estimate how much they have to pay for health care. The uncertain nature of health care will not be met by fee-for-services charges, even though the unit of charges for each item is affordable. It is affordable if the government fixes user charges per admission or per all-inclusive visit (including medicines).

The second problem in public health care financing in Indonesia has been supply side financing. The government provides facilities, health work forces, and all related equipments to public health facilities. To conceptually provide "affordable health care", the government set low user charges for each unit without appropriate costing. The cost recovery rates were low for all levels of services, especially in public hospitals. Since the public hospitals are located in the city or in the capital of districts while the poor normally reside at a distance from public hospitals, the middle class people receive disproportionate public financing. The poor could not get access to the services because of relatively unaffordable total costs (uncertain), higher transportation costs and other cultural barriers. A greater proportion of public financing goes to the better-off than to the poor.

Efforts to establish a more appropriate public financing have been conducted since more than a decade but a significant change has not been conceived. Currently there are discussions to reformulate public-private financing for health care. The concept being discussed is that the government will only finance the public goods aspect of health services, while the private goods aspects will be financed by the private sector, except for the poor. This thought is derived from the concept of public and private goods. While the

concept of public and private goods is clear, there is no direct relationship that the public goods must be financed by the government while the private goods must be financed by individual or a private entity. The WHO report of 1999¹⁴ clearly recommends that certain private goods are justified to receive public finance, regardless of the income status of the population. There are two essential factors to be considered for public financing: externality and catastrophic financing. The current understanding of simplified division of public and private mix in health care financing must be refined to appropriately establish fairness in health care financing. Without adequate understanding of the nature of health care, the appropriate health care financing schemes, and clear division of public and private roles in financing, Indonesia may be trapped into an inefficient and ineffective health care system leading to more health care financing problems in the future.

In the delivery of health services, the trend is that the government will transform public health services into autonomous entities. It could be in the form of for-profit state or local government enterprises (BUMN or BUMD) or in some other form. Health centres are also being transformed into autonomous health care facilities known as *swadana*. Much of this transformation aims at making financial management and the responsiveness of management to local demands more flexible. However, the general trend of this transformation has been the charging of higher user fees by the new facilities, while social protection (insurance) for those who cannot afford to pay health services is not yet established. One serious concern over this transformation is that higher user fees decrease access for the poor or the nearly poor.

Direction of Health Care Reform

After the crisis, there have been strong initiatives to reform Health care system in Indonesia. One of the more significant reforms is the Healthy Paradigm approach introduced by Minister Moeloek and signed by President Habibie in 1999. Under this revival of public health paradigm, the Ministry of Health was taking a lead to the healthy public policy, healthy overall development, and healthy environment. The Ministry of Health set four pillars to achieve Healthy Indonesia 2010, a goal to move toward healthy environment, and universal coverage. The four pillars are: moving to Healthy Paradigm,

¹⁴ WHO Report, 1999

professionalism, development of insurance schemes (*JPKM*), and decentralization of health services.¹⁵ However, this reform has not been systematically and widely implemented under the new Minister.

The requirement to sell only unleaded gasoline to reduce pollution of lead residues and thereby provide a blue sky is one example of a healthy paradigm. A private, not-for-profit coalition has been set up to promote the healthy paradigm. By promoting healthy lifestyle, the government expects to reduce the incidence of illnesses in the country and therefore there will be more productive days.

To improve professionalism, basic nurse education that has been at high school level is now being upgraded to three years university education after high school (Diploma III). Many universities are now developing bachelor level (four year after high school) nurse education. Medical specialist training is now being transferred from university education into competency-based training run by specialty societies. This transformation is expected to speed up the production of specialists in Indonesia. Currently there are only about one fifth of 50 000 doctors in Indonesia who are specialists. The shortage and maldistribution of specialists creates inequity in access to modern health care across the country.

The law of regional autonomy, including health sector, has been implemented nationwide since January 2001. While decentralization provides faster response and more appropriate policy in many aspects, there are some disadvantages of decentralization of health services. Under the law of regional autonomy, local governments are responsible for providing health services in districts. Many local governments perceive that hospital services could be utilized to generate income for local governments. On the other hand some rich districts, such as Musi Banyuasin, are planning to provide health services for free. So decentralization could end up with regional inequities in health care.

Efforts to expand *JPKM* had been undertaken through promotion of *JPKM* *Bapels* and the creation of *pre-bapel*, as explained before. However, more than 99% of such *pre-bapels* were not able to become sustainable and promising organizations leading to the degradation of *JPKM* concept. A study by Ilyas (2003)¹⁶ indicated that all district health officials surveyed in Sumatra

¹⁵ ____ Healthy Indonesia 2010, Jakarta 1999.

¹⁶ Ilyas, Y. *JPKM* Pilar atau Galar. *J MARS*, January 2003

reported that no pre-bapel had survived. This massive failure of JPKM has given some impetus to reforming the concept of JPKM. Attempt by the MoH to establish a JPKM Law by mandating all citizens to choose a bapel aborted. The bapels—at least by the proposed law are for-profit entities that will maximize profits to the stockholders.¹⁷ This is not consistent with the concept of social health insurance that attempts to maximize benefits to the members. The current *Jamsostek* and similar schemes implemented in Chile¹⁸ have proved that running social health insurance by for profit entities leads to severe bias selection and will only benefit investors, not the people. In addition, the small capital of bapels could lead to serious solvency problems. In 2001, none of the licensed bapels had more than Rp 500 million (US\$ 56,000) capital, suggesting very low financial solvability to run high-risk health insurance schemes.¹⁹ Currently, efforts to expand JPKM or health insurance coverage is integrated into the expansion and reform of national social security to be described later.

Existing Health Insurance Schemes

Civil Servant Social Health Insurance Scheme (Askes)

The legal basis of this scheme is based on Government Regulation No 69/1991 and Government Regulation No 6/1992. The number of insured in the civil servant compulsory health insurance (social insurance) scheme this year is a little more than 13 8 million members. The scheme is managed by *PT Askes*, a state owned company. All civil servants and pensioner civil servants, and military personnel are mandated to contribute 2% of their basic monthly salary, regardless of their marital or family status. The government, central and local, had not contributed to the scheme. However, this year the central government is starting to contribute equivalent to half per cent of the basic salary. All members are entitled to comprehensive benefits considered medically necessary regardless of their rank or income. The benefits are provided in provider network, and consist of mainly public health centers and public hospitals. *Askes* pay the providers using prospective payments, mostly on per case and per diem. The Ministry of Health and the Ministry of Internal Affairs determine the level of payment to providers to ensure that *Askes*

¹⁷ ___ Draft RUU JPKM, Jakarta, April 2001

¹⁸ ___ WHO Report 2000, Geneva, 2000

¹⁹ Thabrany, H; Pujiyanto; and Mundiharno. Survei Kapasitas Bapel JPKM. PT MJM. Jakarta, 2001

maintains its solvency. The only difference is that higher-rank civil servants are entitled to first class room and boards when they are admitted to public hospital, while the lower rank are entitled to second and third class room and board when they are hospitalized.

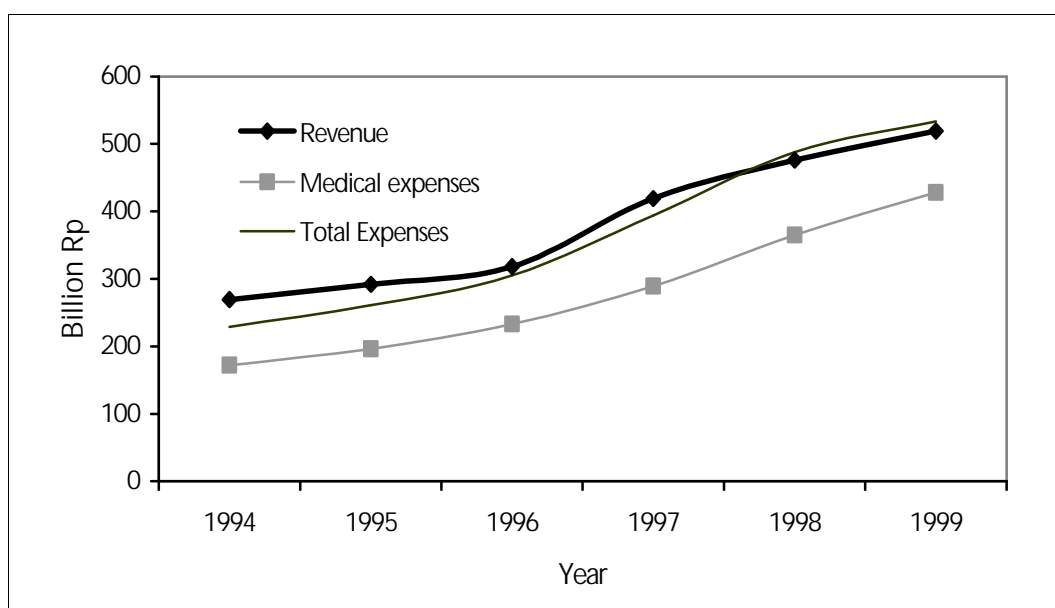
Initially, the scheme was administered by an agency within the Ministry of Health (BPDPK, *Badan Penyelenggara Dana Pemeliharaan Kesehatan*). However, under the Ministry the management of the scheme was tied to bureaucratic fiscal system that was not flexible to respond to the changing needs and demands. In 1984, the agency was transformed into a Public Company (*Perum Husada Bhakti*), a state-owned company in which the employees of the company maintained their civil servant status. In 1992, the status of the company was again transformed into *PT Persero* called *PT Asuransi Kesehatan Indonesia* (in short it is more popular with *PT Askes*), a higher-level autonomous status of state-owned company where the employees were no longer civil servants. After the transformation from *Perum Husada Bhakti* into *PT Asuransi Kesehatan Indonesia*, *PT Askes* is allowed to sell commercial products in accordance with the by-laws. Currently *PT Askes* is selling commercial insurance in the form of HMO products to more than 2 500 companies covering about 1.3 million members, an increase from 131 635 members in 1994.

The membership growth of the compulsory scheme increased with the increasing number of civil servants and military pensioners. However, the number of members declined sharply in 1998 after the management conducted an audit of membership. Computerization of member services resulted in reduction of subscribers (families) due to some duplication that existed before computerization was effected. In addition, the number of dependents fell sharply because *Askes* conducted consistent membership policy that covers only the first two children under the age of 21 years or 25 years if the child is a full-time student. As the result, the membership of compulsory scheme in 1998 decreased by 2 173 448 from the number of members in the preceding year. In the year 2002, the compulsory members remained at about 13.8 million.

The growth of premiums for compulsory members on average has been lower than the growth of health service expenses. The government normally determines the salary levels of civil servants every two-three years. Sometimes the basic salary is not adjusted; instead the government provides additional

lumpsum money to supplement the income of civil servants and military personnel, as was the case in 1999. Because the basic salary was unchanged, the premiums received by *PT Askes* did not increase during that year. On the other hand, health services prices were adjusted to offset the high inflation rate of more than 80% in the same year. This trend threatens the sustainability of the social health insurance scheme, especially during the coming decentralization and transformation of public hospitals into autonomous hospitals (Perjan).

Figure 3. *Askes* Financial Performance, 1994-1999



Source: *Askes* Annual Report, 2001

Although in theory, all members have the right to receive comprehensive health services in the provider network, mostly public health facilities, many *Askes* beneficiaries (especially upper income) did not use services they deserve to. *Susenas* 1998 showed that of 28.2% members who complained had at least one illness symptom, 16.3% sought treatment and only 7.3% sought treatment in *Askes* provider network. Many upper income members did not use outpatient services provided by *Askes* providers and simply pay out-of-pocket for services outside the network. There is harmful for the

members because the charges for outpatient care are affordable. However, for catastrophic medical care, such as haemodialysis and open-heart surgery, almost all members used the services provided. On average, in 1998, each household member of *Askes* paid Rp 19 200 out-of-pocket for outpatient care and Rp 698 000 for inpatient care (Thabrany, 1999). Upper income members often file complaints that they receive poor quality of services in the provider network. Recent surveys indicated that 80% of the members were satisfied with the services provided in the network (Soetadji, 2002)²⁰

Regardless of member satisfaction, the implementation of *Askes* has benefited civil servants, pensioner of civil servants and armed forces personnel, their families, and their survivors for more than 30 years. For higher rank beneficiaries, the scheme has helped beneficiaries in access to expensive medical care and drugs. The scheme has been very helpful for retirees and for major medical expenses (expensive medical care such as inpatient care, haemodialysis, surgical procedures, and cancer therapy). Practically, all beneficiaries utilize their benefits when they have kidney failure and need haemodialysis procedure regularly. About 75% of patients in haemodialysis centres in the country are *Askes* beneficiaries. Susenas data showed consistently that more than two thirds of beneficiaries used their insurance for inpatient care. In contrast, slightly less than half of beneficiaries used their insurance for outpatient care (Thabrany et.al. 1999).²¹

The *Askes* scheme is currently facing several problems. Before 2002, *Askes* members had to pay for cost-sharing that was very high, ranging from 30-60% of the total costs. The high cost-sharing was the result of low reimbursement levels by *Askes* as set by the Ministry of Health while many autonomous public hospitals, especially in large cities, charge the remaining balance to the members. In 2002, the Ministry set new payment levels, in which the *Askes* payees higher-than-published user charges in 40% of public hospitals, but remained below the published charges for the remaining public hospitals. The second significant problem is the perceived poor quality of health services provided in public hospitals. As described before, higher income or higher rank civil servants often do not use their benefits for outpatient care due to this perceived poor quality. The third problem related to

²⁰ Soetadju, O.A. Kebijakan Baru *Askes* untuk Tahun 2003. Paper presented in Provider Seminar, Bali, December 2002

²¹ Thabrany, H. et.al. Potret peserta wajib, Laporan Studi Susenas 98

the goal of universal coverage is the third child and beyond and related pregnancy treatment are not covered. The fourth problem is the relative adverse selection of the scheme from military pensioners. During their active duties, military personnel are not covered by *Askes*. After retirement, when they are at higher risks and receive much lower pension—as compared to their salary, the military personnel and their family members are covered by *Askes*. The fifth problem is the transformation of public hospitals into state own companies followed by increase in prices. Many transformed hospitals express their unwillingness to serve *Askes* members unless *Askes* pays regular prices at set hospitals. The last problem faced by *Askes* is the demand by several local mayors or *bupatis* (head of local government) to manage their employees insurance. This is a misunderstanding regarding the decentralization of power or authority provided under the regional autonomy law implemented just two years ago.

Private Employee Social Health Insurance Scheme (Jamsostek)

The legal basis for this social health insurance programme (*Jamsostek*) is the Law No. 3/92 (social security law), the government decree (*Peraturan Pemerintah*) No.14/93, and the Ministry of Labour decree No. 05/93. All of these regulations also apply for the other three *Jamsostek* programmes namely provident funds, death benefits, and occupational injury. However, the SHI programme differs from other programmes in several ways²²: (1) The participation of SHI is conditional. Employers who have provided health benefits (self insured) or can purchase more generous health insurance are exempted. Because of this provision, the majority of employers choose to opt out from *Jamsostek* and buy health insurance from insurance companies or JPKM bapels. (2) Employers are mandated to pay a premium of 3% (singles) and 6% (married) of employees' salaries while the employees pay nothing (non-contributory scheme). (3) The wage ceiling has remained at Rp 1 000 000 since 1993, freezing revenues while costs of medical care continue to rise. (4) The benefits are in kind, provided through various health care providers contracted, directly or indirectly, by *Jamsostek*, except for limited out of network emergency care that is reimbursable. Other *Jamsostek* programmes pay cash benefits to the beneficiaries. (5) The benefits are

²² Jamsostek. Kompilasi Peraturan Jamsostek. PT Jamsostek, 1999

provided not only to the employees but also to family members—up to the third child.

Operational problems

The regulation mandates all employers, regardless of the legal status of the entities, who employ 10 or more employees, to pay health insurance premiums for their employees except the employers who choose and are eligible to opt out. Employers having less than 10 employees but pay salary, in total, more than Rp 1 million a month are also mandated to enrol their employees into Jamsostek. Under this regulation, many individuals, who have a driver and a housemaid, paying more than one million rupiahs per month are mandated to enrol under *Jamsostek*. If this law were enforced and no opt out option is possible, health insurance coverage would have increased to more than 100 million people or 50% of the population. But, the membership growth of Jamsostek is progressing very slowly (see table-3), increasing from 199 000 in 1991 to 2.9 million people in the year 2002. The average growth of employers enrolling their employees to Jamsostek in the last ten years was 53% a year, but the number of employees enrolled grew only by 40% a year. The number of insured (members, including family members) grew even less at only 38% a year. This means that only small employers (average size of 79 employees per employer) enrolled under *Jamsostek*. Larger employers opted out of *Jamsostek*. As a result, *Jamsostek* covers less than 5% of eligible employees. In 2001, there were 18.8 million employees (of those 9.3 million are active members²³) enrolled in the other three *Jamsostek* programmes. A national labour survey estimated a figure of 56.2 million workers fully employed in the year 2000.²⁴

Data from commercial insurance companies show that total membership of health insurance coverage in the 1999 was about four million people.²⁵ Health insurance premiums (excluding personal accident insurance) received by commercial health insurance companies in 1999 was Rp 279 billion and it is estimated to reach Rp one trillion in 2002. In 2000, Jamsostek collected only Rp 155 billion, much less than the total health insurance premiums

²³ Jamsostek website data, 2002

²⁴ ___ ILO. National labor force survey, 2000

²⁵ Djaelani, F. Perkembangan Asuransi Kesehatan di Indonesia. Makalah disajikan pada Seminar Nasional Asuransi Kesehatan, Jakarta, Oktober 2000

received by the private insurers. Without Jamsostek law, the private insurers may not get such sizeable gross premiums from health insurance products. The opt-out option benefited commercial health insurance companies more than *Jamsostek* and its employees. In addition, the cross subsidy and redistribution effects of social security are not achieved.

Table 4. Memberships growth of social health insurance component of (JPK) *Jamsostek*, 1991-2000

Year	Firm	Employees	Insured	Premium (Rp000)	Claim ratios (%)
1991	723	85,926	199,695	4,553,000	63.9
1992	958	110,345	238,022	8,280,000	62.2
1993	3,419	256,402	537,173	13,657,000	59.1
1994	5,624	458,257	963,619	28,263,000	67.5
1995	8,034	698,052	1,414,175	44,365,000	80.7
1996	9,452	961,594	1,725,618	64,314,563	79.7
1997	10,892	989,094	1,949,011	86,233,060	76.1
1998	14,225	1,110,478	2,338,075	100,220,435	88.5
1999	15,628	1,235,818	2,567,576	136,103,858	74.6
2000	16,707	1,321,844	2,699,977	155,360,770	65.4
Average annual growth 1991-2000 (%)	53%	40%	38%	51%	Av. Cl. Rat 71,77

Source: PT *Jamsostek*, Account Division 2001

In the law enforcement aspect, *Jamsostek* does not have the authority to enforce the law. The Ministry of Manpower and Transmigration (MoMT) does have the authority but it does not have sufficient understanding of the philosophy and the effects of non-participating employers to the growth of social security. Moreover, many officials at the MoMT may not have a good understanding of what social health insurance means to workers and labour productivity. In addition, there is no incentive for the MoMT to enforce *Jamsostek*. Some officials of MoMT even advocate liberalization of *Jamsostek* using the market mechanism without knowing that there is market failure in

the health insurance and social security. Chile and Argentina have experienced severe adverse selection of their social health insurance systems because of this liberalization. The US experience is a very clear example of serious disaster to the population in financing health care because of the market mechanism.

The management of *Jamsostek* needs strengthening in order to provide evidence that social health insurance scheme can provide an acceptable quality of services. Only through such high quality services, memberships could be expanded. However, the current administration of *Jamsostek* is not ready to take responsibility to manage larger membership. The current relative high claim ratio of an average of 71.8% (compared to the other three programmes) and low revenues from SHI contribute to the lack of impetus to administer SHI compared to other *Jamsostek* programmes. In addition, the benefits in kind have also complicated the management of SHI for which most of *Jamsostek* staff are not prepared.

Due to lack of management capacity, in the past *Jamsostek* contracted the management of health care providers and health services to other parties called main providers (MP). The main MP of is JPKM bapel owned by employees of *Jamsostek* and several others MP are also JPKM bapels (i.e insurers, not health care providers). *Jamsostek* paid capitation to MP and then MP paid other capitation on fee-for-services to providers –a reflection of poor capability of *Jamsostek* to manage contracts with health care providers. Certainly this contracting system leads to inefficient and higher costs since the main providers will take some profits. Taking into account 20% administrative costs spent by PT *Jamsostek* and additional administrative costs spent by MPs, the amount of money that goes to health care providers becomes less than 60% of the total contribution received. Such high administrative costs leads to low quality of health care benefits. In most social health insurance schemes in other countries, the administrative costs can be as low as 3% (Taiwan) and up to 5% in Germany. The economies of scale through making one agency responsible for the administration of health insurance, such as the case in Taiwan, Canada, or even Medicare in the US, can push efficiency up to 4% of premiums for administrative costs.

A lot of complaints from providers and dissatisfaction of contracting MPs led to discontinuation of most of the MP systems. At present, *Jamsostek* is managing directly to contract providers with few exceptions. Several regions contract out patient services only with private providers, while others use a

mix at public and private providers. Several regions use public health centres as primary care providers resulting in poor quality perception by members. Members demand service differentiation from those services usually provided for the poor in public health centres.

The payment system applicable all health care providers cannot be based on capitation, as prescribed by PP 14/93. The capitation payment system is required to assure that health services are delivered in a cost-effective way. By regulation, *Jamsostek* must pay all providers on capitation; however, in practice this system is not always possible. Doctors and hospitals are not ready for risk contracting because they are not trained to accept risks and the market for fee-for-services is still dominant. The Ministry of Health regulation on pricing system of hospitals clearly prescribes fee-for-service payment system. The environment is simply not supportive for capitation payment system, except for a relatively small number of primary care physicians. The capitation payments to primary care providers are easier to make since the required number of members for primary care capitation is low and the variance of prices is also small.²⁶ Capitation payment to hospitals is performed only in those branches that have sufficient number of members (Purwoko and Mahmud, 1998).²⁷ Moreover, capitation payments to hospitals require larger number of members due to large variations of costs per admission. Finally, hospital managers are not trained to assume risks for services they provide.

The current information system of *Jamsostek* does not support changes of membership (marital status, family size, change of employers, etc) on timely basis. The main cause of this information lag has been difficulties in updating records caused by employers neglect, employees poor awareness, and *Jamsostek's* poor information management. It is reported that often hospitals billed *Jamsostek*/MPs for services rendered for *Jamsostek* members using higher than pre-negotiated prices, but *Jamsostek* may pay the bills without noticing the errors. Currently there are more than 70 companies offering health insurance and contracting services to hospitals using unique prices negotiated in advance by many insurers. Staff at hospitals may mistakenly quote prices from other insurance carriers and bill the prices to *Jamsostek*. The second possible reason is that the staff at hospitals deliberately charge higher than negotiated prices to increase income, especially when prices of

²⁶ Thabrany H. Rasional Pembayaran Kapitasi. Yayasan Penerbit IDI, Jakarta 2000

²⁷ Paper presented at the First National Conference on Health Insurance, Jakarta, November 9-11, 1998

medical supplies and drugs are not stable. This practice may enable providers to balance overall costs where these otherwise would be lost from other services rendered. This kind of moral hazard is often reported in health insurance literature. The information system of *Jamsostek* must be designed to enable managers to identify moral hazards from health care providers and possibly by members. The existing information system is not designed to signal early warning for moral hazard.

Other problems

The ceiling of salary for premium determination (one million rupiahs) set ten years ago without adjustment is detrimental to *Jamsostek's* financial condition. Under this ceiling, employers contribute only Rp 60 000 (if married) or Rp 30 000 (singles) per month for employees earning more than five million rupiahs a month. If the ratio between employees and total members is 3 (on average two dependents for each employee) then the contribution is only Rp 10 000 – 20 000 per person per month. A commercial product sold by *Askes* costs Rp 20 500 per person per month for less liberal benefits,²⁸ much higher than contribution for *Jamsostek*. On the other hand, the private sector continues to skim the cream. For example, the average premium received by *Jamsostek* per member in 2000 was only Rp 5 224.²⁹ Many employers allocate money for health benefits higher than Rp 100 000 per employee. As a result, companies paying high salaries have more incentive to opt out so as to obtain health insurance from private insurance companies rather than enrolling with *Jamsostek*. *Jamsostek* covers only low-income employees and therefore collects relatively low contribution. The low revenues from this social health insurance puts *Jamsostek* in difficulties in improving the quality of services.

Another structural problem of *Jamsostek* is that inpatient services are limited to 60 days, including a maximum of 20 days in intensive care unit. The level of inpatient care is limited to second-class rooms in designated public hospitals or third-class rooms in designated private hospitals. Considering the limited choice of hospitals compared to the traditional health insurance product from the private sector, employers and employees will prefer the product from the private sector. Haemodialysis, cancer treatment, cardiac surgery, congenital diseases, alcoholism, drug abuses, and organ

²⁸ ___ PT Askes marketing circulations, 2002

²⁹ ___ Accounting Department, PT Jamsostek

transplant, and all services provided by non-contracted providers are not covered (Supriyono, 1998)³⁰. Drugs are covered if doctors prescribe them from a special formulary developed by *PT Jamsostek*. Because some expensive medical cares are not covered, many employees and employers consider that the benefits provided by *Jamsostek* are not sufficient and it is not worth joining it.

Commercial Health Insurance

JPKM (HMOs)

JPKM stands for *Jaminan Pemeliharaan Kesehatan Masyarakat* and is exactly the same as Health Maintenance Organization in the US. It is classified as commercial health insurance providing in kind benefits managed by various care techniques. The JPKM concept was introduced by the Health Act of 1992. More significant actions to promote the development of JPKM have been taken since 1995. Since then, the Ministry of Health has been actively promoting JPKM to various actors such as local governments, private businesses, private insurance companies, and communities at large. The promotion of JPKM aims primarily at encouraging the private sector, mainly businesses, to develop *bapels* (HMOs). A Ministerial decree regulates requirements to be *bapels*, which are basically insurance carriers mandated to provide comprehensive health benefits at the network of providers and to pay providers on capitation payment system. *Bapels* must meet capital requirements that are much less than the capital requirements for insurance companies under the Insurance Act (it can be less than 0.1% of the required capital for insurance company). In addition, *bapels* must provide comprehensive health services, quality assurance, utilization review, grievance procedures, and other cost and quality controls. Businesses that are willing to comply with and meet requirements will be granted a licence by the Ministry of Health to sell JPKM. However, those requirements are good only in theory; in practice, no *bapel* provides all capitation payment and quality assurance. Presently, the majority of licensed *bapels* are actually selling a combination of managed care and traditional insurance products.

There are 22 licensed *bapels* (commercial HMOs) covering less than 500 thousands individuals. More than 90% of those *bapels* are in the form of *Perseroan Terbatas* (a limited liability corporation, for-profit entity). Compared

³⁰ Paper presented at the First National Conference on Health Insurance, Jakarta, November 9-11, 1998

to the regulation of HMOs in America where at the beginning of HMO introduction, 96% of HMO were not-for-profit organizations,³¹ the JPKM regulation is much more liberal.

Although the Ministry of Health had to work hard to promote and develop *baepels*, the result was not promising. All licensed *baepels* could not expand memberships to poor families since the majority of *baepels* are for-profit entities seeking profits. Several pilot projects funded by the USAID and the World Bank had been undertaken in Klaten district and five other districts under the Health Project IV. Unfortunately, those pilot projects promoted business of managed care in small and relatively low-income districts. The premiums were set too low, without actuarial calculation, of inferior products. Definitely people, even the poor ones, would not buy those inferior products. The results were obviously very disappointing.

Efforts to encourage businesses and insurance companies to establish *baepels* and expand memberships have not been fruitful. The conflicting concept of JPKM that combines business and social interests at the same time and low capacity of personnel in the ministry of health did not convince businesses. Many insurance companies and even health officials within the Ministry of Health felt skeptical about JPKM. Currently, under heavy criticism, the expansion of JPKM is on hold.

Traditional Health Insurance

Before 1992, many big companies provided health benefits to their employees on voluntary basis. The scope of health benefits varied significantly from cash benefits, reimbursements, in-kind benefits, or self provision of clinics or hospitals by the companies, depending on the size and location of the companies. There were no regulation-mandating health benefits or regulating health benefit provisions. Many smaller companies often did not (some still do not) provide health benefits at all. The bargaining power of labour unions was normally weak and they rarely demanded health insurance coverage.

An Insurance Act was passed in February 1992 permitting insurance companies to sell health insurance products. The Ministry of Finance was the sponsoring agency to regulate insurance companies. However, this Act does not regulate health insurance contract. It regulates insurance business practice

³¹ ___ Managed Care: Integrating Finance and Delivery of Health Care. HIAA, Maryland, 1997

in Indonesia such as life insurance, general insurance, reinsurance, and other supporting insurance businesses. Based on this Act, insurance companies may sell any health insurance products such as traditional indemnity, managed care (similar to JPKM), personal accidents, and other forms of health insurance. The Directorate of Insurance under the Ministry of Finance is in charge to oversee and control mainly the financial performance of all insurance companies.

After the introduction of the Employees Social Security Act (*Jamsostek*) in the same year, both life and general insurance companies, started to sell health insurance as riders or as separate lines of businesses. Many insurance companies that had long relationships with businesses for life or general insurance could easily negotiate to expand their lines of businesses by offering health insurance to employers. Several foreign insurance companies such as Cigna, Aetna, and Allianz that had experiences abroad could easily transfer the knowledge and expertise to sell health insurance in Indonesia. Although there are relatively a small number of companies that can afford to buy private health insurance, since the population is big, the market for health insurance is promising. By 2001, 64 insurance companies were selling health insurance products covering more than four million people. The total premiums earned by those companies in 1999 was about Rp 700 billion, more than five times the amount of health insurance premiums earned by *Jamsostek*. These traditional health insurance products are the fastest growing business of health insurance in the country.

Micro and Community Health Care Financing Schemes

The Ministry of Health introduced the concept of micro financing scheme called *Dana Sehat* or health fund in the 70s. At that time, it was conceived that the government fund for health would be diminished because the government financing would not be sufficient. Under this assumption, the traditional very low user charges in public health facilities would result in government financing for those who really did not need the government subsidies. The government financing for public health facilities had not been reaching the right population groups such as those who deserved government subsidies and therefore there were suggestions to increase the user charges. Recommendations to increase user charges in public facilities were made by Gani et al. (1997)³² and YPKMI (1994)³³. However, higher user charges might

³² Gani, A. dkk. Laporan Analisis Biaya dan Penentuan Tarif Rumah Sakit dan Puskesmas di Propinsi Jawa Timur. Biro Perencanaan Depkes dan LDUI, 1997

pose a threat to access to health services of low-income groups. Therefore, private funds must be mobilized to finance health care of such groups. The *Dana Sehat* initiatives were introduced to respond to such recommendations. The same initiatives have also been introduced in many developing countries such as reported by Musau (1999)³⁴, Atim et al. (1998)³⁵, and Edmond (1999)³⁶

However, *Dana Sehat* schemes in Indonesia have not addressed the access problems due to very low benefits and limited coverage. Households have been spending very low percentage of their total expenditure on health, ranging from 2-4% of the total household expenditures. This low health expenditure from household sources represents the low ability to pay for health services. Data from Susenas show that many households in low and lower middle income must spend up to 80% of the household income on foods. Therefore there is little money left to purchase other services and goods such as health care and education. The *Dana Sehat* schemes were introduced mainly to the poor and low-income households by setting the contributions based on consensus among those households. This targeting was a big mistake, since the low-income households are supposed to receive financial assistance while those in higher income should actually ought to contribute to the health funds. As a result, the contribution was set at very low levels, ranging from Rp 100 – Rp 1 000 (between US 10-20 cents at the current exchange) per household and the benefits were mostly outpatient care at health centres. On the other hand, in the majority of districts/municipalities, people could get access to health centres for Rp 1 000 (US\$ 0.10) per visit. This is one reason why efforts to mobilize resources through *Dana Sehat* have been fruitless and not sustainable. There was no incentive for households to contribute to health funds when the household could pay health centre services for the same prices.

³³ ____ Laporan Analisis Penentuan Tarif Pelayanan Kesehatan di Propinsi Kaltim dan NTB. YPKMI dan LDUI, Jakarta 1994

³⁴ Musau, N. Community-Based Health Insurance (CBHI): Experiences and Lessons Learned from East Africa .Technical Report 34, Partnership for Health Reform, 1999

³⁵ Atim, Chris, François P. Diop, Jean Etté, Dominique Evrard, Philippe Marcadent, and Nathalie Massiot The Contribution of Mutual Health Organizations to Financing, Delivery, and Access to Health Care in West and Central Africa: Summary and Case Studies in Six Countries, Technical Report 19, May 1998

³⁶ Edmond, A H., Mary A. Paterson, Ahsan J. Sadiq, Linda M. Sadiq, Susan Scribner, and Nena Terrell. Establishing a Family Health Fund in Alexandria, Egypt: The Quality Contracting Component of the Family Health Care Pilot Project, Technical Report 42, December 1999

A study by Thabrany and Pujianto using the National Socioeconomic survey in 1998 found that only 1.87% of the population were holding health cards or were members of health funds. The 2001 Susenas indicated that 0.43% of the population were holding this card. There was no significant improvement in the access to inpatient care among the health fund members, but there was about 47% higher utilization of health centre services among the members compared to those who were uninsured or non-members. Studies by Silitupen³⁷, Iriani³⁸, and Asnah³⁹ indicated that very few households paid contribution for more than two consecutive years. The studies found that drop-out rates from the first year to the second year of health funds were between 60-90%. It is not surprising that since the introduction of this scheme in the '70s, there has been very little progress on such health fund schemes. After the social safety net programme for about 18 million poor families was introduced during the crisis, *dana sehat* schemes across the country were discontinued⁴⁰.

Social Safety Net Schemes

The social safety net programme concept consists of three different types of financial assistance to ensure that the poor get access to necessary health services. There were three different programmes in the health sector: (1) The first programme targeted high-risk pregnant women by providing a block grant of Rp 10 000 per poor household directly to a village midwife. The midwife then could use the fund to refer high-risk pregnant mothers to a health centre or hospital for further treatment such as drugs, services, or transportation costs. This programme increased access to hospital services for quite severe cases such as bleeding and complicated delivery.⁴¹ (2) The second programme was the promotion of JPKM (a model copied from health maintenance organizations in the US). This programme promoted the development of pre-JPKM *bapels* (pre-HMOs) by providing a fund of Rp 10 000 per poor family to companies, cooperatives, or foundations seeking to establish an HMO in each

³⁷ Silitupen, valens. Evaluasi Perkembangan Dana Sehat di NTT. Tesis, FKMUI, 1998

³⁸ Iriani, R. Faktor-faktor yang berhubungan dengan kesinambungan Dana Sehat di Kabupaten Bogor. Tesis, FKMUI, 1999

³⁹ Asnah. Faktor-faktor yang berhubungan dengan kesinambungan Dana Sehat di Lampung Barat, Tesis, FKMUI, 2001

⁴⁰ Azwar, R. Evaluasi program JPKM-JPSBK di Jakarta Selatan, Tesis, FKMUI, 2001

⁴¹ Hasan, F. Evaluasi Program JPSBK terhadap Kehamilan Risiko Tinggi., Thesis December 2000

district. The pre-bapel retained 8% of the funds for administration and marketing HMO products to the non-poor households. The objective was that after two years the pre-bapels could expand membership to non-poor by selling HMO products. Immediately, 354 pre-bapels were created—the majority of those pre-bapels were established by civil servants, pensioners or cooperatives of civil servants within district health offices. They had no experience of developing and selling HMO products. After one year, under heavy criticism, this programme was terminated and the funds for the second year were not distributed. Evaluation of pre-bapels in east Java and in south Jakarta revealed that the pre-bapels had no prospect to become full HMOs (Ekowati⁴² 2000; Azwar 2001⁴³). (3) The third programme was the assistance for health centre services by providing block grant of Rp 10 000 per poor family to all health centres. The health centre could use the money to buy drugs for the poor to supplement essential drugs supplied by the government. (4) In addition, public hospitals received some block grants for operational costs to care for the poor. The programme improved the access to the poor significantly. However, those who are marginally poor (not qualified for assistance such as self-employed, part-time workers, seasonal workers, and farmers, who are unable to pay for expensive medical care) still have financial problems to meet their medical needs. It was reported (Khumaedi, 2000) that more than 90% of beneficiaries were actually poor, met the means test, and about five per-cent of the beneficiaries could actually pay part of the care.⁴⁴

Other Problems in Access to Health Care

Health insurance for Indonesians is available from various sources. The oldest and largest health insurance scheme is the civil servant health insurance (*Askes*) established in 1968. The civil servant health insurance is a social health insurance covering all civil servants, retired civil servants, retired military personnel, veterans, and their families. The premium is two per-cent of monthly basic salary or pension that is deducted automatically by the Ministry of Finance. The benefit is comprehensive and provided in kind in public

⁴² Ekowati. Faktor-faktor yang berhubungan dengan kemandirian pra bapel JPKM-JPSBK di Jawa Timur., Tesis, FKMUI, 2000

⁴³ Azwar, R. Faktor-faktor yang mempengaruhi utilisasi JPKM JPSBK di Jakarta Selatan. Tesis, FKMUI, Depok 2001

⁴⁴ Khumaedi. Evaluasi program JPSBK di RSU Tangerang. Thesis, FKMUI, Depok 2000

health facilities, but high cost sharing applies. The second largest health insurance scheme is the social security scheme for private employees (*Jamsostek*). In theory, this scheme should cover all private employees, but the regulation was diverted to have opt out provision. Unlike the *Askes*, *Jamsostek* started in 1992 after the law of Social Security was passed. The opt-out provision of *Jamsostek* allows private insurance companies to sell various types of health insurance such as indemnity insurance, service benefits, and managed products. In addition, since 1992 the Ministry of Health has been promoting JPKM bapels (Indonesian version of controversial health maintenance organizations) as non-insurance companies selling HMO products. At present there are 67 insurance companies and 22 licensed JPKM bapels selling health insurance in Indonesia.

Health insurance coverage has been very low in Indonesia. A reliable source of health insurance coverage is the National Social and Economic Survey (*Susenas*) conducted annually by the Bureau of Census in Indonesia. Every three years, the survey includes a module of health survey specifically collecting health insurance coverage by types. The *Susenas* data of 1998 showed that only 14% of the population had health insurance of any type.⁴⁵ The *Susenas* 2001 showed that 20% of the population had health insurance, but 6% of the population had health insurance from the government social safety net programme for the poor. About eight per cent of those insured are covered by *Askes*; a state-owned company that administers compulsory health insurance. *Jamsostek*, another state-owned company that administers social security schemes, covers less than 1.5% of the population (the potential of this scheme is about 40-50% of the population). The low health insurance coverage by *Jamsostek* is mainly attributed to the "opt out" provision in the government regulation number 14/1993. Other private insurance companies and JPKM bapels cover the remainder of the insured. For more than a decade the proportion of Indonesians who have health insurance remained relatively stable. In 1990, the data published by the World Bank gave the proportion of the population with health insurance as 13% (World Bank, 1993). However, the absolute number of population covered has increased by almost ten million in the last decade due to the population increase. So the growth of health insurance coverage is about the growth of the population. Most of the

⁴⁵ Thabrany, H and Pujiyanto. Asuransi Kesehatan dan Akses Pelayanan Kesehatan. *Majalah Kedokteran Indonesia*, 50(6), Juni 2000. 282-289

growth of health insurance coverage occurred in the last two years. After the economic crisis, the growth of private health insurance coverage increased sharply due to increasing health care costs in the private sector. The HMO products sold by *PT Askes* currently cover 1.3 million people while the number of people insured by other insurance companies in 2001 has reached almost five million.⁴⁶ An employer survey found that 82% of employers having 20 or more employees in Indonesia provide various kinds of health benefits, including purchasing private health insurance for their employees.⁴⁷

Access to health centres

Primary health care in Indonesia is delivered through public health centres and private clinics or doctors in sole practices. For 85% of the population who do not have health insurance, access to primary health care varies according to their economic status, individual preference, and availability of transportation to health facilities. Local governments normally set user fees in health centres at a very low level so that all people can afford. After the Regional Autonomy Law is implemented, local governments will tend to raise user fees in order to recover the costs of providing basic health services that were funded by the Central government. User fees vary from Rp 500 to Rp 5 000 per visit including three days of medications across districts and provinces. The quality of services at public health centres, and sub health centres, are considered very poor such that the majority of the better off do not use health centres' services. Instead, they go to private practitioners in the evening, often the same doctors who provide services in health centres in the morning. Private practitioners in the evening aim to supplement their low income in the form of government salaries. Some policy-makers are considering increasing user fees so that the health centres will have adequate funds to maintain a certain level of quality. The trade off is that the poor or marginally poor may be excluded from services unless another scheme is in place.

Because user fees in health centres have been very low (less than the price of a bottle of drinking water) almost all people can afford to pay for the services.

⁴⁶ Djaelani F. Health Insurance Development. Paper presented at the Asia-Pacific Summit on Health Insurance, Jakarta 22-26 May 2002

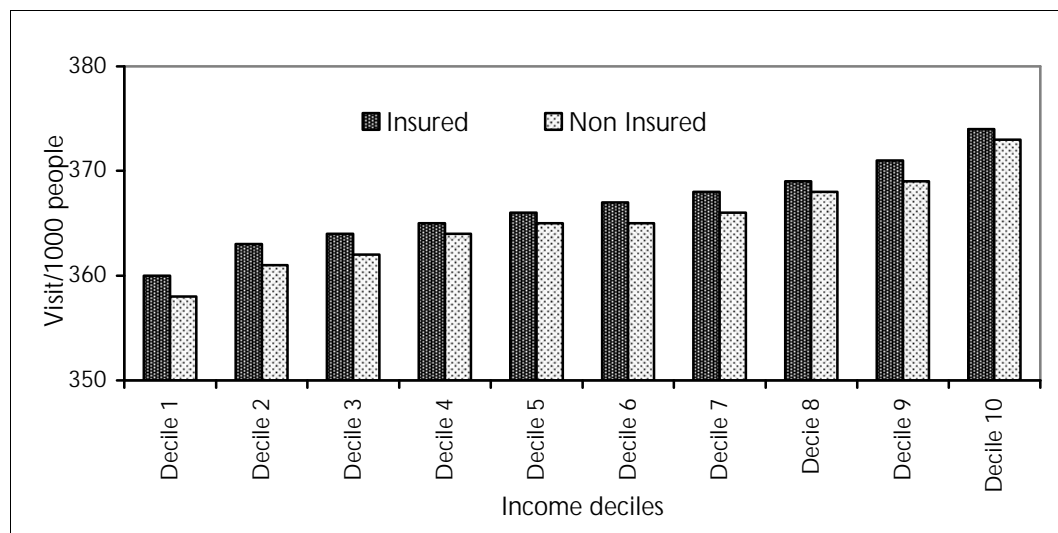
⁴⁷ Chusnun, P. et al. Laporan Final Studi Pembiayaan Kesehatan oleh Perusahaan. Pusat Kajian Ekonomi Kesehatan Universitas Indonesia, Depok 2002

Often the problem is not in the price of services, but in the transportation costs. In rural areas, only one health centre or sub health centre is available for several villages or even for one sub-district. The travel costs to health centers can be the same or ten times more than the user fees set by local governments. Numerous studies have reported that access to health centres is good only for those living within one to two kilometers from the health centre. Beyond that, many people have geographical barriers to health centres. Formal workers who normally live in relatively urban areas may not have geographical barriers to the services. To overcome geographical barriers, the government provides mobile health centres which visit remote villages on certain days. The availability of public health centres (stationary, mobile, and sub-health centre) and low user fees make access to primary health services quite good for all levels of communities. The better off who demand better services may visit private doctor in the afternoon. The chart below (Figure 2) depicts the relatively equitable access to primary health care for all groups of the population (Thabrany 2001)⁴⁸.

Figure 2 shows that the number of visits to a primary care centre per a thousand people by income deciles, from the poorest ten per cent to the richest ten per cent of the population, do not differ significantly. In other words, there has been equitable access to primary health care in Indonesia. There are some differences, however; 15 visits per thousand people between the poorest ten per cent and the richest ten per cent of the population (Figure 3). The poorest ten per cent on an average had 358 visits per thousand people per month while the richest ten per cent had 373 visits per 1 000 people. There were minor differences in primary health care centre visits between the insured and the uninsured. These minor differences were due to low health centre fees, adequate distribution of health centres, sub health centres, nurses, general practitioners, and mobile health centres. If we examine the rate of visits to private doctor's services, the differences between the poor and the rich are quite high. However, those who had low access to private doctor's services had options to visit public health services with almost no barriers. This equitable access may diminish if local governments transform public health centres into *swadana* facilities and raise user fees.

⁴⁸ Thabrany, H. Hospital and Health Insurance. Paper presented at Hospital Seminar and exhibition center, University of Indonesia, August 27-29, 2001

Figure 4. *Visit rates per 1,000 people for any outpatient care by income deciles, Susenas 1998*



One important factor for equitable access to primary health services is the proximity of those services to the population. The Indonesian health policy mandates local government to build one health centre for every 30 000 inhabitants and one sub-health centre for every 10 000 inhabitants. A public health centre has staff of at least one physician (general practitioner), several nurses and midwives, and administrative staff; while a sub-health centre has at least one nurse or a midwife plus administrative staff. There are currently more than 7 000 health centres and more than 21 000 sub-health centres through out Indonesia.⁴⁹

Access to hospital services

Hospital services are available only in the capital of a city or district. Although the government has built one small hospital for every district with at least fifty beds and four types of specialists (internist, pediatrician, surgeon, and obstetrician), the hospital is quite a distance away from the rural residential areas. A district can cover an area as wide as tens of thousands of square kilometers. In several large districts or municipalities there may be a private hospital. The majority of districts have only one public hospital. Geographical access to public hospital is more difficult than access to a health centre.

⁴⁹ Health Profile 2000. Pusdakes MOH, Jakarta, 2001

Drugs and other medical supplies are neither free of charge nor included in user fees in public hospitals. Patients must pay extra for medicines and medical supplies they need. In addition, a public hospital charges the patient for each item of all other services. These kind of charges act as financial barriers in meeting the medical needs of patients.

Although local governments normally set low user charges for hospital confinements, the true costs of a hospitalization may increase 3-10 times of the low cost of room and board. As an illustration, in one public hospital in Jakarta the room charge for third class services is only Rp 15 000 per day. A patient needing a surgical procedure and hospitalized for three days may end up receiving a bill upon discharge of Rp 900 000 covering the cost of operation, drugs and medical supplies. A blue-collar worker earning Rp 650 000 (minimum wage) in Jakarta and having no insurance must spend more than one month of her/his salary.

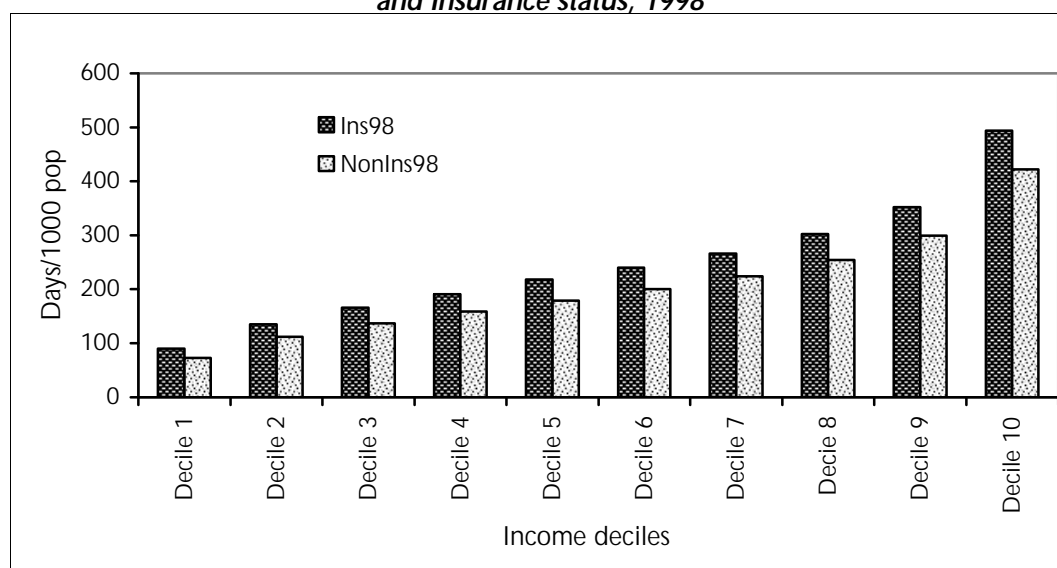
Hospital services are designed to provide secondary or even tertiary care by specialists. However, on many occasions the specialists are not always available in public hospitals because they often spend more of their time in private hospitals or in private wards in the same public hospitals. This is especially true in big cities. The low-income patients feel satisfied if one or two specialists visit them regularly. Such conditions show public hospitals in poor light. Many patients are pushed to utilize second class wards or above to receive better quality services, but then they have to pay more and there is almost no chance to have exemption or reduced charges.

Many low-income families simply do not go to hospitals because they feel that the costs of hospitalization are not affordable. As a result, there is great inequity in access to hospital services, even at public hospitals. The barriers can be geographical, cultural and financial. Financial barriers remain the largest factor. Figure 4 shows the large gaps in access to inpatient care in public hospitals between the poor and the wealthy (Thabrany, 2001). The richest 10% of the population had more than 400 hospital days per 1 000 people and members of *Askes* and *Jamsostek* (insured) had more than 500 hospital days per 1 000 people, higher than those of non-insured. On the other hand, the poorest 10% of the population and uninsured had less than 100 bed days per 1 000 people. The gaps regarding inpatient days between the poor and the rich among *Askes* members remain high because the benefits are inadequate. According to many studies, insured civil servants before the year 2000 had to pay up to 80% of the hospital costs and drugs

(Trisnantoro et al. 2000⁵⁰; Thabrany 2001⁵¹). However, currently *Askes* pay much more reasonable level after the government increased the basic salary of civil servants and contributed some funds to *Askes*. In several hospitals now, civil servants are exempted from cost-sharing except for few expensive procedures.

A study by Thabrany et al. (2000) found that the poorest 10% of the population had to spend 230% (2.3 times) of monthly total household expenditure for one inpatient care (Figure 5). Even the upper income class households on average have to pay more than one month of their salary to pay for inpatient care of their family members. Despite low cost recovery rate of public hospitals, most low-income households do not get access to inpatient care because of costs of medical procedures and expensive and non-subsidized drugs.⁵² Figure 4 and Figure 5 indicate high correlation between low inpatient days, household income, and high financial burden for inpatient care. This financial burden will continue or even become heavier for households in the future because of transformation of public hospitals and lack of insurance coverage.

Figure 5. *Hospital inpatient days per 1 000 people by income groups and insurance status, 1998*

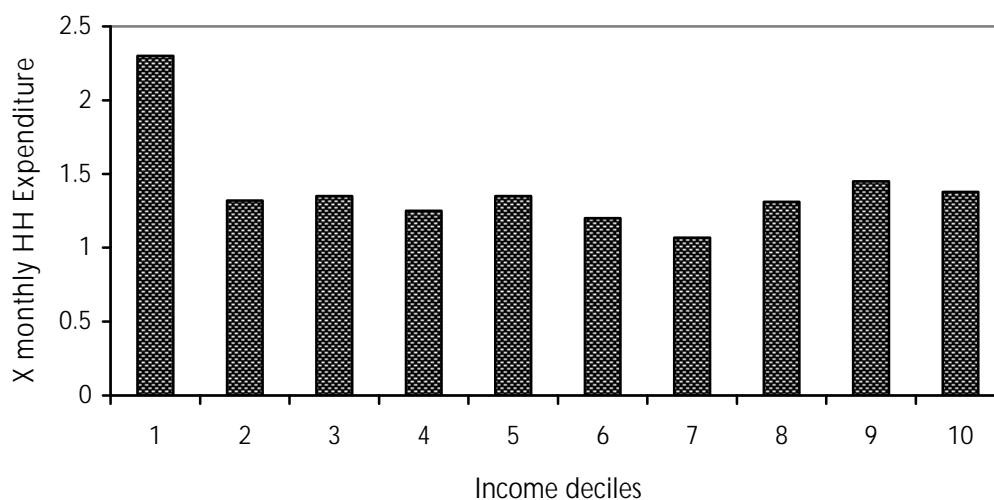


⁵⁰ Trisnantoro, et al. Evaluasi RS Pasar Rebo dalam era desentralisasi, PPEK UGM, Yogyakarta, 2000

⁵¹ Thabrany, H. Perbaikan *Askes* Pegawai Pemda DKI. Unpublished. Jakarta 2001

⁵² Thabrany, et.al. Comprehensive Review of JPK in Indonesia. Yayasan Pengembangan Kesehatan Masyarakat Indonesia, Jakarta 2000

Figure 6. **Average financial burden of households (times household monthly expenditure) for one admission by income deciles**



Quality of health services

The quality of health services, especially in hospitals, is difficult to measure because there is no standard, both in clinical and administrative services. The clinical standard developed by the Indonesian Medical Association provides only about 200 medical conditions/procedures and it is not widely accepted by specialists. Physical appearances of public hospitals and health centres generally are not attractive for middle and upper class. Upper class households generally perceive hospital services, even private hospitals, as providing poor quality services. Therefore, high class people and government officials often prefer to have medical procedures abroad, leading to large trade deficit in health sector in Indonesia.

One of the important measures of quality is user satisfaction. However, no national user satisfaction survey has been conducted in public or private hospitals. In general, policy-makers admit that the quality of services in Indonesia, especially in public providers, is poor. Evidence shows that many patients go to Singapore, Malaysia or Australia for treatment. This is an indicator of poor quality health services in Indonesia. The poor quality of public health providers may also be judged by the fact that middle-and high-

income people tend to use private providers rather than public providers. Few facility surveys showed that 80-90% of patients were satisfied with services of public providers (Warnida, 2001⁵³ and Neneng, 2000⁵⁴). Some doubt the validity and reliability of such surveys. Accreditation of hospitals is not an indication of quality, since the accreditation process emphasized only structural measures.

One of the more objective measures of quality is to examine how people choose medical care when they have options. The *Susenas* 1998 and 1999 data showed that even those who were covered by health insurance under *Askes* chose private health care facilities not covered by *Askes*. This means that those people prefer to utilize health care from the providers they believe are providing better quality, even though they have to pay out of their own pocket. The proportion of insured civil servants who utilized outpatient care from private providers paid the full costs accounting for about half of the total visits.⁵⁵ In general, people perceive that services in public providers, both outpatient and inpatient services, are of poor quality. The *Jamsostek* scheme that uses public health centres as gatekeepers attracts only those in the lower income bracket.

Grand Design of Future Social Health Insurance in Indonesia

Currently two designs have been identified of social health insurance systems. The first one is the design proposed by the Task Force for National Social Security that integrates National Health Insurance into other social security programmes. The Task Force was established by a Presidential Decree to meet the Constitutional Obligation (article 34 item 2) to establish social security for all citizens. This design will be further described in this paper. The other design is the proposal of compulsory health insurance with multiple HMOs submitted by the Ministry of Health. Under this scheme, all people are mandated to contribute to a selected *bapel*. The *bapel* must have a licence by the MoH after meeting certain capital requirements.⁵⁶ This concept is actually promoting the business of managed care (previously known as JPKM). The second design will not be described in this paper.

⁵³ Warnida, Faktor-faktor yang mempengaruhi kepuasan pasien di Paviliun Kartika, RSPAD, Skripsi FKMUI, 2001

⁵⁴ Neneng. Kepuasan pasien *Askes* dan Non *Askes* terhadap rawat jalan di RSUD Bekasi, Tesis, FKMUI, 2000

⁵⁵ Thabrany, H and Pujiyanto. Analisis utilisasi peserta *Askes* dari *Susenas* 98. Pusat Ekonomi Kesehatan, FKMUI, 1999

⁵⁶ Ministry of Health. Rancangan Undang-Undang Jaminan Kesehatan Nasional, Jakarta, February 2003

Indonesia is a very large country with 203 million people scattered in about 7 000 islands. The labour force is estimated at about 98 million people. The labour force comprises: 36.2% of wage earners and salaried workers; 51.9% self-employed; 3.4% employers, and 8.5% family workers.⁵⁷ The self-employed people are farmers, individual retailers, and very few self-employed professionals. With only one third of labour force in formal sector (salaried workers) it is not easy to mobilize financial resources to finance health care for the entire population. In addition, income per capita of Indonesians is relatively low (US\$ 700 at official exchange rates) with little disposable income for health insurance contributions. The low per capita income significantly affects household expenditures in Indonesia. The National Socioeconomic Surveys showed that between 50-70% of household expenditures in 1995 to 2000 were for foods. The disposable income becomes very small for the majority of the population.

A social health insurance system relies on contribution from employees and employers or employees only for the self-employed persons. The social health insurance system must start from formal sectors without "opting-out" provision, to allow higher income individuals share the risk with low-income workers. There are problems in determining and collecting contributions from those who work temporarily, who are self-employed, or seasonal workers. Many of temporary and seasonal workers work without a contract binding and they are paid daily or weekly by employers. Employers often do not count them as employees. The universal coverage through social health insurance means must be implemented gradually in accordance with the above situation. In addition, the scope of health services covered may be limited in accordance with the level of income and the feasibility in collecting contributions from employees and employers. The design should not enforce the informal sector to join until after all workers in the formal sector are covered.

For those people in low income bracket but in salaried jobs, they may be forced into the system with relatively low effect on their daily consumption. Even if the employees earning a low wage must contribute half of the contribution of 6% salaried workers, it may not affect their normal consumption significantly. However, if the total employee contributions for various social security programmes are above 15% of their wages, the low-salaried employees' may confront significant problems in their daily lives.

⁵⁷ Irawan, PB; Ahmed, I; and Islam, I. Labour Market Dynamics in Indonesia. ILO Jakarta, 2000

To be fair, poor and low-income people or non-salaried workers should be entitled to free or subsidized medical care funded from general tax revenues. These kinds of medical care are available in public health centers and some are also available public hospitals. Although the quality of services in public health centres or third-class public hospitals is not good to middle class standard, it is accepted by the low-income people. It is easier and more efficient for the government to provide health cards by which the low-income members are entitled to receive reduced charges or with a small co-payment in public health care facilities rather than asking them to pay regular contribution for a SHI scheme. The poor that are already identified could be provided with membership of a SHI scheme where the government pays the contribution on behalf of the poor.

Figure 6 depicts how the National Health Insurance system will work in the future. The main feature of the design are as follows:

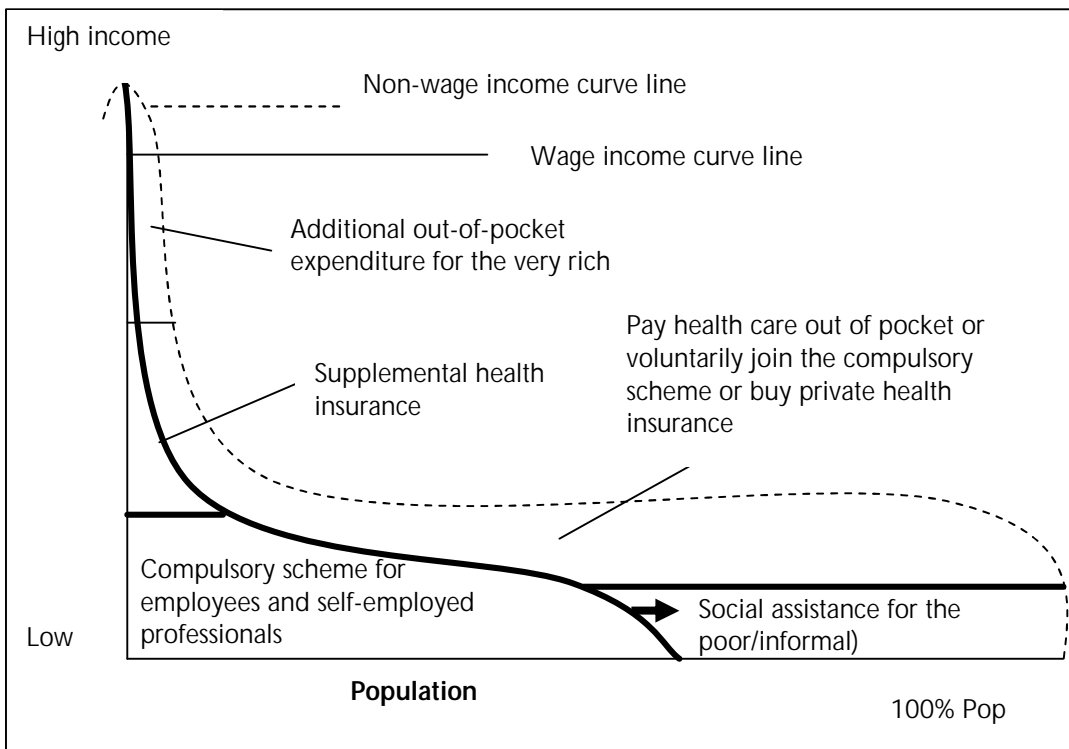
- (1) All salaried workers, and pensioners in the public and private sector regardless of their income level, are mandated to join the NHI. The employers are mandated to deduct 3% of their employees' salary (needs further actuarial study) and employers add another 3% of employees' salaries for contribution to the NHI. Pensioners must contribute 6% of their monthly pension income. There will be the same level of contribution for singles and married employees to simplify administration and to strengthen the social solidarity principle. Within the next five years the compulsory scheme must be imposed on those employers with 10 or more employees, regardless of the legal status of employers. A for-profit corporation, a private hospital, a government unit, a nongovernmental organization, a university etc. are mandated to join the NHI. Expansion of membership will be enforced gradually to include employers with one or more employees by the tenth year of the implementation. Employers must pay the contribution to Social Security Trust Fund (*Badan Administrasi Jaminan Sosial Nasional*) account along with contributions for other social security programmes.
- (2) Those who are not satisfied with the compulsory scheme may purchase supplemental health insurance from private insurance companies or pay directly to providers for differences in prices of preferred services. But they are not allowed to completely opt out of the compulsory health insurance scheme. Their entitlement of benefits from the compulsory scheme can be coordinated with a private health insurance scheme.
- (3) Self-employed professionals such as physicians, lawyers, brokers, agents, etc. are mandated to join the compulsory scheme. The contributions

may be based on the mean reported taxable income in a region and paid directly by the professionals on monthly basis along with the payment of monthly income tax. All people in this group must also be covered by 2015. The Actuarial Committee of the NHI will calculate the levels of contributions annually for each region.

- (4) On Figure 6, the income curve line of salaried and self-employed professionals (bold line) moves to the right (there will be more people belonging to this group) as time goes by and the economy of the country is improving. This means that the members of the compulsory scheme are automatically expanding as formal employment covers more people.
- (5) On the other hand, the incomes curve line for non-salaried workers (dotted line) will not move because this line also represents total population. As economy is progressing and more people are expected to enter into salaried or professional services, the number of non-salaried people will reduce. This process is expected to take 20-25 years.
- (6) The poor and marginally poor (low-income) in the non-salaried workers (under the bold horizontal line on the right) will be provided with financial assistance from the government and/or other charitable organizations. Financial assistance from the government is subject to a means test. Money for this assistance will be taken from general tax revenues or from the reduction of direct financing for health care providers or other subsidized services. This group can be divided into two sub-groups:
 - The very poor will receive financial assistance by receiving membership in the NHI for free. The government will pay the contributions for this group. The number of people in this group varies across regions. Local governments are responsible for identification of the poor by a means test developed nationally and adjusted locally. These people could be covered the same way as the continuation of the existing social safety net programmes that was terminated in 2002.
 - The low-income people and non-salaried (self employed) who do not pass the means test (marginally poor) will still not be able to afford the expensive medical care. This group must be provided with financial assistance for inpatient care and surgical procedures. However, this group should pay outpatient care, at least in public providers. The NHI will enforce these people to join the NHI at a later stage. However, they are free to join in the early stages on voluntary basis.

- (7) Those who are not in the low-income group of non-salaried workers may pay health care out-of-pocket in public or private providers depending on their income or they may voluntarily join the compulsory scheme or purchase individual health insurance from private health insurance companies. The NHI will enforce membership on this group if all-salaried workers, the elderly, and poor are already covered. Once this group enters the formal sector by becoming employees, then they are mandated automatically to join the compulsory scheme.
- (8) If the country's tax system improves significantly, thereby allowing the income of persons joining as members later, to be identified and if contributions, either monthly or annually, could be collected regularly, then they will be mandated to join the compulsory scheme. They may still purchase supplemental health insurance from the market if they perceive that the quality of services provided by the compulsory scheme is not adequate.

Figure 7. **Grand Design of Social Health Insurance Scheme in Indonesia**



The revised compulsory health insurance scheme will focus (first) on those who are not currently covered either by *Jamsostek*, private health insurance, or enterprise provided health benefits. Gradually, after five years of enactment of the law, those who are not in the system but who are currently covered under various schemes must join the system. This expansion will be accomplished by consistently provided quality of health coverage with less cost to employers and employees. It is expected that those who are currently covered under various health insurance systems will voluntarily join the scheme because they will realize that they can get adequate benefits with less money. The stages will be implemented as per the following agenda (Table 5).

Table 5. Agenda to cover the whole population under the proposed National Health Insurance

Year	Stage	People covered	Scheme
2004-2009	I	Formal (waged) employers of ≥ 10 employees, self-employed professionals, and pensioners in the private sector are mandated to enrol under NHI	Social health insurance
2004-2009	I	Small employers (< 10 employees) and self-employed can enrol the compulsory scheme voluntarily. Those who are currently covered under private insurance scheme may switch over voluntarily to the NHI	Social health insurance is not enforced
2004-2009	I	The poor and the marginal poor of informal sector (non-waged) are covered gradually starting from the very poor. Self-employed in upper income levels may join the NHI or purchase private health insurance	Social assistance, free health care at public providers or from charitable organizations, or buy private health insurance
2009-2014	II	Small employers (< 10 employees) and self-employed in low income are mandated to enrol in the NHI All employers who are currently purchasing private health insurance must join the NHI, but may still continue to purchase supplemental health insurance	Social health insurance is enforced for all employers
2015-2030	III	All groups must be covered by the NHI	Social health insurance and social assistance for the poor

Health Benefits to Be Covered and the Related Contributions

The compulsory health insurance scheme cannot be separated from the existing health care delivery system. Generally, public health care delivery system is considered as providing poor health services in term of amenities and physical appearance of the facilities. The public providers are heavily subsidized, ranging from 70-80% of the total investment and operational costs.⁵⁸ In practice, most high-income people do not use health services in public providers except services offered in the private wings of the public providers. On the other hand, private health care providers must provide (perceived) better quality services to be able to attract significant number of users. Under the current regulation, private hospitals are required to provide 25% of beds for the poor to supplement inadequate public providers. In exchange, private hospitals may receive assistance from the government in the form of building construction, medical equipments, or cash money. But in general, the charges for the poor are still relatively more costly than the charges for the same services in third class public hospitals.

One of the important elements of the NHI scheme, for it to be sustainable and attractive, is the benefits that must be acceptable by those in upper-income bracket. The lower-income brackets definitely will be happy to receive better quality services than they normally get from the public providers. Therefore, the benefits must be offered from private providers or private services in the public providers. To be efficient and in order to prevent moral hazards, the benefits must be provided in kind, and not in cash. The scheme should not provide benefits from public health centres or third-class public hospitals, except in areas where a private provider is not available. Inpatient care must be provided at least at the second-class public hospitals and in private providers. Since the level of second-class rooms and boards (semi-private) in public hospitals are lower, the public hospitals must upgrade the semi private rooms and board to be eligible to contract with the NHI. This will finally increase the overall health care expenditures. But this is necessary for a successful NHI. The providers (both public and private) must have certain standards of service to be eligible to contract with the NHI.

The benefits should be comprehensive with some cost-sharing. Cost-sharing for outpatient care must be higher: proposed at 30% of the charges set through negotiations between NHI branch and the association of health care

⁵⁸ Gani, A. et.al. Laporan Mobilisasi Sumber Dana Proyek Kesehatan IV. FKMUI-LDUI, Depok 1998

providers in a region, and facilitated by a provincial and district health offices. Cost-sharing for inpatient care and expensive medical procedures is proposed at 10% of the charges, subject to maximum of one-month minimum salary in the region. Drugs will be covered, based on a drug formulary developed by a Committee in the NHI. The NHI will conduct utilization review to audit appropriateness of medical procedures and treatments given by contracting providers. When there are no adequate providers in a region where the number of members is relatively adequate, the NHI is responsible for establishing or contracting providers, even by contracting foreign doctors if necessary.

The actuarial calculation of contributions which would suffice to bring in necessary revenues must be based on the costs of providing the above level of care. The contributions must also take into account the financial requirements to provide services for pensioners. The actuarial calculation must be conducted very soon and the level of contributions must be adjusted periodically to reflect increasing costs of health care. It is suggested that the level of contribution should not be fixed in the law since revision of a law may take years. The Government Regulation will set the level of contributions after careful calculation and study by the Board of Trustees.

Allocation of Health Insurance Revenues

The NHI is the design to be financed by two main sources of revenue: contributions from those who have regular income and contributions from government for the poor. A nationwide employer survey found that in 2001 on average, an employer spent 5.2% of employee salaries for health (Chusunun, et al., 2002). The proposed contribution of 6% salary paid by employer and employee will not be an additional burden for both employers and employees. Additional revenue will come from investment of idle funds and reserves.

Because the nature of SHI is to maximize benefits for all, the NHI is designed to be very efficient. Therefore, the Task Force decided to have a single payer system organized by a National Trust Fund. In the first five years, when the number of contributors will be relatively small, the administrative expenses may not exceed 15% of revenues from contributions. As membership grows, the administrative expenses will be reduced (economies of scale) to a maximum of 5% of contributions in the 11th year of implementation and beyond. Any surplus from the operation will be

deposited as reserve funds. The five per cent administrative costs will be shared for national and regional expenses, including performance incentives for employees of the NHI. Employees of the NHI may not be civil servants. Currently, the *Askes* scheme spends between 10-15% of the total premium revenues for administrative expenses.

Payment to health care providers will be made on prospective basis, but will not be the same nationwide as currently implemented in the *Askes* scheme. Regional offices of the NHI will negotiate with association of health care providers in a region on the payment mechanism and the level of prospective payment. Both public and private providers meeting certain standards of facilities and health professionals, are eligible for being in the NHI network of providers. It is estimated that 80% of revenues in a region may be used to pay providers in the region. About 10% of revenues in a region will be pooled into a national pool for cross-region expenses such as for referral care. The remaining 5% should be reserved for catastrophic reserve fund. The Actuarial Committee of the Board of Trustees will periodically examine the appropriate share of expenses.

Health Insurance Law

Currently a Bill of National Social Security, including chapters of National Health Insurance, is being drafted. The Task Force and Commission VII of the Parliament⁵⁹ has already set up dates to discuss the Bill intensively. Both the Task Force and the Commission VII have agreed that the National Social Security Law must be passed before the end of 2003. The law will mandate the employers to enrol and pay contributions for NHI fund. In addition, the law will establish Social Security Trust Funds consisting of one administrative and investment trust fund and two trust funds dealing with delivering of benefits. The first one is the Trust Fund for cash benefit programs covering provident fund, pension scheme, death benefit, and temporary unemployment benefit. The second is the Trust Fund for NHI administering health and occupational injury benefits. The Board of Trustees will supervise all trust funds. The Board is a policy-making body responsible for developing operational guidelines for investment and delivering benefits. The Board consists of 21 elected persons representing the employers, employees, and the government. The Ministers of Health, Labour, Finance, Social Affairs,

⁵⁹ This commission is in charge of social affairs, including health, labour, women, and population

National Defense, Industry, and Cooperatives will represent the government in the Board.

The law must strongly mandate employers and members to pay contribution on monthly basis to a SS account along with payment of regular taxes. The SS Administration will manage the memberships, including issuing social security number, investment, and channeling funds to NHI and SS Trust Funds to deliver benefits. The law must be specific and not too detailed.

The NHI Trust Fund

Because of the differences from other cash benefits the in-kind benefits of health insurance will be managed separately from other social security programmes. A special Trust Fund, the NHI Trust Fund, will be established (see Organization chart in the Appendix). The NHI combines programme for civil servants, private employee programmes, and the poor into a single pool. This combination permits cross-subsidy and portability of benefits in decentralized system. At each region, a branch NHI will manage membership administration, payment with providers, delivery of health services, and providers' claims. An oversight committee, representing tripartite parties, may be established in each region.

Efficiency and effectiveness

The combination of compulsory health insurance scheme for civil servants, private employees, and non-salaried workers will improve the overall efficiency in financing and delivery of health care to all citizens (universal coverage). Overall efficiency can be achieved through:

- (1) The collection of premiums remains integrated with other programmes and with tax collection. This collection system is much more efficient than collection by each insurers in pluralistic bapels systems.
- (2) The information system as well as social security number (SSN) will be unified with all other programmes using a unique and portable SSN for each member/beneficiary. This integrated information system will reduce duplications of coverage and memberships leading to higher efficiency and will ease portability of benefits in the dynamic labour market.

- (3) This system will enable a large number of insured to be contracted with health care providers leading to higher possibility to pay providers on a uniform capitation or other prospective payment systems. These payment systems will increase efficiency.
- (4) If non-capitation payment is enforced, this system will allow free choice of providers.
- (5) The large number of members permits the system to utilize the gatekeeper system and promote the development of family physicians as gatekeepers. Thus this system will improve the overall efficiency in delivering health care in Indonesia.

Advantages

As discussed above, there are advantages to workers and their families as well as to employers if all salaried workers are pooled into one compulsory health insurance scheme in a region. The additional advantages are:

- (1) Uniform benefit package for civil servants and private employees creates equity, simplicity and better understanding by members and providers of the uniform benefits (meeting medical needs).
- (2) Pooling of people into one pool creates maximum redistribution of income/financial burden for health services allowing effective cross-subsidies from the rich to the poor and from richer districts to poorer districts.
- (3) A big pool will improve economies of scale that will maximize benefits to members. Similar schemes in Taiwan, Medicare in the US, Medicare in Australia, and in South Korea spend administrative costs as low as 3% of the total contribution revenues.
- (4) The big pool or single payer will create buying power to health care providers that in the end will push health care costs down.
- (5) The pooling of all funds allows redistribution of health care providers in all regions in more equitable way. Under this pool, the money will follow the patients. At present, about 25% of all doctors in Indonesia are residing and working in greater Jakarta, Jabotabek (to serve about 8% of the population).
- (6) Employers do not need to bargain health insurance premiums and benefits annually with private insurers. Bargaining with health insurers needs special skills and understanding of various benefits

and health care costs. Thus, this system will permit employers to concentrate with their core businesses while their employees do not have to worry about changing benefits and insurers overtime.

- (7) This system will build stronger solidarity among employers and employees from various employments and regions. Thus this system will improve the nation building efforts.
- (8) The not-for-profit status of NHI, it will not need to pay income tax and dividends for government/stockholders. Any surplus will be returned to members in the form of services or accumulative reserves and thereby maximize the benefits to members.

Disadvantages

There are, however, disadvantages to employees and employers of this national pool as follows:

- (1) There is no choice of insurance carrier leading to potential dissatisfaction of some members, especially in the upper income. However, one should realize that choices of providers are more important than choice of insurance carriers. Insurance carriers are just payers with little effect on the treatment process and outcomes. In this single payer system, the free choice of providers can be compared to the pluralistic HMO models promoted by MoH.
- (2) Combining PT *Askes* and PT *Jamsostek* into a new Trust Fund could be affected by the previous performances and perception of low quality services created by inadequate premium levels, as well as by the improper structuring of the existing *Jamsostek* and *Askes* schemes.
- (3) The current use of public health centres and public hospitals for *Askes* and *Jamsostek* members may generate distrust among those who are currently under private health insurance schemes. The private employees may perceive that the NHI will provide poor quality health care as currently provided for *Askes* and *Jamsostek* members. To overcome this problem, for the first five years the new scheme must concentrate on those who are not covered by any scheme. Gradually the compulsory health insurance scheme must improve the quality of services while proving that the scheme

could provide quality services with much less contribution compared to purchasing health insurance from the private sector.

- (4) The NHI will manage a huge number of members in very diverse conditions and comprising scattered populations. Nationwide bureaucratic controls and uniform detail policy may create mismanagement. Some autonomous and flexible management styles, but within the framework of a national policy, must be accommodated. For example, decision making methods and the level of payments to providers must be decentralized.
- (5) A national pool of NHI will need a strong leadership by national decision- makers and very strong concept to obtain supports from various political parties and the private sectors. The task force must identify clearly and precisely all risks and the type of support needed by various stakeholders.

Potential risks

Given the existing performance and perception of services provided by *Askes* and *Jamsostek*, the risk of failure to administer the proposed scheme is very high. Therefore, a very careful design and preparation to implement the scheme must be organized. The following issues need serious attention:

- (1) Currently there are five social insurance schemes managed by state-owned companies covering traffic accident insurance, *Askes*, *Jamsostek*, military social insurance (ASABRI), and civil servants pension fund (*Taspen*). The association of social insurance providers in the Insurance Council (*Dewan Asuransi Indonesia*) may perceive that they will be liquidated and therefore oppose the NHI idea.
- (2) The Ministry of Health has already promoted JPKM for about a decade and intensive efforts have been made to establish bapels in each district. The NHI clearly will destabilize previous efforts done by the MoH and Provincial and District Health Offices (*Dinas Kesehatan*). They must be convinced that the NHI will benefit the people more than the current JPKM system. In addition, they must be well informed about the plus and minus of current market oriented JPKM and the pro public NHI.

- (3) Transformation of Askes and Jamsostek into NHI will require transformation of assets and liabilities. Identification of assets and liabilities and merging the two is a very difficult and complicated job. This work may take years to finish with some risks of hiding and losing some assets and increasing liabilities.
- (4) Political interests of so many parties currently in Indonesian Parliament may hinder the NHI. Some parties may view that the establishment of NHI and the National Social Security Trust Fund will benefit only the ruling party. They may oppose the notion based on the political interests rather than the national gain.
- (5) The open and global market forces, especially those in insurance industries, will see the NHI as lowering the probability of making business in the health insurance field. They will be more likely to oppose the NHI
- (6) The availability and the quality of health care providers may not be suitable with the expansion of insurance scheme resulting in underserving populations who have contributed to the NHI. Current shortages of specialists, because of monopolistic behavior of medical specialty societies, provide high risks of undeliverable products to the contributors. In this case, the NHI must be proactive to establish new providers or hire specialists from other countries.
- (7) The requirement of government, as employer to pay 3% contribution in contrast with 0.5% presently, will require additional expenses of about Rp 1.3 trillion annually. In addition, mandating central and local governments to pay contribution for the poor will need additional Rp 5- 8 trillion from central and local governments' budget. Current fiscal problems of the government may delay the coverage for the poor.
- (8) Employers in the private sector may object joining the NHI on the basis of increasing burden for contributions. Although in the long-run the NHI will be more likely to benefit the employers and the employees, current very competitive markets may push the employers to reduce labor expenses, thus opposing any mandatory contributions.

Strategic issues

To be successful, before the NHI starts expanding and merging *Askes* and *Jamsostek*, several strategic issues must be carefully prepared.

- (1) At least a two-year preparation is needed to set up management information systems, and human resources who fully understand and are skilful to run the system.
- (2) The government must develop easy and marketable name, vision, mission, goals, and strategic planning of the new Trust Fund.
- (3) Detailed standard procedures and forms must be developed in the beginning itself, right after the NHI is passed by the parliament. It is estimated that at least two years preparation, by experts on full-time basis, is needed.
- (4) Members of the Board of Trustees and Directors must be recruited professionally and from highly reputable, clean, and dedicated persons. Persons of any doubtful integrity will result in a big failure.
- (5) The management should implement a merit system to optimize benefits to the members and reduce the potential at corruption in managing large amounts of money.
- (6) In the second year after the law is passed, intensive training must be provided for Board of Trustees, Board of Directors, managers of current *Askes* and *Jamsostek*, all operators of *Askes* and *Jamsostek*, and all providers interested in contracting with the NHI. Training can take several days for BOT to several weeks for operators.
- (7) Socialization or social marketing efforts must be executed for all stakeholders intensively through various media (TV, seminars, newspapers, magazines, local networks, web, etc.) at national and regional levels so that all stakeholders are fully aware of the benefits of their NHI to them. They must understand that mandatory membership without exception will benefit them instead of creating more burden. The employers must understand that pooling of all resources into the NHI will give them competitive advantages in the global market by easily predicting labour costs and therefore costing their products competitively.
- (8) In addition to socialization, the Trust Fund must always maintain a website providing current information on contributions, financial

status, administrative expenses, medical expenses (claimed), surpluses, and development plans. This website will provide transparency in the management and must be accessible by any member at any time.

- (9) In addition to the website, conventional communication systems such as newspapers, television, and radio must always be provided to members to encourage them any ideas, concerns, criticism, etc. to improve the management of the Trust Fund.

Further Actions

- Subsidized study tours to neighbouring countries (such as Australia, Taiwan, South Korea, Thailand, and the Philippines) for Parliament members, decision- makers, employers and employees associations may help to pass the law smoothly. The aim of these tours is to desensitize employers and employees in resisting the NHI. They must see what other countries are doing with social health insurance/national health insurance system. Legal and policy-makers and other stakeholders need to be convinced that the proposed NHI will provide more advantages than harm to the stakeholders. Part of the travel costs must be borne by employers.
- Publication of various aspects of the NHI in Indonesia and in other countries through professional media (such as journals, text books, etc.) and public media (newspapers, televisions, magazines, and radios). The new scheme must provide at least 0.5% of the revenues in the first five years for these activities. Academicians, professionals, journalists, and independent writers must be given financial incentives to spread the good news of the NHI in this country and in other countries. The main objective of this programme is to make employers and employees who are currently under the opt-out option realize the benefits of joining the NHI.
- Incorporating social health insurance and social security topics in the curricula of medical, economics, nurse, and public health programmes at various universities. Special workshops must be undertaken for medical, nursing, and hospital communities including the students.

Figure 8. **Organization of the social security and the national health insurance proposed by the task force**

