



Healthcare System Country Notes Asian Region

Indonesia

The purpose of the IMSA National Health Insurance (NHI) web-site is to put in the public domain material and evidence that will progress the technical work of developing a National Health Insurance system in South Africa. This series of Country Notes is a collation of material submitted by independent researchers who are willing to place their research notes in the public domain. The collated notes, together with other studies found in the public domain are presented as a service to researchers, policy-makers and stakeholders who are looking at health reforms around the world.

A. Medi-Clinic Research Notes: The Health System in Indonesia

History:

- In the early 20th century, the Dutch established a mandatory health insurance scheme for civil servants. The provider was the governmental hospital which supplied free, comprehensive package of benefits. In 1938, all civil servants and their families were included under the same benefit package (Askes); in 1948 a 3% co-pay for inpatient services was introduced.
- In 1968, Askes Persero was established to finance and deliver health insurance service to civil servants.
- In 1968, PT Askes was granted the rights to manage its own insurance fund to support administrative and functional operations.
- In 1991, PT Askes broadened its markets and product coverage to the provision of commercial health insurance programs to the public.
- In 1992, Jamsostek social security based program for private employees and employers was introduced.
- The platform for universal coverage was established in 2004 with the introduction of Askeskin, which was designed to increase access to, and the quality of, health services for the poor.
- The program had two components: (i) operational funds provided to the Puskesmas (health center at sub-district) in the form of capitation payments; and (ii) a fee for service health insurance scheme, covering third class hospital beds and reimbursed through PT Askes.
- The program differed from the previous programs for the poor in two major ways: (i) rather than being a purely government-run program, it provided a block grant to PT Askes, which then targeted the poor with Askeskin cards and refunded hospital claims; and (ii) the beneficiary cards in the program were individually targeted rather than household cards as in previous programs.
- In 2008 Jamkesmas program was implemented and will serve as one of the key building blocks of the government's proposed universal coverage scheme, which is designed to synchronize the multiple health insurance schemes.

Current:

- Other than Askeskin, various health insurance schemes that are in operation include a mandatory social health insurance for civil servants (Askes), and the military (Asabri), SHI for private sector employees (Jamsostek), community health insurance, private commercial health insurance and employer-covered health insurance.
- The benefits provided by these insurance schemes vary greatly and are not comparable with each other.

- Askes is a mandatory SHI for civil servants.
- Askes is managed by PT Askes, a state owned health insurance company.
- Under this scheme, all civil servants contribute 2% of their monthly salary which is matched by government.
- The scheme covers about 13.8 million beneficiaries, comprising of 4.5 million civil servants and 9.3 million dependants.
- Regardless of the level of contribution, all beneficiaries are entitled to comprehensive health benefits considered medically necessary.
- A second similar scheme for the police and military and their dependents is managed by PT Asabri, another state-owned insurance company, covering about 2 million people.
- The third is Jamsostek, which is a SHI scheme for private sector employees.
- The scheme is managed by PT Jamsostek, a state owned social security company.
- All companies employing at least 10 workers are mandated to join the scheme, but companies having the same or better health insurance benefits can opt out from the scheme.
- The premium is paid by the employer at 3% for an unmarried employee and 6% for a married employee.
- Because of the opt out clause, out of a total 19.8 million employees enrolled at Jamsostek in 2005, only 2.74 million were signed up in its health insurance scheme.
- In addition there are several private, community, and employer based health insurance schemes. In 1999, it is estimated that around 4 million people are insured through private insurance.
- It can be seen that out of 36 million formal sector workers, only 16.8 million workers (47%) are contributing to Jamsostek and Asabri schemes. This percentage has been declining as employment shifted towards the informal economy or non-complying small business enterprises.
- Health insurance by Askes and Jamsostek have more extensive coverage including family members.
- The number of persons covered by Jamsostek is 3.1 million (1.4 million of them are workers).
- The coverage of Askes is 15.6 million (5.6 million of them are workers).
- Thus about 18.7 million people are covered by the formal health insurance schemes.

Reasons for the low penetration of social insurance in the private formal sector include the following:

- Legally only enterprises with 10 or more workers, or a payroll of over one million rupiah a month are required to enrol their workers in Jamsostek, the social insurance fund for the private sector. If the legislation is interpreted as its original intent, then the potential capture group for Jamsostek could be as high as 70% of the formal sector workers.
- Moreover, there is some evidence of contribution evasion by means of under-declaration of contributory wages. A common type of under-declaration is to report the basic wage only that excludes various allowances and bonuses. This is common practice for Jamsostek health care programme.
- There is an opting out clause for employment injury and health insurance of Jamsostek. Although the coverage is compulsory for the old-age and death benefits, an employer is allowed to "opt out" to a private insurance that provides higher level of benefits. This clause inevitably results in the evasion of large enterprises from the scheme and thus limits the redistributive effect.
- Jamsostek has no inspectors under its own control to enforce compliance, and relies on the activities of Labour inspectors currently deployed into regional government.
- Jamsostek has an unfavourable image amongst many workers, and some are reluctant to contribute to it.

Askeskin:

- In 2005 Indonesia instituted a new health card system for the poor to replace the former Kartu Sehat which had been issued to poor people as part of the Social Safety Net Programme.
- The distinctive feature of the new system was the issue of health cards by Askes, the existing health insurance provider for many formal sector workers, with the Government paying premiums on behalf of the card holders. The health insurance programme for the poor is called Askeskin.
- Two distinct phases characterise the new health card programme:
 1. In the first Semester covering the period January to May 2005, a target of 36.1 million covered individuals was set. This was equivalent to the estimated number of poor people in Indonesia, at just under 17 per cent of the population. Districts were allocated quotas on the basis of the estimated number of poor people resident in the district, with the local authorities providing the lists of qualifying individuals to the local branch of Askes. The cards then issued covered both free outpatient primary care in the local health centres (Puskesmas), and free treatment at hospitals, generally 3rd class public hospitals. Askes received funds to cover both areas, and in turn reimbursed hospitals and health centres on a fee for service basis for health services provided to card holders.
 2. For the second semester covering June to December 2005, a higher target of 60 million was set, to include the estimated number of poor and near-poor. However, a major change in coverage was made. Direct funding of the health centres was resumed, with funding going from the Ministry of Finance via the BRI Bank to the District Health Office. Fund holding by Askes was limited to the amount allocated to pay for use of hospital services. Health card holders continued to get free treatment in the health centres. Under the revised system funding for services delivered by Puskesmas is thus allocated directly to each district, as previously, with an allocation also to the provincial government to fund support services. Askes receives the funding for hospital health services for the poor who hold their issued cards.
- As of mid-2007, the coverage of this programme was estimated at 76.4 million. It should be noted that the funding arrangement was changed again in 2006 where the funds for both primary out-patient care through health centres and inpatient care at hospitals are channelled through Askes. In the second-half of 2007, the funding arrangement was once again changed to a separate system for direct funding to local health centres and for social health insurance through Askes covering in-patient care. One reason for the frequent policy changes would be the insufficient budgetary allocation by the government. In 2007, the Department of Health initially allocated only Rp. 1.7 trillion for this programme, while the estimated premium for Askes was Rp. 4.3 trillion.
- Askeskin holders can receive basic outpatient health care and third class hospital care for free.
- In addition, Askeskin coverage includes an obstetric service package, mobile health services and special services for remote areas and islands, immunization programmes and medicines.
- Based on the SHI scheme, benefits are comprehensive with a managed care concept.
- Benefits for the indigent consist of:
 - Primary health care at centres, sub health centres; care provided by midwives due to shortage of doctors.
 - Secondary health care at district hospitals as referred from the health centres (no referral in an emergency).
 - Birth delivery by midwives, doctors in hospitals or clinics.
 - Drugs based on the Drug List of PT. ASKES.
- The premium for the poorest segment is paid by the government (a population of 36 million)
- The premium is Rp. 5 (US\$ 0.53) per member per month.
- Those that are less poor pay their own premiums.
- According to the National Social Security System, the health insurance program for the indigent is embryo to the NHI.

- Management of funds to compensate health centres and hospitals for delivered services under Askeskin is delegated to PT Askes.
- Almost all public hospitals have negotiated an agreement with PT Askes about programme coverage under Askeskin.
- Programme coverage appeared to be wide and problem with fund disbursements were minimal, with an average of 26 days before reimbursement is received.
- More than 90% of hospitals have negotiated coverage for emergency services, outpatient services and most inpatient services (such as third class accommodation, medium and large scale operation and birth assistance).
- The majority of the private sector is not participating in Askeskin. Only a third of private health care providers accept Askeskin cards for some services.
- In 2007, the coverage increased to 76.4 million.

Problems experienced so far with the new system in terms of coverage include:

- Problems in reaching all the poor. In the first phase only an estimated 80 per cent of the quota numbers were actually achieved. There was some difficulty in registering those who did not have local residence cards.
- Targeting accuracy was problematic, with some poor households missing out on card allocation, and some non-poor people receiving cards. Also, it was difficult to quantify the number of poor people within the country (for planning purposes).
- Socialisation problems in getting some card holders to believe that they will actually receive the services covered by the cards
- Excess allocation of cards by some districts.
- The “temporary letter” from village heads giving people the equivalent of Health Card free services in Puskesmas (local health centres) still seems to be operating.
- There are also some administrative issues around the interface between Askes and the government, and Askes and the hospitals.
- The costing basis for bulk funding Askes is still in evolution. There is still limited available information to assess premium and benefit setting. The initial allocation of Rp. 5,000 per month per card holder was reduced to Rp. 3,000 once the shift back to direct funding of district health centres was made.
- It has not yet been possible to replace fee-for-service funding to hospitals by capitation payments, although this is the intent of the policy direction. Cost estimates are Rp. 150,000 a day for 5-6 days for inpatient care.
- Excess claims are investigated by monitoring teams. However, there is a fund to cover some catastrophic care cases.
- Hospitals have complained about late reimbursement by Askes.
- Reimbursement of hospitals on a fee-for-service basis is likely to create long term problems of cost control.
- The return to direct government funding of the health centres removes any funding pressure for efficiency improvement in these centres. Currently, the Puskesmas are of highly variable quality.

Provision:

- There are a mix of public and private providers. The government provides primary health care centers known as Puskesmas to all of the sub-districts.
- There are more than 7,200 Puskesmas all over Indonesia. Each puskesmas has at least one medical doctor and other assisting health service personnel. The government has been trying to provide a midwife as well to every village.
- The private sector also contributes primary health care services, mostly delivered by physicians in private practice and allied health personnel.
- In the 1980s government decided to limit new construction of hospitals until the year 2000 in order to control public expenditures.
- To meet anticipated increases in demand, the government has adopted a policy to deregulate and encourage private investment in hospitals. The policy has resulted in a major growth in private hospitals and beds.

- Following a Presidential Decree in 1991 which encouraged the development of autonomous institutions for all public services which serve social functions, the Ministry of Health established standards for public hospitals to become more autonomous. These standards included demonstrating a level of cost recovery of at least 50% of operating costs. These hospitals are known as Swadana hospitals.
- In these cases, the hospital acts like a tax collector for the local government. Unlike many other countries, the fees collected by Indonesian hospitals have been significant — 30-80% of total income.
- Swadana hospital management is allowed some discretion over setting of fees, however it is always subject to the approval of authorities.
- Fees for three classes of hospital bed service (VIP, First and Second) are officially at the discretion of the hospital (within some limits) and the Third Class (for the poor) were established by the national or provincial authorities.
- The non-Swadana hospitals have little incentive to collect the fees, and in many districts and provinces the local government subsidy is less than the own source revenues that are turned over to them.
- There are approximately 1.234 hospitals in Indonesia, out of which about 41% are government owned. Approximately 9.% of the hospitals are owned by military organizations and the remaining hospitals are owned by private companies.
- Most of the private hospitals which operate in the big cities are profit orientated.
- PT Askes reimburses hospitals on a FFS mechanisms and Puskesmas on a capitation basis mechanism.

Funding:

- The Ministry of Finance transfers funds to the MOH based on the budget, rather than needs and demands.
- In 2007, the MOH took the responsibility for reimbursing hospitals for care provided under Jamkesmas.
- The private health sector, which provides services to some 40% of the population, exists in parallel, with little public oversight regarding the quality of services.
- An impressive expansion of public health system infrastructure occurred in the 1970s and 1980s. Construction of the primary care networks and Puskesmas was financed mainly from the central government budget.
- By 2006, there were more than 8000 Puskesmas, of which about 31% provide inpatient facilities.
- Access to public health services has been further improved with the establishment of about 22,200 health sub-centres (Pustus), and about 8,500 mobile health centres.
- In 2006, 36% of total beds were in the private sector and 44% of total hospitals were in the private sector.

Problems with the current system: Outcomes vs. objectives

- The current system is inequitable, with benefit packages and contribution levels varying significantly between the three schemes (Jamsostek, Askes and Askeskin).
- Each of the three major health financing programs has a particular constituency and its own set of eligibility criteria.
- There are some differences in drug benefits and differences in whether services can be obtained from largely public (Askes and Askeskin) versus private providers (Jamsostek).
- Jamsostek does not cover certain high cost treatments.
- Askes covers catastrophic health expenditures, but many participants go outside the program, particularly for outpatient medical care. This has resulted in significant OOP costs have resulted for Jamsostek and Askes beneficiaries (estimated at 40% of total costs). Continuing large OOP payments suggest that the level of financial protection provided by those insurance funds may be limited.

- Jamsostek is funded by 3% payroll contribution, Askes by a 4% premium split by government and employees, and Askeskin is funded through general revenues. Furthermore, there are no cross-subsidies between the schemes and no risk equalisation, leading to fragmented pools.
- There are large urban and rural inequalities, and overall low quality of service provision.
- A number of design and targeting issues have led to a much larger expenditure level than foreseen; budgets have tripled since the start of the program and have continued to increase. Healthcare expenditure as a % of GDP rose from 1.9% in 1996 to 2.2% in 2006. The public share increased significantly from 42% in 1996 to 50% in 2006. Government health expenditures as a share of the budget increased from 4.3% to 5.3%, while household OOP spending decreased only slightly from 36% of all spending to 33%.
- Healthcare spending per capita increased from US\$20 in 1996 to US\$34 in 2006.
- Direct OOP payments constitute a large share of the financing of health care, and are potentially a significant burden on poor households.
- The increase in OOP payments by the poor may be related to higher levels of utilization resulting from the introduction of cover. Households that would have forgone care in the past may now be seeking care at health facilities because they now own a health card.
- However, the health card does not cover all costs of treatment, particularly drug costs if the drugs are not available in the facility itself, which may have led to increased OOP costs.
- The rate of increase in utilization rates was higher for the poorest quintile than for the richest quintile for all types of public sector services.
- In particular, the poorest quintile's utilization of the public hospital inpatient services quadrupled during this period, compared with a more moderate increase of approximately 50% for the richest quintile.
- There are insufficient health professionals to meet demand.
- Since 2004, public service utilization has increased, while private provider utilization rates have decreased. Public health service utilization rates have increased by almost 100% since 2004.
- Medical doctors are in short supply, not well distributed and are often absent from public facilities during working hours, tending to their private clinics instead.
- Health insurance coverage via Jamsostek for private employees is voluntary for smaller firms (only 14% of total private employees are covered).
- Furthermore, private employers have the option of opting out of Jamsostek and purchasing private health insurance. This has led to inconsistencies between coverage rates of private employees.
- PT Askes (which administers Askes and Askeskin) and PT Jamsostek (which administers Jamsostek) are for-profit entities.
- Both PT Askes and Jamsostek also sell private commercial insurance for their employees.
- Almost 50% of the population lives below the poverty line (US\$2 a day).
- Most of the population have informal employment, making premium collection difficult.
- At the end of 2008, Askeskin covered about 76.4 million poor people.
- Certain critical health outcomes, such as maternal mortality, are poor, and improvements in others have stagnated.
- Poor quality of care results in high levels of self-treatment.
- Dual practice of public physicians impacts public sector access, efficiency and overall health system and OOP costs.
- Hospital occupancy rates are low- about 60% in 2006, and there are large regional differences in hospital efficiency.
- Over half the population has no formal health insurance coverage.

Mandatory health insurance goals:

- The ultimate purpose of the reform is to improve health outcomes; provide financial protection from impoverishment resulting from large, unexpected health care costs and ensure responsiveness of the system to consumers.

Recent steps taken:

- In 2008, Askeskin (health insurance for the poor population) evolved into Jamkesmas (health insurance for the entire population).
- The scheme was changed after the MOH found alleged mark-ups at PT Askes.
- Jamkesmas will serve as one of the key building blocks of the government's proposed universal coverage scheme, which is designed to synchronize the multiple health insurance schemes.
- The MOH has given PT Askes until October 2009 to become a not-for-profit entity. Failure to do so would result in the MOH taking the role of the administrator.
- In the meantime, the MOH has taken on the responsibility of reimbursing hospitals for care provided under Jamkesmas.
- The difference between Askeskin and Jamkesmas is that under Askeskin, insurance claims were verified by PT Askes and the money was paid to hospitals through the firm. With Jamkesmas, claims are verified by independent auditors and the money is paid directly to hospitals.
- In a recent survey of 868 Jamkesmas cardholders, 40% said they still had to pay a large part of hospital fees. Most respondents were also unaware of the privileges they were entitled to with Jamkesmas cards.
- In 2008, government spent \$405 million on Jamkesmas to cover 76 million people.

Factors to be taken into consideration:

- Overall management of the health sector is highly fragmented across several ministries, among different levels of government.
- The legislation contains few specifics with regard to critical aspects of the new system, including timing, transitional arrangements, exact roles of existing insurance entities, the exact form and governance structure of the ultimately unified NHI, breadth and depth of benefits covered, contracting arrangements, provider payment mechanisms, contribution levels, etc.
- Another complexity resulting from the law is an allowance for local governments to opt out of the national system so long as they can provide comparable coverage.
- If opt outs are allowed, as they now are for Jamsostek, employers must be compelled to live up to their social responsibilities and to provide and purchase PVHI effectively.
- There is still geographic inequity around access to medical specialists and hospitals.
- The number of for-profit private hospitals almost doubled in the last five years, while the number of not-for-profit private hospitals remained the same.
- Jamkesmas finds it difficult to compete against the fee for service system for doctor and medical specialists.
- No attention in reforming the doctor payment. The fee for medical doctor from Jamkesmas is too low, and specialists therefore prefer treating middle/upper income patients as they can receive higher fees.

Reform options:

- The Social Security Law, as enacted, appears to envision a single mandatory health insurance system based on social health insurance and equity principles – contributions from the employed and government contributions for the poor.
- Existing public health insurance programs would convert to non-profit entities and be absorbed into the administrative structure of the MHI system.

Option 1: Jamkesmas for all (an Indonesian National Health Service)

- The first approach approximates an NHS like those in Sri Lanka and Malaysia. It reflects the fact that over half the Indonesian population are poor, and thus have very limited ability to pay. It also recognizes that more than 60% of workers are in the informal sector. By covering formal sector workers through general revenues, firms might be more competitive because their 3-6% payroll contributions would be eliminated or could be replaced by more efficient and equitable taxes.

Option 2: A single integrated MHI fund

- This approach approximates the new national SHI model (now called MHI), in which MHI would be funded through both wage-based contributions for public and private sector employees, and general revenue contributions by the government for the poor.
- Under this approach, there would be a single standardized NHI fund (although multiple funds could be established, as in Germany and Japan).
- The government would need to decide if informal sector workers would be covered like the poor (as in Thailand) or whether mechanisms can be developed to effectively identify them and have them contribute some share of their earnings.

Option 3: Universal coverage through an MHI system

- Existing programs would be scaled up to include the entire population.
- All the poor would be covered through Jamkesmas.
- All private sector workers would be covered through Jamsostek (possibly through elimination of the opt-out, employer size, and wage ceiling restrictions and adding requirements to cover retirees).
- Civil servants and civil service retirees would be covered through Askes (or Askes could be folded into Jamsostek).
- A decision would need to be made about how to handle informal sector workers.
- The three programs would have separate administrative structures, but would operate under the same set of rules concerning issues such as benefits, contracting for services, and provider payment.
- Cross-subsidies across programs might be required on the financing side.

Issues in costing:

- Obtaining appropriate data, including claims data, to do actuarial costing studies has also been difficult.
- One actuarial study estimated that to cover actual costs for Askeskin, premiums should be on the order of Rp 8,500, 60% above the current levels.
- Another study of scaling up the existing programs to achieve UC with a standard Basic Benefit Package (BBP) showed that public expenditures would increase from 0.7% of GDP in 2010 to 2.9% in 2025.
- Looking at utilization estimates, it was estimated that by 2025, if the current system remained unchanged, outpatient visits would increase by 33% and inpatient visits by 30%. However, if Jamkesmas was extended to the entire population, there will be a 79% increase in outpatient utilization, and a 134% increase in inpatient utilization by 2025, given supply constraints and utilization differentials between the insured and uninsured.
- Comprehensive fiscal sustainability and actuarial analyses of Jamkesmas, as well as universal coverage options have not been undertaken.

References:

International Labour Organisation, Indonesia: Providing Health Insurance for the Poor

World Bank, Health Financing in Indonesia- A Reform Road Map

Thabrany H., Politics of National Health Insurance of Indonesia: A New Era of Universal Coverage, 2008

Sparrow R et al, Public Health Insurance for the Poor in Indonesia: Targeting and Impact of Indonesia's Askeskin Programme, June 2008

Hidayat B., The Effects of Mandatory Health Insurance on Equity in Access to Outpatient Care in Indonesia, Health Policy and Planning; 19(5): 322-335, 2004

Produced during 2009 and supplied to IMSA March 2010.

B. The Joint Learning Workshop on Universal Health Coverage: Indonesia

"The Joint Learning Workshop on Universal Health Coverage, held in Gurgaon, India on February 3-5, 2010, convened 120 representatives from six countries – Ghana, India, Indonesia, Philippines, Thailand and Vietnam – and several international organizations to share experiences in carrying out health coverage reform domestically, as well as to learn from the experiences and challenges of reform processes in other countries."

<http://jlw.drupalgardens.com/>

The site has one report on Indonesia:

A brief description of the context and history of health insurance reforms in Indonesia, as well as the design, implementation and operations of the current national health insurance scheme.

<http://jlw.drupalgardens.com/content/country-case-study-indonesia>

Accessed March 2010.

C. WHO Regional and Country Experiences

Strategy on Health Care Financing for Countries of the Western Pacific and South-East Asia Regions (2006–2010)

http://www.who.int/health_financing/documents/cov-wprosearo-strategy2010/en/index.html

"Supporting adequate, sustainable, equitable and effective health financing to improve health outcomes is one of the most important goals of the World Health Organization. The Executive Board of WHO and the Fifty-eighth World Health Assembly have discussed and provided strategic directions on sustainable health financing, universal coverage and social health insurance.

The Strategy on Health Care Financing for Countries of the Western Pacific and South-East Asia Regions (2006–2010) is intended to translate this important policy direction into regional, national and sub-national actions. The strategy aims to provide operational and practical guidance to Member States in improving overall health care financing policy development to achieve adequate, stable and effective health financing that provides equitable access to health services of assured quality.

The strategy is closely linked with broader health system and sector development issues. The WHO functional framework for health system financing is used to address health care financing issues and challenges together with international health and development goals. The strategy reflects the main findings and recommendations from international, regional and country-specific experiences, available evidence, regional and bi-regional meetings and consultations on health care financing."

Country Experiences: Indonesia

"A selection of countries' experiences with recent health financing policy reforms are included here. The examples, although by no means exhaustive, highlight specific concerns of policymakers from different countries, and related policies to address these concerns."

Recent developments in Indonesia

"... intense debates on health financing reform, focusing on the establishment of an Indonesian National Health Insurance Scheme, have taken place in Indonesia. On the 19th of October, 2004, the

president at the time, Mrs Megawati, signed the National Social Security Act (NSSA), which stipulates that all residents contribute to the proposed health insurance scheme, with government paying the contributions for those who are unable to pay. The WHO has been supporting a core team of national experts in drafting the first details for the implementation of social health insurance.”

http://www.who.int/health_financing/countries/searo/en/index2.html

These notes have been collated for IMSA from submitted research material.
The material has not been independently reviewed, checked or verified.

Professor Heather McLeod

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