Article : Social Health Insurance Development

Social Health Insurance Development as an Integral Part of the National Health Policy: Recent Reform in the Indonesian Health Insurance System

Adang Setiana
*** Deputy Coordination for Social Welfare, Coordinating Ministry for People's Welfare the Republic of Indonesia, Jakarta, deputi1@menkokesra.go.id*

Abstract

The concept of Social Health Insurance (SHI) has the potential to achieve universal coverage to ensure that every body will get access to medical care he/she needs. In line with the Indonesian National Health Policy that has put the rights to health care in the Constitution amended in 2002, recently the Indonesian government has reformed the National Social Security Law that also provides the foundation for a National Health Insurance Program (NHIP) is enacted on October 19 th , 2004.

The concept of social health insurance has been poorly understood in Indonesia. Most people understand social health insurance as program for the poor. This misunderstanding has caused difficulties in introducing Social Health Insurance in Indonesia; even though a social health insurance program for the government employees has been implemented since 1968, and a social health insurance program for private employees since 1992. Several International organisations, such as GTZ, European Union, ILO, and WHO provided technical assistance to expand health insurance through social security reform. The new Cabinet chaired by President Susilo Bambang Yudoyono has a strong commitment to provide access to health care for every body, a policy that is in line with the concept of social health insurance. As a start, the Ministry of Health has insured about 60 million of the poorest Indonesians by paying their contributions to Askes, the insurance scheme for civil servants. The paper will discuss the existing implementation of SHI in Indonesia, the expansion of coverage to 60 million poorest Indonesians, and the political process and economic feasibility for expansion of social health insurance coverage for 220 million people. A qualitative analysis will be presented on political process, conflict of interests, oppositions, and prolonged debates on the expansion of coverage as a National Health Policy. Short-term evaluation of the existing policy will also be discussed.

Introduction

Indonesia is a country located between Asia and Australia comprising more than 17,000 islands spread over about 5,000 Km length and 3,500 Km width crossing the equator line. More than half of the population are living below € 1.6 a day, the standard poverty line defined by the World Bank. Successful family planning programs implemented in the last thirty years, have controlled population growth, and Indonesia has now an annual population growth rate of 1.3 %. However, due to low education level, the unemployment rate remains high, and the wage level is low. The GDP per capita in 2005 was at € 850 (= US$ 1,050).

Actually, Indonesia had achieved a GDP per capita of more than US$ 1,200 in 1996. But the exchange and financial crisis of 1997 that hit Asia decreased the Indonesian economy followed by political crises resulting in a sharp fall of the country's GDP and economic competitiveness. Currently, the political and economic stability are improved significantly. Although, some small-scaled political unrest occurred in areas, the political commitment of the current government to improve Indonesia's stability in politic, economy and investment conditions, as well as the people's welfare, has been gaining trust from the international community. At the same time, social security, including social health insurance scheme has received significant commitment.

Traditionally, to provide health services, Indonesia provides public health centres, sub-health centres (both stationary and mobile) and public hospitals. User fees are determined by local governments using fee for service payment system. This user fees hinder access to severe health problems where expensive and multiple medical procedures are needed. In addition, people perceive that the services in public health care providers are in poor quality. The better off who demand higher quality services may visit private clinics of the same doctors, who work in the centre, in the afternoon and pay much higher fees. One important factor for equitable access to primary health services is the proximity 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 a staff of at least one physician (general practitioner), several nurses and midwives, other health related personnel and administrative staff. A sub-health centre has at least one nurse or a midwife plus few administrative staff to provide very basic health services to the community. There are currently more than 7,000 health centres and more than 21,000 sub-health centres throughout Indonesia (MoH, 2001). In addition, there are about 50,000 doctors who offer private medical services in their offices with various degrees of charges. It has to be pointed out that there is no regulation on private medical fees in Indonesia.

Public hospitals, providing secondary and tertiary care, consist of four types: (1) small district hospitals (less than 50 beds with four specialists: internist, obstetric-gynaecologist, surgeon, and paediatrician) provide basic secondary care at district level, (2) municipality hospitals (50-100 beds with more than four specialties) deliver secondary and tertiary care for a larger district, (3) provincial hospital (100-400 beds with a variety of specialists) providing more specialised referral care at provincial level, and (4) regional and national hospitals (up to 1,500 beds) designed to provide top (national) referral care. Users of public hospitals are charged according to the number and type of services received (regulated and subsidised fees-for-service system in public facilities). User charges at health centres and third-class rooms of public hospitals cover about 50-80 % of the unit costs, depending on the type of facility. Currently Indonesia has about 700 public hospitals across the country, and in addition there are about 600 private hospitals owned by various organisations and companies. The growing numbers of privately owned and foreign investor hospitals are competing to sell higher quality services to the richest quintile of the population.

Until recently, there has been great inequity in access across income groups, even in public hospital services, and not to mention in private hospitals. Additional problems such as geographical (distance) and cultural (education and beliefs) barriers remain significant factors for low access to hospital services. A study by Thabrany (2005) indicates that in 2001 the richest 10 % of the population consumed more than 400 hospital days per 1,000 people, and members of Askes and Jamsostek (insured) had more than 500 and thus more than the non-insured. On the other hand, hospital days incurred less than 100 per 1,000 people for the poorest 10 % of the population and the uninsured.

Physicians working at health centres and public hospitals are public servants receiving low basic salaries. To supplement their income, every medical staff working with the government is allowed to work in private clinics after office hours. Nurses and midwives are officially not given this kind of privileges; however in practice they also have private practices (especially in small towns or districts). The charges in private clinics run by the same physicians working in public facilities in the morning are 3 to 10 times higher than the public sector fees.

Social Health Insurance Systems before Reform

Social-Economic Survey of 2004 indicated that 20.6 % of the 220 million Indonesians are covered by any kind of health insurance. About seven percent of the population were covered by Askes

(civil-servant social health insurance scheme), the most comprehensive scheme in the country. Currently there are many health insurance schemes, including Askes, social health insurance for private employees (Jamsostek), community health insurance, private commercial health insurance, and employer-covered health insurance. The benefits of those insurance schemes are not comparable one to another, and one should not assume that the 20.6 % of the population covered by health insurance are completely free from financial risks once they are suffer from a severe or catastrophic illness.

The legal bases for the Askes scheme are the Government Regulations No 69/1991, No 6/1992, and No 28/2003. The scheme covers about 13.8 million beneficiaries comprising about 4.5 million affiliated employees and 9.3 million dependents. All civil servants and civil service pensioners, personnel of the armed forces, and veterans are mandated to contribute 2 % of their basic salary monthly, regardless of their marital status. In the past, the government, as employer did not contribute. Starting in 2004, the government started to contribute 0.25 % to match the 2% employee contribution. The government contribution is to be increased annually by 0.25% of employee salary to reach the matching of 2% (fifty-fifty contribution) by 2007. Regardless of an employee's wage level, all beneficiaries are entitled to a comprehensive health benefits considered medically necessary. With regard to non-medical services, however, benefits are differentiated in two different levels. Highest rank civil servants are entitled to first class rooms and boards in public hospital, while the low and middle range employees and their dependents have access to second class rooms only. All other health benefits, deemed medically necessary, are not discriminated by ranks. The Askes scheme is covering benefits delivered in contracted provider network consisting mainly of public health centres and public hospitals. Services rendered out side the network are not covered. Contracted providers are paid prospectively by capitation, per case or per diem. The Ministry of Health and the Ministry of Internal Affairs determine the level of provider payment in order to ensure Askes' financial solvency.

Besides social health insurance for government employees, private employees are covered under Jamsostek scheme. The legal bases for Jamsostek are the Social Security Law No 3/1992 and the Government Regulation No 14/1993. All employers having 10 or more employees are obliged to insure their employees through Jamsostek. However, the Law prescribes that (1) the employers that prefer better health benefits may opt out from the scheme; (2) only employers are mandated to pay contribution of 3 % (for singles) and 6 % (for married employees) of the wages; (3) the scheme set a wage ceiling that has not been changed since 1993 at one million Rupiah (equivalent to 80 €) salary per month, freezing revenues for SHI contributions while costs of medical care continue to rise; (4) the benefits are provided to employees and family members up to a maximum of three children; (5) some expensive medical procedures such as cancer treatment and haemodialysis are not covered fully; and (6) coverage terminated when employees are retired or loss their jobs.

The membership has grown very slowly from 199,000 members in 1991 to 2.74 million people (1.26 million employees) in the year 2005. Due to opt out option, only a small number of employers, mostly small and medium size, are enrolling their employees to Jamsostek while larger employers opted out of Jamsostek to buy private health insurance or provide their other types of health benefits. By 2005 Jamsostek covers less than 5 % of eligible employees. On the other hand, 19.8 million employees were enrolled in the other three Jamsostek programs (occupational accident scheme, death benefit scheme, and provident fund scheme) since the beginning of the implementation of Jamsostek Law, but only about 8 million members were actively paying contribution in 2004 (Jamsostek 2005). Even if all employees were enrolled, it was still relatively small number of workers was covered by social security scheme as a national labour survey in the year 2000 estimated that there were number of 56.2 million workers in Indonesia (ILO 2000). Data from commercial insurance companies showed that total membership of the private health insurance market in 1999 was only about 4 million people (Djaelani 2002). In addition to the two SHI schemes (Askes and Jamsostek), about 2 million people are insured by the military health services system covering all armed forces, civil servants of the Ministry of Defence, and their families.

The New National Agenda of Askeskin: The Most Expansive Initiative

After the monetary crisis that hit Indonesia severely in 1997, a series of political, economic, and social reforms have been undertaken in Indonesia. Decentralisation of authority to local governments to run various public services, including health care and health financing, has been the main focus of the reform. The Indonesian Constitution has been amended three times between 1999 and 2002 that had never before occurred during the first 55 years after the country's independence. One of the most important political measures was the reform of social security including health insurance. The constitutional amendment of 2002 obliged the government to establish social security for all citizens. This amendment was followed by the issuance of a law on the National Social Security System (*Sistem Jaminan Sosial Nasional* - SJSN) at October 19, 2004.

The National Social Security System Law mandates employers, including the government, to provide social health insurance (SHI) through Askes or Jamsostek. In addition, for the first time this law mandates the government formally to pay contributions to the SJSN for the low income population to enable them to earn income. Once they work and earn income above the poverty line, they are mandated to contribute for health benefits. One day after the law was enacted; the new cabinet headed by President Susilo Bambang Yudoyono came into power. In the General Five Year Plan, the new cabinet put high priority to improve access to the Indonesian health care system. The new cabinet is willing to relieve the financial burden of the low income groups to meet their health care needs. The initial new agenda was provision of free hospital services in third class room and board in public hospitals then was formulated in line with the stipulation of the SJSN law. The Ministry of Health then designated Askes to administer the initiative and paid contribution on behalf of the poor to Askes. This concept is in line with which all people are mandated to contribute. The only difference is that while the poor has not adequate income (temporarily) to contribute, the government subsidize contribution.

Although the detailed regulation of the SJSN law on how and how much the government should contribute is still being formulated, the Ministry of Health has taken a bold initiative to start health insurance for the low income under the name of Askeskin. Since 2005, the new initiative (Askeskin) has extended health insurance coverage to an additional of 60 million people (27 % of the population).

Askeskin: The Health Insurance Program for Low Income People

In early 2005, the Bureau of Census identified that Indonesia had about 36 million poor people measured by the national poverty line. Before 2005, to compensate increasing prices and cost of living due to increased of oil prices, the government had provided the poor with a "health card" that entitled the holders to free health care in public health facilities. The fund for the compensation program was distributed directly to public health centres and public hospitals according to the number of the poor individuals within the catchment's area of each facility. The distribution of fund was similar with the concept of capitation payment. Health centres provided primary health care, maternal and child health services, and childbirth; while public hospitals provided outpatient and inpatient care. The evaluation of this program showed many access and equity problems. In one hand utilisation of health services was low while utilisation of public hospitals was much higher than expected. However, the fund allocated to a health facility could not be transferred to other facilities resulting in inequity across facilities and populations.

As a pilot project, Askes had initiated a program to provide health care for the poor to which local government contribute monthly on per capita basis in the Musi Banyuasin district in South Sumatra. The program started in 2002 when Askes was contracted by the Musi Banyuasin

government to cover 20,000 poor individuals, mostly in remote areas. The district government paid a monthly contribution of Rp. 5,000 per person (equivalent to 0.40 € per capita, but this amount was adequate to cover already heavily subsidized user charges in public health facilities). In 2003, the number of poor covered by this program was expanded to 167,000 people (about one-third of the district population) at the same level of contribution. Based on this experience, the Ministry of Health then initiated the extension of the scheme at the national level. This initiative is in accordance with the SJSN law that prescribes mandatory government contribution to insure the poor through a designated social security implementing agency (known as *Badan Penyelenggara Jaminan Sosial,* BPJS—literally means Social Security Corporation, of the law of SJSN).

In November 2004, the Ministry of Health discussed with Askes to administer the scheme planned to start in January 2005. The official designation of Askes was issued by the Ministerial Decree No. 1241 of the Minister of Health in December 2004. At the beginning, the number of poor covered was 36,146,700 individuals and the monthly contribution was fixed at Rp 5,000 (0.40 €) per capita. In January 2005, the program was started and all basic principles of SJSN were implemented. The fund has been managed by Askes on a not-for-profit basis to cover comprehensive health services equivalent to the health benefits for the government employees. The only different with the government employee's scheme is that for inpatient care, the poor entitle to be confined only in a third class public hospital ward. The program was implemented nationwide in order to ensure portability of health care benefits all over the country. This is very important because the availability and the range of services across districts vary widely. The portability principle ensures the poor to obtain tertiary care in public hospitals across districts or provinces.

Six months after the implementation the number of people covered has been increased to 60 million people to accommodate those who are nearly poor who cannot afford to pay the health care needs. The delivery of health benefits has been changed slightly to adjust with previous health card schemes. However, at the beginning of 2006, the whole program resumed to the original concept of covering comprehensive benefits through Askes.

Table 2 : Description of Askeskin Program in 2005 and 2006

Description	First Semester 2005 and in 2006	Second Semester 2005
Scheme	Health insurance, government pays contribution for the poor for comprehensive services to Askes	Direct provision of primary care in public health centres. Health insurance scheme cover inpatient only, in third class ward of public hospitals and participated private hospitals
Number of beneficiaries	Poor population: 36,146,700 persons	The poor and nearly poor: about 60,000,000 persons
Appointment to Askes	To cover comprehensive health care	Outpatient referral and inpatient hospital care
Budget	Rp. 1 Trillion (80 million €) in the first semester of 2005 Rp 3.7 Trillion (about 300 million Euros)	Rp. 1.323 trillion (110 million €)

Registration of the poor

Based on census data collected by the Central Statistics Agency in December 2004, there 36,146,700 poor people to be insured by the Ministry of Health by paying contribution (premium) of Rp 5,000 per person per month. Those data tell the MoH the number of poor people in each district but did not identify names and address of those people. The district government then identified the persons to be insured and sent the names and address to Askes to be issued Askeskin card with which the holders are eligible for comprehensive health benefits. In practice, the identification of beneficiaries was made by the head of a village often with the support of midwives, village's women organisations, and health centres. At the beginning, it was not easy for district government to select the number of poor as allocated by the MoH. Some districts had already similar programs or other poverty alleviation programs with the number of poor (using the district poverty line) resulting in much higher number of poor. The difference in the number of poor between what was insured by the MoH and the number of the poor identified by district sparked protests by the poor and NGOs in some districts to the MoH. Later, the number of poor insured by the MoH via Askes then was increased to 60 million to accommodate the difference.

Benefits and Procedures

Benefits for the Askeskin program comprise of various levels of health care. Primary health care is provided at health centres, sub-health centres, and midwife services in smaller villages. To be eligible to receive benefits of secondary care provided in district hospitals, a referral from a primary health care provider is required. In case of emergency, however, a patient may visit a public hospital without referral from health centre. Accordingly, a district hospital can refer a patient to a provincial hospital in case of there is insufficient medical equipment or a specialists and the patients need tertiary care. Birth delivery services are provided by accredited midwives at village level or by general practicing physicians working in health centres, hospitals or clinics. Because there are more than 13,000 drug names, drugs are covered only if doctors prescribed drugs listed on the formulary developed by Askes, known in Indonesia as DPHO (*Daftar Plafon Harga Obat,* literally means *List of Drugs and Prices* for Askes members). Finally, the Askes scheme covers also other medical supplies, deemed medically necessary.

Due to geographic difficulties in providing basic maternal and child health, other than requiring a freshly graduated general practitioner providing mandatory services in health centres, a midwife is appointed to provide primary maternity care (antenatal care and delivery) in a village. By assigning a midwife in each village to provide services at the village level, access to maternity care was made easier. In addition, the midwife can also provide treatment for simple medical problems and deliver very basic drugs for first aid such as anti-diarrhoea or pain killers or when no physician is available. The midwife is working under the supervision of a physician in health centres.

Problems and Constraints

The Askeskin is the largest expansion of insuring 60 million people in about a year. Certainly, in the fields there were many technical problems identified. The first difficulty was to identify poor households among the poor and near poor who were eligible for receiving financial assistance in the form of paying contribution for a SHI scheme. Before the Askeskin was implemented, local governments were provided with seed money to create some kind of medical aids where local governments match the fund and create local systems. Overall, local governments claimed that they already covered more than 54 million people (however, the benefits were not comprehensive and varied across districts) whereas the Askeskin started with only 34 million people. Of course, even with much less comprehensive benefits, people who were covered before and then were not eligible for Askeskin would be very disappointed and felt discriminated. This problem was finally overcome by adding MoH commitment to cover up to 60 million people in the second semester of 2005.

To avoid misused of Askeskin it was first designed to attach each Askeskin card with a photo of each beneficiary. This ambitious work, putting photo of each individual of more than 36 million people within six months, had caused serious administrative difficulties in taking photo, sticking appropriate photo with name and address of each person, and distributing the card was a nightmare. Finally it was decided distribute the card without photo and to cover all people who claim they are unable to pay user charges as long as they are willing to be confined in a third class room ward in public hospitals, even if they had no Askeskin card. Thus, this decision eliminates administrative problems in identifying each individual eligible for the government program and then if a person actually poor, a card was issued for him/her and the family members.

Due to very large country of Indonesia (it spans over about 5,000 Km from East to West and 1,500 Km from North to South), many hospitals and even health centres in small districts are geographically difficult to reach. Covering health care only, though it relieves financial burden to get health care, it does not solve health problems of the poor. Transportation, often an air plane is needed in remote areas, to health facilities hinder the sick to receive treatments provided through Askeskiin. As the MoH budget remains insufficient to cover transportation costs, local governments were urged to support the program by providing transportation costs or by bringing mobiles clinics, including personnel and medical supplies, to remote areas.

The Progress

Regardless of geographical, technical, and administrative problems, the Askeskin program has brought a reasonable relieve for low income groups to meet their health care needs. The registration of the indigent people has been completed and the cards have been distributed to eligible individuals. The claim data submitted by health care providers indicate evidence that the distribution of cards has been effective, health care providers understood their function, and the poor used their entitlements of health care. At the first semester of 2006, 2.9 million hospital outpatient referral visits and 800.000 inpatient care have been claimed to Askes (Marisi, 2006). Data of 2005 indicated that about 15 % of the beneficiaries utilized health care in public health centres and hospitals. The following tables shows the total utilisation numbers (Table 3), the corresponding claim expenditures (Table 4), and the epidemiological profile of enrolees (Table 5) (Sutadji, 2006).

Table 3 : Reported Health Care Utilisation for the Askeskin Program by September 2005

Description	Utilization	Ratios to Insured
Total visits	50,517,586	15.02
Referral visits	4,051,512	8.02
Secondary health care visits	3,277,438	6.48
Number of admissions	429,223	0.84
Number of haemodialysis cases	437	

Table 4 : Distribution of Health Care Costs Incurred (Claimed) for Expensive Medical Procedures, in Indonesian Currency (Rp) as of September 2005

No	Medical Procedures	Costs incurred (Rp)
1	Heart surgery	3,134,600,000
2	Haemodialysis	643,264,255
3	Cardiac catheterisation	580,000,000
4	Caesarean section	458,831,000
5	Congenital diseases	172,000,000
6	Craniotomy	142,064,000
7	Explorative laparoscopy	119,817,000
8	Radical mastectomy	64,755,000
9	Appendectomy	53,349,724
10	Hysterectomy	15,650,000
Total		5,384,330,979

Table 5 : Distribution of Ten-Most Reported Diagnoses among Askesin Beneficiaries Reported by Health Care Providers as of September 2005

No	Diagnosis	Number of Cases	%
1	Unidentified cause of fever	90,045	34.41
2	Acute diarrhoea	39,985	15.28
3	Upper respiratory tract infections	37,577	14.36
4	Typhoid and paratyphoid fever	25,488	9.74
5	Birth problems/complicated delivery	20,542	7.85
6	Tuberculosis	11,226	4.29
7	Dyspepsia	10,703	4.09
8	Injuries	10,389	3.97
9	Dengue hemorrhagic fever	8,557	3.27
10	Bronchial asthma	7,170	2.74
	Total	**261,681**	**100.00**

Conclusion

Coverage by social health insurance is dominated by formal sector employees and beneficiaries of government subsidized contribution (Askeskin). Among formal sector employments, coverage is limited to all civil servants, military personnel, police personnel, veterans, and less than 5 % of employees of the private sector. In 2005, the government underpinned its strong commitment to increase access to health care by paying social health insurance contributions for the poor as prescribed by the SJSN Law of 2004. This program is known as Askeskin is the largest expansion of health insurance in the Indonesian history, may be in the World. Within two years, the Askeskin program covers about 60 million low income people across Indonesia and improves access to health care significantly. This program is expected to accelerate the reduction of maternal and

infant mortality to speed up attainment of Millennium Development Goals.

References

Central Bureau of Census. Indonesian Profile of 2005. Jakarta, BPS, 2005

Djaelani. F (2002). Development of Health Insurance Products in Indonesia. Paper presented at the Asia-Pacific Summit on Health Insurance, Jakarta, May 22-24, 2002

International Labour Office (2005). Labour Survey of Indonesia. Jakarta, 2000 Jamsostek. Paper presented in SHI seminar. October 18-19 2005. Jakarta.

Marisi U (2006). Askeskin: Concept and the Progress. Paper presented on Workshop on Askeskin for Women Organizations. Cisarua, September 6, 2006

Ministry of Health (MoH) (2001). Health Profile 2000. Pusdakes MOH, Jakarta.

Sutadji, OA (2006). Progress Report of the Askeskin Program. National Planning Workshop on Health. Medan, March 2006

Thabrany, H (2005). The 36 Years Experience of Health Insurance in Indonesia. Paper presented in IHEA Conference, Barcelona, July 10-13, 2005.

RESUME: Adang Setiana

Date of Birth : 8 July 1953

Education : Ph.D. in Environmental Biology, The University of Manchester, UK (1991)

Position : Deputy Coordination for Social Welfare, Coordinating Ministry for People's Welfare, The Republic of Indonesia

Scope of Coordination :

- Implementation of National Social Protection System.
- Empowerment for Disable and Ageing Persons.
- Social Assistance in Emergency Response.

Address :
Jalan Merdeka Barat No.3
Jakarta Pusat 10110
Indonesia.