World Health Organization
Regional Office for South-East Asia

Regional Conference on "Revitalizing Primary Health Care"
Jakarta, Indonesia, 6-8 August 2008

SEA/RPHC/2008/13
31 July 2008

Health System Strengthening using Primary Health Care Approach

Panel C: Health Financing and Poverty Alleviation

Topic:

Health insurance for the poor

By: Professor Dr Ali Ghufron Mukti

HEALTH INSURANCE FOR THE POOR

As in other developing countries, Indonesia is facing problems of access, equity, efficiency, quality of health services and approximately 70% of health care expenditure is currently paid “out-of-pocket”. These problems have been exacerbated by the 1997/98 economic crisis, and it is leading to a fall in the national per capita income. At the same time, a government reform through decentralization was implemented. Since 2001, local government has authority in almost all aspect, except .fiscal, national security, foreign policy and religious affair.

The most vulnerable and affected group during the struggling finance phase is the poor. For the poor, the risk of severe illness and earlier death from disease is considerably higher than for those who are financially better off. Due to this condition, they are less able to recover from the financial consequences of out-of-pocket payments and loss of incomes related with ill health. For most people illness still represents a huge threat to their income earning capacity. Besides the direct costs for treatment and drugs, indirect costs that resulting from the lost labor because of illness have to be shouldered by the household. The poor do not just undergo the high risk in their life, within its consequences they actively try to manage risk and cope with. Delay treatment, self medication or even doing nothing is among their choices.

The emergence of the Indonesian for poor health insurance system was influenced by the above mentioned problems. The crisis and the decentralization have raised awareness and concern over a sustainable health care financing in Indonesia. Government is increasingly realizing the value of developing health systems that provide health care, in a way of financially protecting the people in the fairest way possible. To protect the poor and reducing out-of-pocket payments, the central government started in 1998 with the development of pro-poor policy such as social safety net for health (JPS-BK). Government has developed a health financing scheme namely the *Jaminan Pemeliharaan Kesehatan* (JPK). In 2003, a pilot project started in 15 districts and two provinces in Indonesia, and the following year was expanded to some additional regions. The name of this program has changed several times. In 2005, it was known as Health Care Security for the Poor (JPK-MM), then became Health Insurance for the Poor (Askeskin) and it was known as Community Health Security (*Jamkesmas*) since 2008.

Government's commitment to ensure that health care is accessible for the poor through this scheme is much appreciated. With a slogan „Health for the people“ and funded by central government budget (APBN), JPK-MM Askeskin has implemented as a step toward to universal coverage. A question that remains of paramount importance in a majority of the world’s countries is how their health financing systems can provide sufficient financial risk protection to all of the population against the cost of health care. Increasing utilization of health care will increase the cost of health insurance scheme. While the spending is remaining increase and hospital or primary health care center is unable to overcome within the Jamkesmas budget, Local government has a responsibility to finance the gap. It can be a burden on the budget of local government (APBD) in a low fiscal area.

Health-care programs in Indonesia have elements of a three-tiered health insurance system. Under the first tier, social health insurance is provided through PT Askes and PT Jamsostek. Askes is a compulsory health insurance scheme for active and retired civil servants, retired military and police officers, veterans and national patriots, and their families. Jamsostek is the social security scheme for private sector workers and

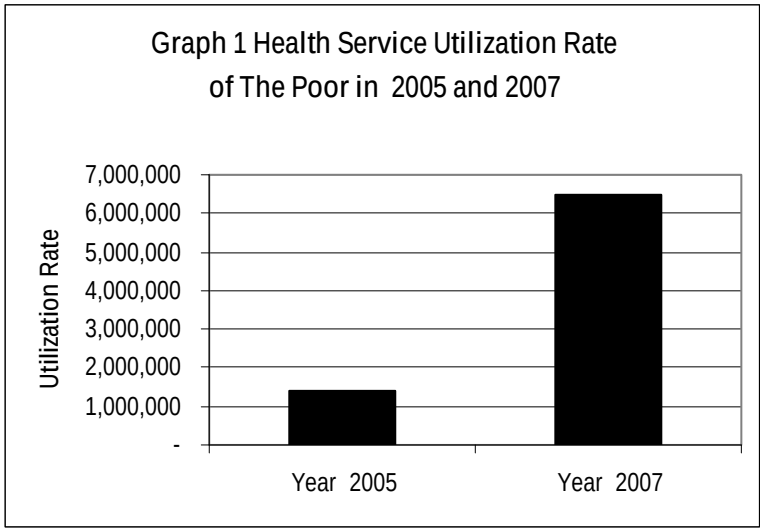
includes a health component. It provides health insurance for some formal sector workers. Under the second tier, private health insurances provided through private insurance companies, self-insured schemes and other initiatives. Under the third tier, the Ministry of Health and local authorities run public health-care systems for the uninsured through Jamkesmas and Jamkesda (local government initiatives) or direct financing to health care providers.

Contribution of local government will address the provision of : health service tariff's difference (compare to the price set by the central government), drugs out of formularium list, transportation cost, and of the poors who are not yet registered in the system. A key issue to be considered is that one must ensure that the poor are effectively reached. This suggests the need to involve local government from the very beginning of the process, such as registration phase. As the law of decentralization has been enacted, local government play an important role in providing health services for the people in their own regions. Some districts have developed Jamkesda or local government initiatives, such as : Kota Balikpapan, Kalimantan started in 2006; Jembrana, Bali since 2003; Sinjai, Sulawesi in 2004; Purbalingga, Central Java established in 2003 and Yogyakarta province in 2003. East Java province has just issued a local regulation on Jamkesda. In addition, Purbalingga provides a different premium subsidy depending on people's income, thereby increasing the beneficiaries outreach. This premium subsidy really increased the utilization of primary care services.

Jamkesmas covers about 76.400,000 people with an almost unlimited benefit package. The broader benefit package of Jamkesmas compare to the civil servant's, is attractive enough for civil servant shifting the membership to a contribution free scheme (Jamkesmas). From a previous study (Mukti, 2008) shown that 79.8 % of the total respondent from 3 different fiscal areas (low, middle and high) mentioned they were eligible to be a member of Askeskin. When the same question asked to the respondents who already engaged as PT. Askes beneficiaries, 32 % of them mentioned the same issue.

The premium for the poor is subsidized by the Government, and is currently IDR 5,000 ($ 0.50) per person per month. At the early phase of transition from JPK-MM Askeskin to Jamkesmas, government allocated preliminary budget as a down payment to the provider both public and private (that have been contracted by the scheme) hospitals. Hospitals are reimbursed by Jamkesmas using a standard package set by the central government. Case mix system has planned to be the near future payment mechanism, known as INA-DRG (Diagnosis-related groups Indonesia). Implementation of INA-DRG has been designed starting from July 2008, but most hospitals were not ready yet. Therefore, it was postponed until September 2008. Hospital felt that shifting and implementing INA-DRG need more infrastructure preparation. In other hand for Primary Health Care, budgets are allocated directly.

This Jamkesmas scheme has improved the financial protection and access to the poor. The utilization of health care services, both in primary care and hospitals, has increased dramatically. *Bed Occupancy Rate* in third class in many hospitals reached more than 90%. The utilization among the poor and near poor increased more than 392% from 1,4 million in 2005 to 6,5 million in 2007 (see graph1). Hospital admission increased 432% from 562.167 in 2005 to 2.431.139 in 2007. While the utilization in Jamkesda varies. From a report from Jamkesda in Jembrana Bali (JKJ) shown a huge increase of the poor who seek for treatment, from 29 % in 2003 (when JKJ was starting) to 80 % at the end of 2004. The patients were not only seeking for treatment but also for family planning services and consultations.



However, the scheme has some challenges; for example, transport costs for those who live far from health facilities are high. In rural areas that many people have geographical barriers to health centres, often the problem is not in the price of services but in the transportation costs. The low distribution of health facilities such as only one health centre or sub health centre is available for several villages or even for one sub-district, can lead the higher travel costs in a various times more than the user fees set by local governments. From a study (Mukti, 2008) tried to record that in middle and low fiscal area, transportation was the second priority to be considered in choosing the benefit package after the type of disease being covered.

The number of poor is estimated by the Central Bureau of Statistics, whereas local governments identify potential beneficiaries for Jamkesmas. The signed list of these beneficiaries is sent to PT Askes and PT Askes will issue membership cards. Those who are not-poor may be covered by their local government. Drastic increasing number of the poor who seek for treatment was shown since in the beginning of implementation. On the other hand, being labeled as poor for getting a free access to the health services, seems became a trend in society. As mentioned before that the total numbers of JPK-MM Askeskin beneficiaries were 76.4 millions in 2007, while in 2006 were 60 millions and only 36.14 millions in 2005. Data on those who are eligible for the scheme need to be validated and clearly defined. Sincronizing source of data is crucial for minimizing the discrepancy between BPS and Local government data. For eligible persons who are not listed as JPK-MM Askeskin member, should be covered by the Local Government as part of the system.

The benefit package includes all services available from the primary care to a more specialized care when needed. In this case beneficiaries will be referred to the hospital where an insured is entitled to the third class. Limitations were set including some high technology diagnostic examination, infertility treatment, supporting instrument such as hearing aids and glasses.

Due to overstretched services in 2007, funds were not sufficient to compensate PT Askes. Budget available for JPK-MM-Askeskin was 2.23 billions Rupiah in 2005, and increased in 2008 as 4.7 billions. In 2007 the budget was 1.826 billions and increased by the end of the year into a total amount of 3.526 billions. While in 2007, instead of 3.526 billions PT.Askes estimated that the budget was not sufficient for 76.4 millions insured people. At least around 4.6 billions should be needed to cover all the expenses.

Shifting from JPK-MM Askeskin to Jamkesmas in 2008, aims to increase efficiency and to improve quality for a better health care delivery for the poor. However, with the transition phase still ahead, improvement and adjustment are on going. Direct payment to the provider using INA-DRG need time to prepare an appropriate infrastructure to run the scheme. Pilot project on implementing INA-DRG has started since 2006 in 15 hospitals in Indonesia. One of the important result was corrective action should be taken by hospital management, especially in pharmaceutical usage and other supplement supplies. Hospital should make a critical evaluation on their own capacity and make an improvement on management system, human resources, communication and performance excellence.

The new Jamkesmas envisages a management of membership to be delivered by PT.Askes, verifying of beneficiaries and distributing member card are part of the task. Including advocation to the local government as partner in defining the members by name, and to promote cooperation for a better role of local government in terms of excess of member's quota set by the central government. Moreover, the consequence of budgeting will be supplemented by the local government. In addressing the case for extending insurance coverage to the poor, local government through Jamkesda play an essential role.

To encourage better management capacity for stakeholders with the experience and financial capacity to operate such schemes, capacity building as an integrated applied training is needed. Often the focus is on the knowledge and skills, while it is much more difficult to change the attitude. A situation can be found, where the knowledge and skills have already achieved but they do not applied in daily work. From a study (Mukti, 2008) shown that 29,7 % of respondents felt not satisfied with services provided by the health care. It was the second barriers of accessing health care, after unable to pay. A better approach of training to strengthen the capacity of health provider is needed, in essence of answering the question of: How would I feel and what would I expect, if I were the patient?

Equally important is that the system can provide a cost-effective service and be sustainable. Various measures were taken, such as tight monitoring. Verificator or verifier were recruited as an idea to verify services provided and finance in administrative manner. They were recruited by Provincial Health Office on behalf of Ministry of Health, based on District Health Office proposal. Medical investigation in some hospitals is another type of tight monitoring, also reduced benefit packages etc. Lesson learned from the past JPK-MM Askeskin due to lack of sufficient fund, Ministry of Health responded by cutting expenditures of many programmes, rationalizing the use of utilities and travel. Other various measures such as internal audit and strengthening capacity for utilization review were also taken.

As in other developing countries, formal-sector workers have access to health insurance, and the poor have some access to health services through social assistance , but large population groups are not covered. Financial feasibility and sustainability of scaling up beneficiaries is being conducted by sharing responsibility and finance with other parties, for example local governments and communities. Involving private sector as a public-private mix can also be an option.

Currently, strategies to integrate the schemes into a consolidated national pool are still in a process of design. Two issues are relevant for the purpose, first is “Integrated Decentralization Management”. Developing a Health insurance system with a concept of integrated decentralization is a response to the judicial review on Law No.40, 2004. As reflected in Law No.32, 2004 on local governance, health insurance can be developed by local government with a non exclusive manner. In

another way around, central government should involve local government in implementing the national system. Funds will be split into three different levels as follows, central level, provincial level and district level. When the fund at each level is not sufficient, they will be the one who responsible to fulfill the gap. Transparency is needed to monitor the use of fund, each level will report to their stakeholders and public. The advantage of this system is high liquidity of fund, local government will be responsible to ensure the cash flow, better transparency, central and local budget has a reciprocal responsibility. Second, local government's contribution in the field of management to the existing Jamkesmas scheme.

Lessons learned from the Jamkesmas scheme can be summarized as follows. In principle, the scheme has made a significant impact on reducing financial barrier of the poor. A higher level of utilization both in primary and secondary as well as tertiary care has been achieved, especially for the poor. To some extent, the increasing of the utilization for both of primary health care and hospitals need to monitor and evaluate. The problem with utilizing the referral system such as portability, is still remaining. Many patients from provincial level referred to the national referral hospital, with limited capacity of beds some of them were not able to access treatment. Long term delay in reimbursement process, can lead to an increasing number of referral cases. Therefore down payment was introduced.

In addition, with limited budget on dissemination of information, Ministry of Health was not able to reach all the target. Within unclear guideline and difficulties to meet the need of clarification, can lead to a dispute environment that is not condusive for providing the best quality of service. In some cases, budget has already sent in Hospital's account but the hospital still afraid of using it even though they were lack of operational fund. This gradually has reduced. The manual as operational guideline is not clear enough to provide information in a daily-work based. A start-up workshop and training was initiated and has been provided in collaboration of Ministry of Health, Universities other third party. Using this media, information and clarification were made in a forum of discussion. A number of the same workshop and training are still needed, because of the limited coverage of participants in the previous event.

There is room for improvement in each of these areas, many recommendation were made. Some effort need to be done such as, splitting the responsibility among the different level as central, provincial and district level. Greater accountability and transparency will be easier to achieve, and greater participation of population all lead to a better system.

Hospitals were experienced in difficulties of covering prescribed drugs out of formularium standard. In this case, Jamkesmas is not responsible for the cost and hospital has to search other sources to cover. There are two possibilities relevant to the cost issue: the extent to which an overprescribed drugs is a high cost care and the extent to which underprescribed drugs or delays in their use may cause even more expense due to complication or more severe in the course of disease. Since the supplies of drugs in Jamkesmas scheme is the responsibility of the hospital management, it has to be carefully planned. Due to cost containment, strong commitment is crucial in shifting to a more rational prescription among the provider.

Many details remain to be worked out about strengthening capacity on management and administrative issues, clear role of various stakeholders and how to engage different actors in the scheme, management information system, financial sustainability and developing benefit packages. Strategies to manage health cost, should include the prevention of health problem so that can reduce the need of treatment cost.